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October 2025 | OEI-07-24-00340

Vermont Medicaid Fraud Control Unit: 2024 Inspection

HHS Office of Inspector General

REPORT HIGHLIGHTS

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Why OIG Did This Review

OIG administers the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, annually recertifies each Unit, and oversees the Units' performance in accordance with the requirements of the grant. As part of this oversight, OIG conducts periodic reviews of Units and issues public reports of its findings.

What OIG Found

The Vermont MFCU reported 32 indictments, 28 convictions, 10 civil settlements, and nearly $1.3 million in recoveries during our review period of fiscal years 2022–2024. In addition to the findings below, we observed that the Unit undertook several efforts to build strong relationships with other agencies, increase awareness of its mission in the community, and improve its operations.

OIG identified the following four findings:

Despite the Unit taking steps to encourage fraud referrals, the State's Accountable Care Organization did not submit any fraud referrals to the Department of Vermont Health Access Special Investigations Unit or the MFCU during our review period or at any time prior to our review period.

The Unit lacked a central repository for case information, making access to case data and pertinent case documents inefficient.

The Unit maintained positive working relationships with Federal law enforcement partners but lacked established practices on how to coordinate with these partners.

The Unit did not report two of its four adverse actions to the National Practitioner Data Bank within the appropriate timeframes during our review period.

What OIG Recommends

To address the findings, we recommend that the Unit (1) build upon its efforts to increase fraud referrals from relevant partners; (2) implement a comprehensive case management system that allows the Unit to efficiently access, maintain, and report case information and performance data; (3) develop and implement a plan to improve communication and coordination with OIG and other Federal partners; and (4) take steps to report all adverse actions to Federal partners within the appropriate timeframes. The MFCU concurred with all four recommendations.

TABLE OF CONTENTS

BACKGROUND

OBJECTIVE

To examine the performance and operations of the Vermont Medicaid Fraud Control Unit (MFCU or Unit).

Medicaid Fraud Control Units

MFCUs investigate Medicaid provider fraud and patient abuse or neglect, and prosecute those cases under State law or refer them to other prosecuting offices.[1, 2, 3] Under the Social Security Act (SSA), a MFCU must be a "single, identifiable entity" of State government, "separate and distinct" from the State Medicaid agency, and employ one or more investigators, attorneys, and auditors.[4] Each State must operate a MFCU or receive a waiver.[5] Currently, 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operate MFCUs.[6]

MFCUs are funded jointly by Federal and State governments. Each Unit receives a Federal grant award equivalent to 90 percent of total expenditures for new Units and 75 percent for all other Units.[7] In Federal fiscal year (FY) 2024, combined Federal and State expenditures for the MFCUs totaled approximately $396 million, of which approximately $297 million represented Federal funds.[8]

[1] SSA § 1903(q)(3)–(4). Regulations at 42 CFR § 1007.11(b)(1) clarify that a Unit's responsibilities may include the review of complaints of misappropriation of patients' private funds in health care facilities.

[2] As of December 27, 2020, MFCUs may also receive Federal financial participation to investigate and prosecute abuse or neglect of Medicaid beneficiaries in a noninstitutional or other setting. Consolidated Appropriations Act, 2021, Public Law 116-260, Division CC, § 207.

[3] References to "State" in this report refer to the States, the District of Columbia, and the U.S. territories.

[4] SSA § 1903(q).

[5] SSA § 1902(a)(61).

[6] The territories of American Samoa, Guam, and the Northern Mariana Islands have not established Units.

[7] SSA § 1903(a)(6). For a Unit's first 3 years of operation, the Federal Government contributes 90 percent of funding, and the State contributes 10 percent. Thereafter, the Federal Government contributes 75 percent, and the State contributes 25 percent.

[8] OIG analysis of MFCU annual statistical reporting data for FY 2024. The Federal FY 2024 was from October 1, 2023, through September 30, 2024.

OIG Grant Administration and Oversight of Medicaid Fraud Control Units

The Office of Inspector General (OIG) administers the grant award to each Unit and provides oversight of Units.[9, 10] As part of its oversight, OIG conducts a desk review of each Unit during the annual recertification process. OIG also conducts periodic inspections and reviews. Finally, OIG provides ongoing training and technical support to the Units.

In its annual recertification review, OIG examines the Unit's reapplication materials, case statistics, and questionnaire responses from Unit stakeholders. Through the recertification review, OIG assesses a Unit's performance, as measured by the Unit's adherence to published performance standards;[11] the Unit's compliance with applicable laws, regulations, and OIG guidance;[12] and the Unit's case outcomes.

OIG further assesses Unit performance by conducting inspections and reviews of selected Units. These inspections and reviews result in public reports of findings and recommendations for improvement. OIG reports may also include observations regarding Unit operations and practices, including beneficial practices that may be useful to share with other Units. OIG also provides training and technical assistance to Units, as appropriate, during inspections and reviews.

Vermont MFCU

The Vermont Unit is located within the Office of the Attorney General in Montpelier and has statewide jurisdiction to prosecute Medicaid provider fraud and patient abuse and neglect cases. At the time of our inspection in October 2024, the Unit employed nine staff—three attorneys (including the Director), three investigators (one civil investigator and two criminal investigators, including the Chief Investigator), two auditors (including the Chief Auditor), and one paralegal. During the review period of FYs 2022-2024, the Unit spent approximately $4.5 million, with a State share of approximately $1.1 million.

[9] As part of grant administration, OIG receives and examines financial information from Units, such as budgets and quarterly and final Federal Financial Reports that detail MFCU income and expenditures.

[10] The SSA authorizes the Secretary of Health and Human Services to award grants (SSA § 1903(a)(6)) and to certify and annually recertify the Units (SSA § 1903(q)). The Secretary delegated these authorities to OIG in 1979.

[11] The most recent version of the MFCU performance standards is published at 89 Fed. Reg. 76431 (September 18, 2024). The previous version of these standards was applicable to the review period for this inspection and is found at 77 Fed. Reg. 32645 (June 1, 2012). The performance standards were originally published at 59 Fed. Reg. 49080 (September 26, 1994).

[12] OIG occasionally issues transmittals to provide guidance and instruction to MFCUs. OIG transmittals are located at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp.

Referrals

There are several sources from which the Unit may receive Medicaid provider fraud and/or patient abuse or neglect referrals: the Department of Vermont Health Access Special Investigations Unit (SIU),[13] the Accountable Care Organization (ACO),[14, 15] the State Survey and Certification agency,[16] the Office of Professional Regulation (OPR),[17] and local law enforcement, among others. The Director reviews each referral with the Unit and may request additional information from the referring agency if needed to evaluate the referral. The Director decides whether to open a case or decline it for investigation.

Investigations and Prosecutions

Once the Director decides to open a case, it is assigned to a team that consists of an attorney, at least one investigator, and an analyst. Throughout the investigative phase of a case, Unit attorneys provide guidance to the investigators and analysts assist with data analysis. Investigators participate in periodic supervisory reviews of cases with the Director, analysts, and attorney assigned to the case. Upon completion of investigative activities, the matter is either charged as a criminal or civil matter or closed.

[13] The Vermont Agency of Human Services (AHS) is the Medicaid single State agency. The Department of Vermont Health Access (DVHA), through an inter-governmental agreement with the AHS, operates the Vermont Medicaid program. Within DVHA, the SIU is responsible for executing Vermont's Medicaid program integrity activities.

[14] The ACO, OneCare Vermont, distributes payments to contracted network providers for covered services rendered on behalf of Vermont Medicaid enrollees.

[15] According to the MFCU's memorandum of understanding (MOU) with the SIU, the ACO would submit any referrals to the SIU for review prior to the SIU submitting the matter to the MFCU.

[16] The State Survey and Certification agency is known as the Division of Licensing and Protection within the Department of Disabilities, Aging and Independent Living.

[17] OPR protects the public from incompetent or unethical practitioners by ensuring that applicants are qualified; complaints of unprofessional conduct are investigated and prosecuted; and standards of practice are well defined through licensing boards and advisor groups. Vermont Secretary of State, https://sos.vermont.gov/opr/about-opr/. Accessed on June 13, 2025.

Vermont Medicaid Program

As of September 2024, the Vermont Medicaid program served approximately 154,000 enrollees.[18] Approximately 84 percent of Vermont Medicaid enrollees were members of the ACO.[19, 20] In FY 2024, Vermont's Medicaid expenditures were approximately $2.3 billion.[21]

The SIU, the State Survey and Certification agency, and Adult Protective Services investigate allegations or complaints of potential Medicaid fraud and patient abuse or neglect and refer cases to the Unit when appropriate.

Methodology

OIG conducted an onsite inspection of the Vermont MFCU in October 2024. Our inspection covered the 3-year period of FYs 2022–2024. We based our inspection on an analysis of data and information from 7 sources: (1) Unit documentation; (2) financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with the Unit's managers and other selected staff; (5) a review of a random sample of 84 case files from the 379 nonglobal case files that were open at some point during the review period; (6) a review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period; and (7) an onsite review of Unit operations. See the Detailed Methodology on page 16.

In examining the Unit's operations and performance, we applied the published performance standards, but we did not assess adherence to every performance indicator for every standard.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued in 2020 by the Council of the Inspectors General on Integrity and Efficiency. These inspections differ from other OIG evaluations in that they support OIG's direct administration of the MFCU grant program. They are subject to the same internal quality controls as are other OIG evaluations, including internal and external peer review.

[18] Centers for Medicare and Medicaid Services (CMS), *Updated September 2024 State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data*. Accessed on Feb. 20, 2025.

[19] This percentage is associated with data available as of December 2022. CMS, *Vermont All-Payer ACO Model*. Accessed on Feb. 20, 2025.

[20] CMS published its fourth evaluation report of the Vermont All-Payer ACO Model (VTAPM) in June 2024 using data from January 1, 2022, through December 31, 2022.

[21] OIG, *MFCU Statistical Data for FY 2024*. Accessed on March 3, 2025.

PERFORMANCE ASSESSMENT

Case Outcomes

The Unit reported 32 indictments, 28 convictions, and 10 civil settlements for FYs 2022–2024.

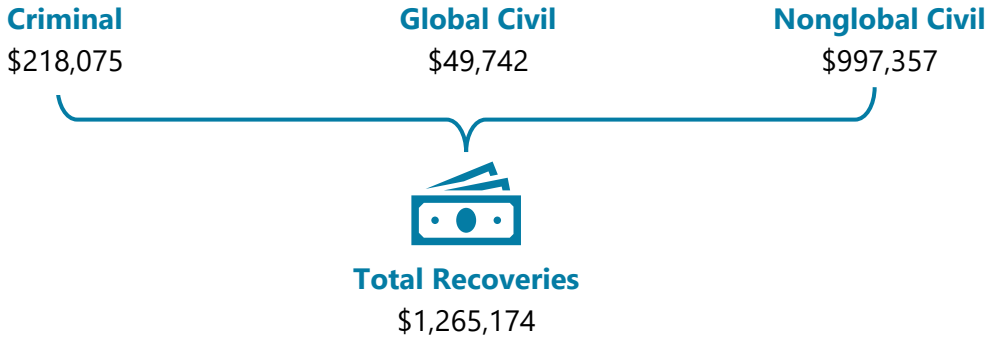
Of the 28 convictions reported by the Unit, 17 involved provider fraud and 11 involved patient abuse or neglect.[22]

32 Indictments

28 Convictions

10 Civil Settlements & Judgments

The Unit reported combined criminal and civil recoveries of about $1.3 million for FYs 2022–2024.



Source: OIG Analysis of Unit statistical data, FYs 2022–2024.
Note: "Global" civil recoveries derive from civil settlements or judgments in global cases, which are cases that involve the U.S. Department of Justice and a group of State MFCUs and are facilitated by the National Association of Medicaid Fraud Control Units (NAMFCU).

[22] OIG provides information on MFCU operations and outcomes but does not direct or encourage MFCUs to investigate or prosecute a specific number of cases. MFCU staff should apply professional judgment and discretion in determining what criminal and civil cases to pursue.

Performance Standard 1: Compliance with Requirements

A Unit conforms with all applicable statutes, regulations, and policy directives.

Observation: The Vermont MFCU generally complied with applicable laws, regulations, and OIG guidance.

From the information we reviewed, we found that the Unit generally complied with applicable requirements. However, we identified two concerns related to the Unit's coordination with Federal partners and to the Unit not reporting two of its adverse actions to the NPDB (see findings on page 10 and 11).

Performance Standard 2: Staffing

A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.

Observation: The Unit maintained adequate staffing levels, and the Unit's staff had extensive experience related to their professional discipline.

We observed that the Unit was either fully staffed or nearly fully staffed during our review period. In FYs 2023–2024, the Unit filled all of its nine approved positions, and it filled seven of its nine approved positions in FY 2022.

We also observed that some Unit staff had extensive experience that was relevant to their respective professional discipline. For example, the Unit's Chief Investigator had been employed with the Unit for more than 21 years and the Unit's Chief Analyst for more than 13 years. Additionally, one Unit investigator had previous experience in law enforcement, and two Unit attorneys previously worked at either the U.S. Attorney's Office (USAO) or the criminal division within Vermont's Office of the Attorney General.

Performance Standard 3: Policies and Procedures

A Unit establishes written policies and procedures for its operations and ensures that staff are familiar with, and adhere to, policies and procedures.

Observation: The Unit maintained policies and procedures, and staff were familiar with them.

The Unit maintained a policies and procedures manual that reflected current operations and practices. Unit staff reported that they were familiar with Unit policies and procedures and could access the manual electronically on the Unit's shared drive or physically in their office.

Performance Standard 4: Maintaining Adequate Referrals

A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.

Observation: The Unit took steps to maintain an adequate volume and quality of patient abuse or neglect referrals.

During our review period, we observed that the Unit maintained positive and productive working relationships with State partners who refer cases of patient abuse or neglect. MFCU staff also attended quarterly meetings with the Division of Licensing and Protection, sharing case updates and participating in joint training. The Unit also reported that it worked to improve its relationships with other referral sources, including the Office of Professional Regulation and local law enforcement, during our review period.

The Unit reported that it received 572 patient abuse or neglect referrals, of which 322 came from the State Survey and Certification agency. Of the 322 referrals from the State Survey and Certification agency, the Unit opened 57 as cases. See Appendix A for all sources of referrals involving fraud and patient abuse or neglect during FYs 2022–2024.

Finding: Despite the Unit taking steps to maintain an adequate volume of fraud referrals, the Unit did not receive any fraud referrals from the ACO.

The MFCU Director took several steps to encourage fraud referrals. Unit staff reported that the Director attended meetings with the SIU and the ACO during the review period to encourage fraud referrals. The Director also provided training to the ACO. The Unit received 26 fraud referrals from the SIU during our review period and opened 20 of those referrals as cases.

Despite the steps to encourage referrals from the ACO, the ACO did not submit any fraud referrals to the SIU or the Unit during our review period or at any time prior to our review period.[23] The ACO staff reported to OIG that the ACO would have referred potential fraud to the MFCU, but it did not have cause to submit any referrals prior to, or during, our review period. The ACO further explained that it did not examine claims-level data to identify fraud, and any complaints that it did receive lacked the type of allegation of fraud that would warrant a referral.

After our onsite review, the ACO announced that it would cease operations with Vermont by the end of 2025. In anticipation of the ACO discontinuing its participation, Vermont applied to participate in CMS's Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model in March 2024. AHEAD is a state total cost of care model for Medicare, Medicaid, and private coverage. The State's health care regulatory board, Green Mountain Care Board, recently agreed to and signed onto the model, to become effective in January 2027.

[23] Under the Vermont All-Payer ACO Model, the ACO began participating in the Vermont Medicaid program in 2017.

Performance Standard 5: Maintaining Continuous Case Flow

A Unit takes steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases.

Observation: The Unit took steps to maintain a continuous case flow and to complete cases within appropriate timeframes.

Consistent with Performance Standard 5, we observed, the Unit took steps to maintain a continuous case flow, including conducting periodic supervisory reviews of cases. According to Unit policy, supervisory reviews of case files should be conducted every 90 days, and Unit staff reported that they engaged in case review meetings more frequently than required. Unit staff reported that the supervisory case review meetings were collaborative and helped ensure regular case progression. The Unit did report assigning a high number of cases to each investigator. However, we did not observe any delays in investigations during our review of case files.

Performance Standard 6: Case Mix

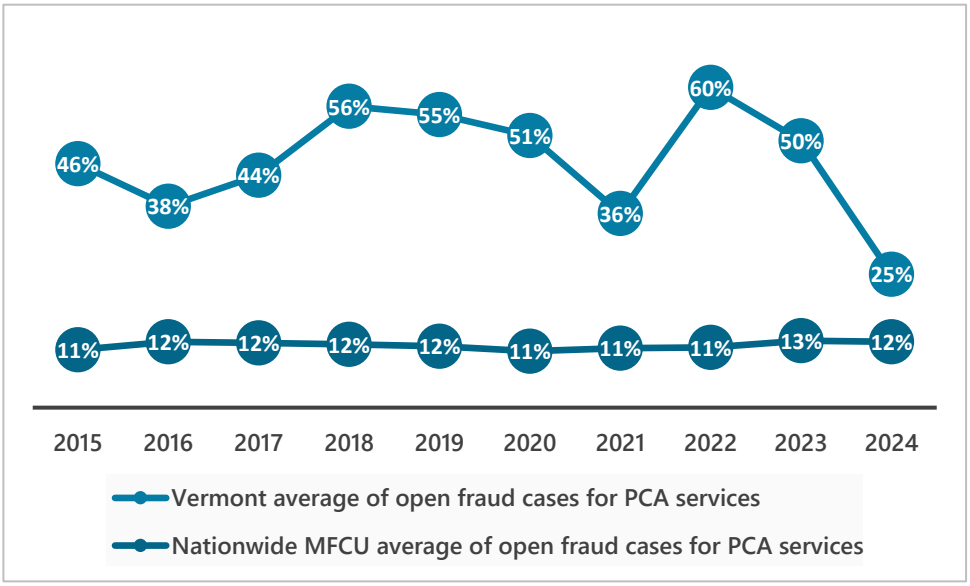
A Unit's case mix, as practicable, covers all significant provider types and includes a balance of fraud and, where appropriate, patient abuse and neglect cases.

Observation: The Unit's case mix included both fraud and patient abuse or neglect cases, and the Unit worked many fraud cases involving personal care attendant services.

The Unit maintained a balanced case mix of provider fraud and patient abuse or neglect cases, which included investigating many personal care attendant (PCA) fraud cases. Of the 379 cases that were open during FYs 2022–2024, 33 percent (125 cases) involved provider fraud and 67 percent (254 cases) involved patient abuse or neglect. During this period, the Unit's cases involved 32 different provider types, including assisted living facilities, nursing facilities, and PCA services.

We observed that the Unit has been investigating many PCA cases for at least the last decade (see Exhibit 1 below). Since 2005, Vermont's AHS has operated a PCA services waiver program to support the State's Medicaid residents aging at home instead of in an institutional setting. The waiver program has allowed nonmedical individuals to carry out activities of daily living services, and AHS has not required these individuals to have provider numbers or licenses to bill for PCA services. To improve their case mix, the Unit has provided training and guidance on increasing the variety of referral types with the SIU. As a result, PCA cases accounted for 25 percent of the Unit's open cases in FY 2024, thus improving the balance of the Unit's case mix.

Exhibit 1: The Unit's percentage of PCA open investigations as compared to the national MFCU average of PCA open investigations from FYs 2015 to 2024



Source: OIG analysis of Unit statistical data, FYs 2015–2024.

Performance Standard 7: Maintaining Case Information

A Unit maintains case files in an effective manner and develops a case management system that allows efficient access to case information and other performance data.

Finding: The Unit lacked a central repository for case information, making access to case data and pertinent case documents inefficient.

Performance Standards 7E and 7F state that the Unit should have a case management system that manages and tracks case information from initiation to resolution and allows for the monitoring and reporting of case information.

We found that the Unit had a bifurcated process for maintaining and tracking its case information. The Unit used its parent agency's electronic case management system as its primary system to maintain documentation associated with the prosecution phase of criminal cases and its own electronic file structure to maintain documentation associated with the investigative phase of cases. Although the primary system can track limited investigative activities such as opening and closing dates and supervisory case file reviews, it was designed for tracking prosecutions, not investigations. Unit investigators reported that they use a separate electronic file structure to create and maintain information about their investigative activities. As a result, they must remember to copy information associated with those investigative activities into the primary system.

Although we did not find significant delays, we found that the Unit's bifurcated process for its case management was inefficient and outdated. From our review of the Unit's cases, we noted that the Unit's case management system was burdensome in tracking cases administratively through the primary case management system and the Unit's electronic file structure. In staff interviews, the Unit described the current case management system as "archaic" and "cumbersome" in its capabilities to upload documents and track cases. Unit staff also reported that the Unit had to track case information using spreadsheets and that preparing the Unit's annual statistical report for submission to OIG required substantial manual effort.

During the onsite visit, we learned that the Unit's parent agency is planning to procure a new case management system in late 2025. The Unit Director reported that she requested to participate in the selection committee of the new case management system. She volunteered for the committee to validate that the new system will meet the Unit's needs and requirements.

Performance Standard 8: Cooperation with Federal Authorities on Fraud Cases

A Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health care fraud.

Finding: The Unit maintained positive working relationships with Federal law enforcement partners but lacked a practice of regular coordination and meetings with these partners.

Federal regulation states that a Unit should communicate regularly and coordinate with OIG and other Federal partners and establish written policy regarding cooperation and coordination with these partners.[24] Vermont participates in the New England Prescription Opioid Strike Force, leading to joint casework with OIG agents, the USAO, and other Federal partners. Further, the Unit worked five joint cases with OIG during the review period and maintained a positive relationship with both OIG and the USAO.

Although the Unit maintained positive working relationships with Federal law enforcement partners, we found that the Unit did not have practices in place for regularly coordinating or deconflicting its cases with OIG or the USAO.[25] The Unit attributed the inconsistent coordination to the fact that the sole OIG agent based in Vermont retired during the review period, and, as a result, the Unit no longer had any local OIG agents to coordinate or deconflict cases. In interviews, staff from OIG and

[24] 42 CFR § 1007.11(e)(1)-(5). Performance Standard 8A also states that the Unit communicates on a regular basis with OIG and other Federal agencies investigating or prosecuting health care fraud in the State.

[25] Deconfliction is a process to identify and avoid any duplicative and overlapping actions by different law enforcement agencies.

the USAO suggested that establishing procedures to consistently deconflict cases with the Unit would be beneficial.

Finding: The Unit did not report two of its four adverse actions to the NPDB within the appropriate timeframes during our review period.

Federal regulations require that any adverse actions resulting from investigations or prosecutions of health care providers be reported to the NPDB within 30 days of the final adverse action.[26, 27] However, the Unit did not report to the NPDB two of its four adverse actions within the appropriate timeframes during our review period. We found that the Unit submitted these two adverse actions more than 90 days after the final action. If a Unit fails to report adverse actions to the NPDB, individuals may be able to find new health care employment with an organization that is not aware of the adverse action against them.

We found that the Unit's policies and procedures addressed how to submit NPDB submissions, but they were not followed. The Unit Director reported that the reason these submissions to the NPDB were delayed involved an internal misunderstanding among staff regarding the Unit's process and requirements for submissions. At the time of the OIG's onsite inspection of the Unit, the misunderstanding had been addressed.

Performance Standard 9: Program Recommendations

A Unit makes statutory or programmatic recommendations, when warranted, to the State government.

Observation: The Unit made written programmatic recommendations during the review period.

Performance Standard 9 states that the Unit should make program or statutory recommendations, when warranted, to the State government. The Unit did not make any formal policy or statutory recommendations to the State government during the review period. However, the Unit made several programmatic recommendations by suggesting proactive provider education to agencies designated with directing services around the state.[28]

[26] 45 CFR § 60.5. Examples of adverse actions include, but are not limited to, health care-related criminal convictions and civil judgments (but not civil settlements), and program exclusions. See SSA §§ 1128E(a)and (g)(1).

[27] The NPDB is intended to restrict the ability of physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice and adverse actions.

[28] Performance standard 9B states that "[t]he Unit, when warranted and appropriate, makes other regulatory or administrative recommendations regarding program integrity issues to the State Medicaid agency and to other agencies responsible for Medicaid operations or funding."

Performance Standard 10: Agreement with Medicaid Agency

A Unit periodically reviews its MOU with the State Medicaid agency to ensure that it reflects current practice, policy, and legal requirements.

Observation: The Unit's MOU with the State Medicaid agency generally reflected current practice, policy, and legal requirements.

The MOU between the Unit and the SIU was amended in July 2024 and reflected current practice, policy, and legal requirements.

Performance Standard 11: Fiscal Control

A Unit exercises proper fiscal control over its resources.

Observation: From our limited review, we did not identify issues in the Unit's fiscal control of its resources.

From the Unit's responses to a detailed fiscal controls questionnaire and OIG follow-up with fiscal staff, we identified no issues related to the Unit's budget process, accounting system, cash management, procurement, electronic data security, property, or personnel. In our inventory review, we accounted for all 11 inventory items.

Performance Standard 12: Training

A Unit conducts training that aids in the mission of the Unit.

Observation: The Unit provided training to its staff that aided in the mission of the Unit, and Unit staff participated in MFCU-related training.

From the information we reviewed, staff composed of each professional discipline completed training that aided in the mission of the Unit, including training provided by the National Association of Medicaid Fraud Control Units.

CONCLUSION AND RECOMMENDATIONS

The Vermont Unit reported case outcomes of 32 indictments, 28 convictions; 10 civil settlements and judgments; and approximately $1.3 million in recoveries for FYs 2022–2024. From the information we reviewed, we observed that the Unit took steps to maintain a continuous case flow, maintained positive working relationships with Federal law enforcement partners, and maintained a training plan for each professional discipline. However, we identified four areas in which the Unit should improve its adherence to performance standards or program requirements.

To address the findings identified in this report, we made the following recommendations to the Vermont Unit.

Build upon its efforts to increase fraud referrals from relevant partners

The Unit should develop and implement a plan to ensure that it receives an adequate volume of referrals from the SIU, ACO, and other applicable entities associated with Vermont's Medicaid program. For those contracts between the Medicaid agency and applicable referral sources, the Unit could request to review the contract provisions that govern fraud referrals and provide recommendations, as appropriate. Although the Unit reported meeting with the SIU and ACO, it should assess whether it should adopt another approach for ensuring that it receives fraud referrals. Beyond encouraging its partners to submit fraud referrals, the Unit could develop and implement enhanced joint training and community outreach among its referral sources and partners.

Implement a comprehensive case management system that allows the Unit to efficiently access, maintain, and report case information and performance data

At the time of the inspection, the Unit reported that its parent division was in the process of replacing the Unit's primary case management system, with a new system operational in late 2025. We recommend that the Unit, in adopting this system or another alternative, take steps to ensure that the system meets the Unit's needs for efficiently accessing and maintaining case information and performance data. This could include implementing a single case management system that fully meets the Unit's needs or implementing a system that can efficiently synchronize files from the Unit's electronic file structure. Additionally, the Unit should take steps to ensure that the new system includes functionality that assists in accurately reporting case information and other performance data to OIG and other agencies, as appropriate.

Develop and implement a plan to improve communication and coordination with OIG and other Federal partners

The Unit should develop and implement a plan to ensure that it communicates and coordinates with OIG and other Federal partners on a consistent basis. As part of the process, the Unit should obtain input from Federal partners that addresses communication and coordination, and case deconfliction. Once developed, the process should be documented in the Unit's policies and procedures to ensure that existing and future staff adhere to the policy.

Take steps to report all adverse actions to Federal partners within the appropriate timeframes

The Unit should take steps to ensure that it reports all adverse actions to the NPDB within 30 days of the action. The Unit should develop a process to ensure that staff report adverse actions consistent with its policies and procedures. These steps could include implementing automated reminders for staff to submit adverse actions in accordance with federal regulations.

UNIT COMMENTS AND OIG RESPONSE

The Vermont MFCU concurred with all four of our recommendations.

First, the Unit concurred with our recommendation to build upon its efforts to increase fraud referrals from relevant partners. The Unit reported that it will continue to encourage referrals from the ACO before the ACO ceases operations in December 2025. Further, the Unit will work with the SIU to include fraud referrals as part of its program integrity efforts for any new health care delivery model, as appropriate.

Second, the Unit concurred with our recommendation to implement a comprehensive case management system. The Unit reported that the Vermont Attorney General's office is in the process of obtaining a new case management system, which is scheduled for implementation by fall of 2025.

Third, the Unit concurred with our recommendation to develop and implement a plan to improve communication and coordination with OIG and other Federal partners. The Unit reported that it updated its policies and procedures manual to include protocols for coordination with Federal partners, would be enrolling in a shared deconfliction system with OIG, and began discussions with local Federal partners on setting regularly scheduled meetings.

Fourth, the Unit concurred with our recommendation to take steps to report all adverse actions to Federal partners within the appropriate timeframes. The Unit reported that it had already updated its policy and procedures manual to clarify the responsibilities of employees who report adverse actions and added to its closing memo a mandatory field to verify its timely Federal submissions.

We appreciate the steps the Unit has taken and plans to take to address the recommendations in the report. We believe that these steps will improve the Unit's adherence to performance standards and program requirements and will strengthen its operations. To close these recommendations, the Unit should submit to OIG documentation of its implementation of each recommendation within 6 months of the issuance of this report.

For the full text of the Unit's comments, see Appendix B.

DETAILED METHODOLOGY

Data Collection and Analysis

We collected and analyzed data from the seven sources described below to identify any opportunities for improvement and instances in which the Unit did not adhere to the MFCU performance standards or was not operating in accordance with laws, regulations, or policy transmittals. We also used the data sources to make observations about the Unit's case outcomes as well as the Unit's operations and practices concerning the performance standards.

Review of Unit Documentation

Before the inspection, we reviewed the Unit's recertification materials for FYs 2022–2024, including (1) the Unit Director's recertification questionnaires; (2) the Unit's MOU with the State Medicaid agency; (3) the program integrity director's questionnaires; and (4) the OIG Special Agent in Charge questionnaires. We also reviewed the Unit's policies and procedures manual and the Unit's self-reported case outcomes and referrals included in its annual statistical reports for FYs 2022–2024. Additionally, we examined the recommendations from the 2013 OIG onsite review and the Unit's implementation of those recommendations.

Review of Unit Financial Documentation

We conducted a limited review of the Unit's control over its fiscal resources. Before the onsite inspection, we analyzed the Unit's responses to a questionnaire about internal controls and conducted a desk review of the Unit's quarterly financial reports. We also selected all 11 items from the Unit's inventory list maintained in the Unit's office and verified those items onsite.

Interviews with Key Stakeholders

In July and August 2024, we interviewed key stakeholders, including officials in the Department of Vermont Health Access, ACO, as well as OIG agents and the staff in the U.S. Attorney's Office. We focused these interviews on the Unit's relationships and interactions with the stakeholders, as well as opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management and other staff.

Onsite Interviews with Unit Management and Other Selected Staff

We conducted structured interviews with the Unit's management and other selected staff in October 2024. Of the Unit management, we interviewed the Director and Chief Investigator. Of the other staff, we interviewed two attorneys, two investigators, and one auditor. In addition, we interviewed the supervisor of the Unit—Legal Division Chief of the Attorney General's Office. We asked these individuals questions related to (1) Unit operations; (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance; (3) opportunities for the Unit to improve its operations and/or performance; (4) clarification regarding information obtained from other data sources; and (5) the Unit's training and technical assistance needs.

Onsite Review of Case Files

To craft a sampling frame, we requested that the Unit provide us with a list of cases that were open at any time during FYs 2022–2024 and include the status of each case; whether the case was criminal, civil, or global; and the dates on which the case was opened and closed, if applicable. The total number of cases was 609.

We excluded all global cases from our review of the Unit's case files because global cases are civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a group of State MFCUs. We excluded 230 global cases and public record requests, leaving 379 case files.

We then selected a simple random sample of 84 cases from the population of 379 cases. This sample allowed us to make estimates of the overall percentage of case files with various characteristics with absolute precision of no more than +/- 10 percent at the 95-percent confidence level.

We reviewed the 84 case files for adherence to the relevant performance standards and compliance with statutes, regulations, and policy transmittals. During the review of the sampled case files, we consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation.

Review of Unit Submissions to OIG and the National Practitioner Data Bank

We also reviewed all 28 convictions submitted to OIG during the review period and all 4 adverse actions submitted to the NPDB during the review period. We reviewed whether the Unit submitted information on all sentenced individuals and entities to OIG for program exclusion and all adverse actions to the NPDB for FYs 2022–2024. We also assessed the timeliness of the submissions to OIG and the NPDB.

Onsite Review of Unit Operations

During the onsite inspection, we observed the workspace and operations of the Unit's office in Montpelier. We observed the Unit's offices and meeting spaces; security of data and case files; location of select equipment; and general functioning.

APPENDICES

Appendix A: Unit Referrals by Source for Fiscal Years 2022-2024

Referral Source	FY 2022		FY 2023		FY 2024		3-Year Total		
	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Total
Accountable Care Organization (ACO)	0	0	0	0	0	0	0	0	0
Adult Protective Services	5	34	2	45	9	20	16	99	115
Anonymous	1	3	0	0	0	0	1	3	4
HHS-OIG	1	0	2	0	1	2	4	2	6
Law enforcement—other	1	8	1	8	0	3	2	19	21
Licensing Board	2	14	3	1	6	2	11	17	28
Local Prosecutor	0	0	0	1	2	3	2	4	6
Long-Term Care Ombudsman	0	0	1	1	0	2	1	3	4
Medicaid agency—Program Integrity	4	1	9	2	13	3	26	6	32
Private Citizen	4	6	7	4	9	8	20	18	38
Private Health Insurer	6	0	0	0	0	0	6	0	6
Provider	0	4	8	1	4	3	12	8	20
Provider Association	9	8	18	4	18	5	45	17	62
State Survey and Certification agency	2	82	2	138	3	102	7	322	329
State agency—other	9	3	3	12	20	17	32	32	64
Other	3	2	7	10	8	10	18	22	40
Subtotal	**47**	**165**	**63**	**227**	**93**	**180**	**203**	**572**	**775**
Total	**212**		**290**		**273**		**775**		

Source: OIG analysis of Vermont MFCU data, 2024

Appendix B: Unit Comments

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August 12, 2025

Ann Maxwell
Deputy Inspector General for Evaluation and Inspections
Office of Inspector General Office of Evaluations and Inspections
Medicaid Fraud Policy and Oversight Division
U.S. Department of Health and Human Services
330 Independence Avenue, SW Rm. 5660 Washington, DC 20201

Re: OEI-07-24-00340 - Vermont Medicaid Fraud Control Unit: 2024 Inspection

Dear Deputy Maxwell,

Thank you for sharing HHS-OIG's draft report, *Vermont Medicaid Fraud Control Unit: 2024 Inspection, OEI-07-24-00340*, dated July 9, 2025. We have reviewed the report and your recommendations.

We appreciate the time that the Office of Inspector General put into the review of our Medicaid Fraud Control Unit's operations, and we thank the review team for recognizing that the Unit maintains strong relationships with its State partners, has maintained an adequate volume and quality of case referrals, and has worked to increase awareness of its mission in the community.

HHS-OIG's draft report includes four recommendations for areas of improvement. As this letter will demonstrate, we share the review team's goals of improving the operations of the Unit, and we are committed to meeting the highest standards of performance expected of the program. Each recommendation is discussed below, as well as the affirmative steps the Unit has taken in response.

Recommendation 1: the Unit build upon its efforts to increase fraud referrals from relevant partners.

> Finding: despite the Unit taking steps to encourage fraud referrals, the State's Accountable Care Organization did not submit any fraud referrals to the Department of Vermont Health Access Special Investigations Unit or the MFCU during our review period or at any time prior to our review period.

Response: the Unit generally concurs with this recommendation. The Unit acknowledges that the State's ACO, OneCare, should be submitting fraud referrals to the State. It seems worth noting, since OneCare's inception in 2017, they have not referred a single instance of fraud, waste, or abuse the State, despite their contract clearly delineating the responsibly to do so. As recognized in the draft report, the Unit took numerous steps to encourage referrals from OneCare. This included providing training on fraud, waste and abuse, and the mission of the Unit. The Director and Chief Investigator also attended meetings with the Department of Vermont Health Access Special Investigations Unit ("SIU") and members of OneCare's compliance team. We also discussed with the single state agency our concerns about the lack of referrals from OneCare. Before OneCare ceases operations in December 2025, the Unit will continue to attend the compliance meetings and continue to encourage referrals.

As Vermont moves forward with participation in the All-Payer Health Equity Approaches and Development model ("AHEAD"), the Unit plans to work with the single state agency to ensure that this new model's program integrity activities are robust and when appropriate, requesting to review contracts and contract provisions that govern fraud referrals and provide recommendations.

Recommendation 2: implement a comprehensive case management system that allows the Unit to efficiently access, maintain, and report case information and performance data.

> Finding: the Unit lacked a central repository for case information, making access to case data and pertinent case documents inefficient.

Response: the Unit concurs with this recommendation. The Vermont Attorney General's office has been in the process of obtaining a new case management system for the office. The Unit has been heavily involved in the selection process and plans to continue that involvement during implementation. At this time AGO leadership's focus for the case management system will be implementing the data management portion of the system. However, the Unit is advocating document management be employed as well and as soon as possible. The office expects to implement the new case management system fall of 2025 with MFRAU being one of the first to integrate the system into our work.

Recommendation 3: develop and implement a plan to improve communication and coordination with OIG and other Federal partners.

Finding: the Unit maintained positive working relationships with Federal law enforcement partners but lacked a practice of regular coordination and meetings with these partners.

Response: the Unit concurs with this recommendation and the Unit has already taken steps to implement this recommendation. The Unit's manual is in the process of being updated to set a more robust protocol for coordination with federal partners. The Unit's investigators will be tasked with enrolling in "DICE" and will enter information into "DICE" for deconfliction as appropriate. In addition, the Unit Director has begun discussions with local federal partners, including USAO-VT and the Boston Regional Office of Investigations, with the goal of setting regularly scheduled meetings.

Recommendation 4: take steps to report all adverse actions to Federal partners within the appropriate timeframes.

Finding: the Unit did not report two of its four adverse actions to the NPDB within the appropriate timeframes during our review period.

Response: The Unit has already taken steps to correct the timely reporting of adverse actions to the NPDB. This includes working to update the Unit's policy and procedures manual to clarify the responsibilities of relevant Unit members and adding a new mandatory field to the Unit's closing memo. The Unit believes these changes will help ensure that reportable actions are properly submitted to the NPDB.

Thank you for the opportunity to respond to the draft report for the Vermont Medicaid Fraud Control Unit 2024 Inspection. We again appreciate the time and effort OIG took to conduct its review and write its report. As the Director, I am committed to ensuring compliance with all regulations and recommendations as they pertain to the Unit. The Vermont Attorney General's Office looks forward to continued collaboration with HHS-OIG. Please do not hesitate to contact me should you have any follow up questions.

Sincerely,

Elizabeth L. Anderson

Elizabeth L. Anderson, Director

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