Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW YORK STATE MEDICAID FRAUD CONTROL UNIT: 2011 ONSITE REVIEW

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EXECUTIVE SUMMARY: NEW YORK STATE MEDICAID FRAUD CONTROL UNIT, 2011 ONSITE REVIEW (OEI-02-11-00040)

WHY WE DID THIS STUDY

The Office of Inspector General is responsible for overseeing the activities of all Medicaid Fraud Control Units (MFCU or Unit). As part of this oversight, the Office of Evaluation and Inspections conducts periodic reviews of all Units and prepares public reports based on these reviews. The reviews describe the Units' caseloads; assess performance in accordance with the 12 MFCU performance standards, identifying any opportunities for improvement; identify any instances of noncompliance with laws, regulations, or policy transmittals; and highlight any noteworthy practices.

HOW WE DID THIS STUDY

We based our review on an analysis of data from seven sources: (1) a review of policies and procedures and documentation on the Unit's operations, staffing, and caseload; (2) structured interviews with key stakeholders; (3) a survey of Unit staff; (4) structured interviews with the Unit's management; (5) an onsite review of case files; (6) an onsite review of financial documentation; and (7) an onsite review of Unit operations.

WHAT WE FOUND

From fiscal years 2008 to 2010, the New York Unit filed criminal charges against more than 400 defendants, obtained over 400 convictions, and was awarded more than $750 million in recoveries. Although the number of referrals to the Unit increased during this time, the number of cases that the Unit opened and closed decreased. Additionally, the Unit did not establish annual training plans for each of the three professional disciplines—i.e., for auditors, investigators, or attorneys—and provided limited training opportunities to staff. The Unit also lacked policies and procedures to reflect many of its current practices, and its case files lacked consistency and uniform supervisory reviews. Finally, the Unit lacked a number of internal controls. At the same time, our review found no evidence of significant noncompliance with applicable laws, regulations, or policy transmittals. Further, Unit managers, staff, and stakeholders cited a number of the Unit's noteworthy practices, including its approach to patient abuse and neglect cases, its list of ongoing investigations (created to avoid conflicts among investigating agencies), and its use of technology.

WHAT WE RECOMMEND

We recommend that the New York MFCU: (1) seek to expand staff sizes to reflect the number of staff approved in the Unit's budget; (2) establish annual training plans and increase the number of training opportunities available to staff; (3) ensure that its memorandum of understanding, its policies, and its procedures reflect current practices; (4) ensure that its case files are maintained with greater consistency and reviewed more frequently; and (5) establish written policies and procedures for certain internal controls. The New York Unit concurred with all five of our recommendations.

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OBJECTIVES

To conduct an onsite review of the New York Medicaid Fraud Control Unit (MFCU or Unit).

BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under State law.[1] Under the Medicaid statute, each State must maintain a certified Unit unless the Department of Health and Human Services (HHS) determines that operation of a Unit would not be cost-effective because minimal Medicaid fraud exists in that State and that the State has other adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.[2] Currently, 49 States and the District of Columbia have created such Units.[3] In fiscal year (FY) 2011, HHS and the States spent a combined total of $208.6 million on these Units. Of this amount, $40.5 million, or 19.4 percent of the total, was spent on the New York Unit.[4]

Each Unit must employ sufficient staff consisting of at least an investigator, an auditor, and an attorney to carry out its duties and responsibilities in an effective and efficient manner.[5] The staff review complaints provided by the State Medicaid agency and other sources and determine their potential for criminal prosecution. Collectively, in FY 2011 the 50 Units obtained 1,230 convictions as well as 906 civil settlements or judgments.[6] That year, the Units reported recoveries of more than $1.7 billion.[7]

Units are required to have either Statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an office with

[1] Social Security Act § 1903(q).

[2] Social Security Act §§ 1902(a)(61) and 1903(q)(3). Regulations in 42 CFR § 1007.11(b)(1) add that the Unit's responsibilities may include reviewing complaints of misappropriation of patients' private funds in residential health care facilities. For the purposes of this study, misappropriation of patient funds is combined with patient abuse and neglect.

[3] North Dakota and the territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands have not established Units. For the purposes of this review, we refer to the District of Columbia as a State.

[4] Office of Inspector General (OIG) analysis of Office of Management and Budget Forms SF-269 for FY 2011.

[5] Social Security Act § 1903(q)(6); 42 CFR § 1007.13.

[6] OIG, *State Medicaid Fraud Control Units Fiscal Year 2011 Grant Expenditures and Statistics*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2011.asp on June 14, 2011.

[7] Ibid.

such authority.[8] In 43 States, the Units are located within Offices of State Attorneys General; in the remaining 7 States, the Units are located in other State agencies and refer cases to other offices with prosecutorial authority.[9] Additionally, each Unit must be a single identifiable entity of State government, distinct from the single State Medicaid agency, and each Unit must develop a formal agreement, e.g., a memorandum of understanding (MOU), that describes the Unit's relationship with that agency.[10]

Oversight of the MFCU Program

The Secretary of HHS delegated to OIG the authority both to annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs in operating a certified Unit.[11] All States currently operating Units are reimbursed by the Federal Government on a 75-percent matching basis, with the States required to contribute the remaining 25 percent.[12] In order to receive Federal reimbursement, each Unit must submit an initial application to OIG.[13] OIG reviews the application and notifies the Unit if the application is approved and the Unit is certified. Approval and certification is for a 1-year period; the Unit must be recertified each year thereafter.[14]

Under the Medicaid statute, States must operate Units that effectively carry out their statutory functions and meet program requirements.[15] To clarify the criteria that OIG applies in assessing whether a Unit is effectively carrying out these functions and meeting program requirements, OIG developed and issued 12 performance standards.[16] Examples include maintaining an adequate caseload through referrals from several sources, maintaining an annual training plan for all three of the professional disciplines (i.e., for auditors, investigators, and attorneys),

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[8] Social Security Act § 1903(q)(1).

[9] In most States, the Unit shares responsibility for protecting the integrity of the Medicaid program with the section of the State Medicaid agency that functions as the Program Integrity Unit. Some States also establish an Office of Medicaid Inspector General that conducts and coordinates fraud, waste, and abuse activities for the State agency.

[10] Social Security Act § 1903(q)(2); 42 CFR § 1007.9(d).

[11] The portion of funds reimbursed to States by the Federal Government for its share of expenditures for the Federal Medicaid program, including the MFCUs, is called the Federal Financial Participation (FFP).

[12] Social Security Act § 1903(a)(6).

[13] 42 CFR § 1007.15(a).

[14] 42 CFR §§ 1007.15(b) and (c).

[15] Social Security Act § 1902(a)(61).

[16] 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Performance%20Standards.pdf on November 22, 2011. OIG revised these standards on June 1, 2012 (see 77 Fed. Reg. 77106). The standards referred to throughout this report are those from 1994, which were in effect at the time of our review.

and establishing policy and procedure manuals to reflect the Unit's operations. See Appendix A for a complete list of these performance standards.

New York State MFCU

The New York Unit is located within the Office of the New York State Attorney General and has the authority to prosecute Medicaid cases. At the time of our review, it had 283 employees. The Unit is composed of seven field offices located around the State. Although most of its staff work on Medicaid fraud cases, the Unit also includes a Patient Protection Section, which focuses exclusively on the investigation and prosecution of patient abuse and neglect cases. The Unit also includes a Civil Enforcement Division, which handles complex civil fraud investigations, including *qui tam* (whistleblower) actions.

The Unit receives referrals of fraud, abuse, or neglect primarily from the State Medicaid Agency, which includes the Office of the Medicaid Inspector General. Other sources of referrals include law enforcement agencies, the State Long Term Care Ombudsman, and other State agencies. From FYs 2008 to 2010, the Unit received an average of 879 referrals each year.

When the Unit receives a referral, it makes a determination as to whether it should be opened as a criminal or civil case, or whether it should be referred to another agency. In addition to receiving referrals, the Unit may generate its own cases. Once a case is opened, the Unit may close it through criminal prosecution, civil action, or administrative action. The Unit may also close a case if there is insufficient evidence or by referring it to another agency.

Previous Review

In 2005, OIG conducted an onsite review of the New York Unit. Based on the findings in that report, OIG recommended that the Unit develop internal policies and procedures for conducting undercover investigations, ensure that Unit equipment is not used by non-Unit staff to conduct non-Medicaid related activities, reinstitute the annual training conferences for its staff, and provide specialized training to investigators in its Patient Protection Unit. The report also noted that the Unit should consider recruiting and retaining more investigative staff with medical/technical expertise.

METHODOLOGY

We based our review on an analysis of data from seven sources: (1) a review of policies and procedures and documentation on the Unit's operations, staffing, and caseload; (2) structured interviews with key stakeholders; (3) a survey of Unit staff; (4) structured interviews with the Unit's management; (5) an onsite review of case files; (6) an onsite review of financial documentation; and (7) an onsite review of Unit operations.

We analyzed data from all seven sources to describe the caseload and assess the performance of the Unit, identifying any opportunities for improvement. We also analyzed the data to identify any instances in which the Unit did not fully meet the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.[17] Lastly, we identified the Unit's noteworthy practices.

Data Collection and Analysis

Review of Unit documentation. We requested and reviewed policies and procedures and documentation on the Unit's operations, staffing, and caseload, including its annual reports, quarterly statistical reports, and responses to recertification questionnaires. We also requested and reviewed the Unit's data describing how it detects, investigates, and prosecutes Medicaid cases. Data collected included information such as the number of referrals received by the Unit and the number of investigations opened and closed. We requested and reviewed these data for the 3-year period of FYs 2008 to 2010.

Interviews with key stakeholders. We conducted structured interviews with key stakeholders who were familiar with the operations of the Unit. Specifically, we interviewed the Deputy Medicaid Inspector General in the State Medicaid Agency, an official in the U.S. Attorney's office, and the Special Agent in Charge for OIG's New York region.

Survey of Unit staff. We conducted an electronic survey of nonmanagerial Unit staff. In total, we sent the survey to a simple random sample of 80 of 266 nonmanagerial staff. We received responses from 76 of them, a 95 percent response rate.[18] Our questions focused on opportunities for improvement and noteworthy practices of the Unit. The survey also sought information about the Unit's compliance with applicable laws and regulations.

[17] All relevant regulations, statutes, and policy transmittals are available online at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp.

[18] At the time of our review, there were 283 staff; we sent surveys to 80 nonmanagerial staff.

Interviews with Unit management. We conducted onsite and videoconference interviews with 17 Unit managers, including the Director and Deputy Director of the Unit, the Regional Office Directors, and the supervisors of the three professional disciplines.[19] We asked these managers to provide us with additional information needed to better understand the Unit's operations, as well as to identify opportunities for improvement and noteworthy practices. We used the information obtained from stakeholders and nonmanagerial staff to develop questions for the onsite interviews with Unit management.

Onsite review of case files. We selected a simple random sample of 94 case files from the Unit's 1,887 cases that were open at some point during FYs 2008 to 2010. We reviewed the 94 sampled case files and the Unit's processes for monitoring the status and outcomes of cases.

Onsite review of financial documentation. We reviewed certain financial documents from the Unit, such as the Unit's equipment inventory and purchase records, to determine compliance with applicable laws and regulations, as well as to determine whether additional internal controls were needed.

Onsite review of Unit operations. While onsite, we reviewed the Unit's operations, including its process for receiving referrals, its electronic case management system, its method for case file storage and security, and its general operations.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

[19] We interviewed all 11 of the Unit's managerial staff and 6 of the Unit's 24 supervisors. These 17 Unit managers and supervisors will hereinafter be referred to as "managers."

FINDINGS

From FYs 2008 to 2010, the New York Unit filed criminal charges against more than 400 defendants, obtained over 400 convictions, and was awarded more than $750 million in recoveries

From FYs 2008 to 2010, the Unit filed criminal charges against 452 defendants, of which 332 were charged with provider fraud and 120 were charged with patient abuse and neglect. The Unit also obtained 423 convictions during this 3-year period.[20] Further, it obtained monetary settlements and court orders requiring the payment of $753.9 million, including $29.5 million in criminal restitution.

Additionally, as part of its efforts against patient abuse and neglect, the Unit used hidden cameras to uncover and deter the criminal abuse and neglect of nursing home residents. In 2010, for example, the Unit reported that 22 health care workers from 2 nursing homes were charged using evidence from hidden camera investigations and 10 convictions were obtained in these and prior hidden camera cases.

Although the number of referrals to the Unit increased, the number of cases the Unit opened and closed decreased

According to the performance standards, the Unit should maintain an adequate workload through referrals from the single State agency and other sources. The Unit should also have a continuous case flow. As noted earlier, the Unit receives referrals from the State Medicaid Agency which includes the Office of Medicaid Inspector General as well as a variety of other sources, such as law enforcement agencies, the State Long Term Care Ombudsman, and other State agencies. From FYs 2008 to 2010, the number of referrals received by the Unit increased by 22 percent—from 770 to 940. (See Table 1.)

[20] These 423 convictions are not necessarily derived from the 452 charges of criminal fraud filed during the same period. Some of these convictions may have derived from criminal charges that occurred prior to the 3-year period. Similarly, not all of the criminal charges from this 3-year period may have resulted in convictions during this period.

Table 1: Unit Referrals from FYs 2008 to 2010, by Type

Type of Investigation	FY 2008	FY 2009	FY 2010
Fraud	352	446	470
Patient Abuse and Neglect	418	481	470
Total	**770**	**927**	**940**

Source: OIG analysis of New York MFCU data, 2011.

When a referral is received, the Unit makes a determination as to whether it should be opened as a criminal or civil case, or whether it should be referred to another agency.[21] Over the past 3 years, the number of cases the Unit opened decreased by 25 percent. In FY 2008, the Unit opened 421 cases, compared to 316 in FY 2010. (See Table 2.)

Table 2: Cases Opened from FYs 2008 to 2010, by Type*

Type of Investigation	FY 2008	FY 2009	FY 2010
Fraud	376	342	279
Patient Abuse and Neglect	45	63	37
Total	**421**	**405**	**316**

*Includes only new cases opened during the FY.

Source: OIG analysis of New York MFCU data, 2011.

Once a case is opened, the Unit may close it through criminal prosecution, civil action, or administrative action. The Unit may also close a case if there is insufficient evidence or by referring it to another agency. Since FY 2008, the number of cases closed by the Unit decreased by 20 percent. In FY 2008, the Unit closed 364 cases, compared to 291 in FY 2010. (See Table 3.) See Appendix B for information about the Unit's cases by provider category.

Table 3: Cases Closed from FYs 2008 to 2010, by Type

Type of Investigation	FY 2008	FY 2009	FY 2010
Fraud	311	288	244
Patient Abuse and Neglect	53	49	47
Total	**364**	**337**	**291**

Source: OIG analysis of New York MFCU data, 2011.

[21] When the Unit encounters an issue outside of its regulated activities, it makes referrals to other agencies. The Unit most commonly sent referrals to the State Medicaid Agency, other State agencies, or private health insurers.

Several managers and staff attributed the decreases in their overall caseload to a decrease in the Unit's staff and funding during this 3-year period. According to the performance standards, the Unit should maintain staff levels in accordance with staffing allocations approved in its budget. As a part of its oversight role, OIG approves the number of staff requested by the Unit in its annual budget.[22] At the time of our review, the Unit employed 283 staff members—a 16 percent decline from FY 2008 when the Unit employed 336 staff members. Additionally, the Unit's staff levels were significantly below the number of staff that the Unit requested and OIG approved. For example, in FY 2010, the Unit employed 306 staff members, even though the Unit requested and OIG approved funding for 380 positions.

Several managers attributed the decline in staff levels to State budget constraints and acknowledged the effect this has had on the Unit. According to one manager, "There are cases we probably should do but can't because we don't have the manpower; we have to refer them back." In addition to the decline in the Unit's staffing, the Unit has also seen a decline in its funding from the State, which has affected the Unit's total annual expenditures. For example, from FYs 2009 to 2010, the Unit's expenditures fell by18 percent, dropping from $49.6 million to $40.5 million.

The Unit did not establish annual training plans and provided limited training opportunities to staff

According to the performance standards, the Unit should establish annual training plans for each of the three professional disciplines. The training provided under these plans should aid the mission of the Unit. Managers acknowledged that the Unit did not have annual training plans for any of these disciplines; however, several noted that doing so would be useful for the Unit.[23] As one manager noted, "No question it would be helpful… It would be good to expand [staff] knowledge."

Several managers also stated that few training opportunities have been available for staff in recent years. Almost half of the Unit's staff surveyed reported that there was a need for additional training to improve the

[22] The Units are reimbursed by the Federal Government at a 75-percent matching rate.

[23] Although we reviewed training records, we did not evaluate the staff's professional qualifications. Rather, we applied the performance standards to evaluate whether the Unit maintained a formal training plan for each professional discipline, as well as training opportunities specific to MFCU operations. We recognize that attorneys, investigators, and auditors receive professional and law enforcement training, and that the lack of an annual training plan does not necessarily mean that professional staff are unqualified.

overall management, operations, or performance of the Unit. For example, prior to 2008, the Unit held separate training conferences for each of the three disciplines; however, over the last 4 years, the Unit has not held such trainings. Additionally, prior to 2003, the Unit held regular multidisciplinary training conferences, which brought together staff of all disciplines from across the State. Unit managers attributed the lack of such training to State budget restrictions, rather than a lack of interest by the Unit.

Many staff and managers called for the reinstatement of annual training conferences and other training opportunities. As one manager noted, "We have experienced staff, but we are also consistently confronted with new and novel areas." Several managers and numerous staff stated that the lack of training from FYs 2008 to 2010 presented a significant morale problem for staff and also contributed to difficulties in retaining staff. Managers anticipated that additional training will be offered in the upcoming years; one manager noted that training is a priority for the present State Attorney General's Office.

The Unit lacked policies and procedures to reflect many of its current practices

According to the performance standards, the Unit should establish policies and procedures for its operations. These policies and procedures should reflect current practices within the Unit. At the time of our review, the Unit did not have an MOU with the State Medicaid Agency that reflected key legislative changes, including the June 2006 establishment of the Office of the Medicaid Inspector General. The Unit also lacked updated procedures manuals that clearly describe staff roles and responsibilities for each of the three professional disciplines. In addition, it had no policies governing the maintenance of case files.

MOU. According to the performance standards, the Unit should periodically review its MOU with the State agency and seek amendments as necessary to ensure it reflects current law and practice. However, the Unit's MOU was last updated in 2005 and did not include any reference to the Office of the Medicaid Inspector General, nor did it reflect the enactment of the State's false claims act. Although the Unit and the State Medicaid Agency have worked on amending the MOU, one manager stated that they have not been able to complete negotiations because of leadership changes—in the Unit, the Attorney General's Office, and the State Medicaid Agency, including the Office of the Medicaid Inspector General—that occurred during the period of review.

Procedures Manuals. The performance standards state that the Unit should establish policies and procedures for its operations. However, the Unit did not have a procedure manual for its auditors and its manuals for attorneys and investigators were out of date; investigator manuals were more than 7 years old and attorney manuals were more than 10 years old. Because of their age, these manuals lacked information about key changes to the Unit's operations, such as the Unit's increased reliance on electronic data management. Managers cited the lack of updated manuals and acknowledged the need to update them.

Several managers emphasized the importance of having current policies and procedure manuals and noted their value when experienced managers or staff retire or leave the Unit. In addition, one staff member expressed what it was like to be a new employee: "I know that I felt absolutely clueless about any policy and procedures for quite some time, and still run into situations where I [am] expected to know something but have not been told the way things normally work."

Case File Policies. The Unit did not have written policies governing the maintenance of case files. Several staff acknowledged the need for written policies or guidelines governing case files. As discussed below, variation in how the Unit maintains its case files further demonstrates the need for such policies.

Case files lacked consistency and uniform supervisory reviews

According to the performance standards, the Unit should complete cases within a reasonable timeframe. As a part of this effort, supervisors should approve the opening and closing of cases and note any supervisory case reviews in the case file. The Unit's case files, however, had inconsistent documentation of both the opening and closing of cases and supervisory reviews.

Most notably, case files did not always contain documentation on the opening or closing of the case. Specifically, 10 percent of all case files were missing any form of an opening memorandum, and 7 percent of the closed case files did not include a closing memorandum detailing the case closure. In addition, supervisory reviews were not consistently noted in the case files. In fact, almost half of the case files (48 percent) did not include any documentation indicating at least one supervisory review

between the opening and closing of the case.[24] See Appendix C for confidence intervals.

When asked how to improve the Unit's overall management, operations, and performance, a number of staff called for increased case reviews or improved case management. One staff member noted that "having case reviews more frequently would help keep all parties involved in a case on the same track and informed. [A] case that isn't moving quickly can be forgotten and these reviews get the parties thinking about it again." Managers indicated that although they periodically review cases, no policies or guidelines currently exist governing their review. Managers acknowledged that the frequency of such reviews has historically been left to the discretion of relevant managers, and that this is an area warranting formal policy.

Finally, our review of the Unit's case files uncovered one instance of the Unit pursuing a case that did not involve allegations of fraud in the administration of the Medicaid program, in the provision of Medicaid services, or in the activities of Medicaid providers. To receive Federal funding, fraud investigations must involve one of these three activities.[25] The Unit is working with OIG to repay the grant for the time spent on the case.

Although no major concerns were identified in the Unit's financial oversight, the Unit lacked a number of internal controls

According to the performance standards, the Unit should exercise proper fiscal control over its resources. Although we identified no major concerns, our review of the Unit's financial systems identified a lack of internal controls over purchase cards, reconciliation of accounting records, and vehicle sale and transfer. Within each of these areas, the Unit lacked certain policies and procedures necessary to mitigate the risk of error or fraud.

Notably, the Unit lacked internal controls over the authorization and payment of purchase cards. The same staff member was responsible for authorizing purchase card accounts, approving purchase card expenditures, directly receiving purchase card statements, and making

[24] Unit managers stated that a lack of documentation of supervisory review in case files does not necessarily indicate that the review did not take place. According to these managers, all major events in a case are subject to supervisory approval. They considered the lack of documentation to be an issue of case file management.

[25] Social Security Act § 1903(q)(3); 42 CFR § 1007.11(a).

purchase card payments. The Unit did not have any policies and procedures to segregate the authorization, custody, and recordkeeping functions for purchase cards.

Additionally, the Unit lacked written policies and procedures to formalize its accounting process. Due to limitations in the State's accounting software, the Unit's financial staff must manually enter data into a separate accounting subsystem.[26] This accounting subsystem is used to track Federal funds and to report expenditures on OIG's Financial Status Report. At the time of our onsite review, staff were unable to provide sufficient documentation for several expenditures in the accounting subsystem.

Finally, prior to our onsite review, the Unit identified and alerted OIG to a lack of internal controls over the sale and transfer of vehicles. During the period under review, Unit vehicles that were no longer needed were transferred to the New York State Department of General Services for auction or transfer to another State agency, and the Unit did not receive the proceeds of the sale or transfer.[27] The Unit lacked written policies and procedures for determining and documenting the value of vehicles and for appropriately accounting for their sale or transfer to ensure that the Federal Government was reimbursed accordingly. Since identifying the issue, the Unit has worked with OIG to develop an adequate model for determining the value of vehicles and has reimbursed the Federal Government accordingly.

Managers, staff, and stakeholders cited a number of noteworthy practices

Managers, staff, and stakeholders familiar with the Unit's operations highlighted a number of noteworthy practices. These practices include its approach to patient abuse and neglect cases, its list of ongoing investigations (created to avoid conflicts among investigating agencies), and its use of technology.

The Unit's approach to patient abuse and neglect cases. Virtually all of the Unit's stakeholders and numerous managers and staff cited the Unit's approach to patient abuse and neglect cases as a noteworthy practice. Managers, staff, and stakeholders highlighted the establishment of a

[26] We learned during our discussions with Unit accounting staff that the State of New York is developing new accounting software that may address some of our concerns.

[27] Prior to our review, the Unit was decommissioning vehicles without determining the fair market value, which is necessary to ensure that any Federal reimbursement is identified and returned.

separate Patient Protection Unit as important to the Unit's success in this area. One Unit manager noted that when the Unit separated patient abuse and neglect cases into a distinct unit, staff no longer felt pressured into prioritizing multimillion-dollar fraud cases over these cases. This resulted in additional resources and expertise being devoted to patient abuse and neglect cases.

Multiple parties cited other practices related to patient abuse and neglect cases, including the use of hidden cameras in nursing homes and the use of nurse analysts employed by the Unit. Many staff surveyed mentioned the use of hidden cameras, which the Unit installs in nursing home residents' rooms with the consent of the residents' families. Specifically, one staff member noted, "I believe that we are one of the first Units to implement the use of hidden cameras in nursing facilities. This has proven very effective in attempts to curtail neglect, abuse, and mistreatment of residents." One manager agreed, attributing a drop in neglect cases to "a real change in the behavior of some of the nursing homes [as a result of the hidden camera cases]." Unit managers also cited the use of nurse analysts as important to the success of such cases. In the Unit, nurse analysts provide medical expertise to the case, including reviewing hidden camera data. According to one manager, "All of our medical analysts are nurses and worked with nursing homes before they came here. Having that knowledge in-house is key."

The Unit's list of ongoing investigations. To avoid conflicts among investigating agencies, the Unit created a list of names associated with ongoing investigations. The Unit shares this list with the Office of the Medicaid Inspector General and helps facilitate communication about ongoing investigations. As part of its investigations, the Office of the Medicaid Inspector General checks this list and contacts the Unit to obtain information about investigation status. Unit managers believe that the list reduces the likelihood that an ongoing investigation will be compromised by another investigation. One manager also noted that this list will be helpful in instituting the new payment suspension rules mandated by the Affordable Care Act, which permit the State Medicaid agency to suspend payment in cases of suspected fraud identified by the Unit or by the Office of the Medicaid Inspector General.[28]

The Unit's use of technology. Many managers, staff, and stakeholders also highlighted the Unit's innovative use of technology. Specifically, the Unit established a group of staff called the Electronic Investigative Support

[28] The Patient Protection and Affordable Care Act, P. L. 111-148, § 6402(h)(2), amending Social Security Act § 1903(i)(2) and implemented in 42 CFR § 455.23.

Group that is dedicated to providing technical assistance throughout a case. As one staff member noted, "The Unit added specialists, including electronic data [and] systems technicians, computer forensic specialists, and clinical specialists. This team approach is essential to the success of the Unit." Another added, "[The Electronic Investigative Support Group] created a discovery team along with procedures that our attorneys follow when collecting electronically stored information. It has worked very well and has saved our unit a lot of time and money." Others highlighted the group's expertise in assisting in undercover operations, such as the Unit's hidden camera cases, discussed above.

CONCLUSION AND RECOMMENDATIONS

From FYs 2008 to 2010, the Unit filed criminal charges against more than 400 defendants, obtained over 400 convictions, and was awarded more than $750 million in recoveries. Although the number of referrals to the Unit increased during this time, the number of cases that the Unit opened and closed decreased. Additionally, the Unit did not establish annual training plans for each of the three professional disciplines and provided limited training opportunities to staff. The Unit also lacked an up-to-date MOU with the State Medicaid agency, as well as policies and procedures to reflect many of its current practices. Further, its case files lacked consistency and uniform supervisory reviews. Finally, the Unit lacked certain internal controls with respect to purchase cards, reconciliation of accounting records, and vehicle sale and transfer. At the same time, our review found no evidence of significant noncompliance with applicable laws, regulations, or policy transmittals. In addition, Unit managers, staff, and stakeholders cited a number of the Unit's noteworthy practices, including its approach to patient abuse and neglect cases, its list of ongoing investigations (created to avoid conflicts among investigating agencies), and its use of technology.

Based on these findings, we recommend that the New York MFCU:

Seek to expand staff sizes to reflect the number of staff approved in the Unit's budget

The Unit should seek to maintain staff levels in accordance with staffing allocations requested by the Unit and approved by OIG.

Establish annual training plans and increase the number of training opportunities available to staff

The Unit should develop formal training plans that indicate the type and duration of training expected each year for employees in each professional discipline. The Unit should also provide additional training opportunities and consider reinstituting the annual training conferences.

Ensure that the MOU, policies, and procedures of the Unit reflect current practices

The Unit should update its MOU with the State agency so that it addresses recent changes, such as the establishment of the Medicaid Inspector General and the State false claims act. The Unit should also develop up-to-date policies and procedures manuals for each professional discipline and for the maintenance of case files.

Ensure greater consistency in how case files are maintained and increase the frequency and documentation of supervisory reviews

Unit supervisors should periodically review case files to ensure they include all necessary documentation. Additionally, supervisors should include notation of such reviews in the case files, to ensure timely investigation, prosecution, and closure of cases.

Establish written policies and procedures for controls over (1) purchase cards, (2) reconciliation of accounting records, and (3) the sale and transfer of vehicles

The Unit should develop and disseminate written policies and procedures for purchase cards to ensure that staff responsible for acquiring cards are not the same staff responsible for paying them. The Unit should also develop an electronic means of maintaining accounting records. Finally, the Unit should develop policies and procedures for decommissioning its vehicles in accordance with Federal regulations.

UNIT COMMENTS

The New York State Unit concurred with all five of our recommendations and provided a detailed plan for how it will implement each of them.

The Unit concurred with our recommendation to expand its staff to reflect the number approved in the Unit's budget. The Unit reported that it has already hired additional staff members and that vigorous recruitment efforts are continuing.

The Unit also agreed with our recommendation to establish annual training plans and to increase the number of training opportunities available to staff. The Unit has implemented annual training plans based on a "credit-hour" model to give it more flexibility in uncertain budget times and has established training committees for each of the professional disciplines.

The Unit agreed with our recommendation to ensure that the MOU, policies, and procedures of the Unit reflect current practices. The Unit expects that an updated MOU with the State agency and the State's Office of the Medicaid Inspector General will be in place by July 2012; the Unit also reports that it is revamping its approach to maintaining its policy statements, and anticipates that an easily accessible and updateable electronic system will be completed by August 2012.

The Unit concurred with our recommendation to ensure greater consistency in how case files are maintained and to increase the frequency and documentation of supervisory reviews. The Unit states that it has created several new approaches to electronic files that will be integrated with its software used for investigative work.

Finally, the Unit concurred with our recommendation to establish written policies and procedures for controls over (1) purchase cards, (2) reconciliation of accounting records, and (3) the sale and transfer of vehicles. The Unit noted that it is revising the handling of purchase cards and that it has already adopted a solution to the vehicle disposition issue. Also, now that a new Statewide accounting platform has been launched, the Unit has plans for a records-maintenance system.

APPENDIX A

Performance Standards for Medicaid Fraud Control Units [59 Fed. Reg. 49080, Sept. 26, 1994]

1. **A Unit will be in conformance with all applicable statutes, regulations, and policy transmittals.** In meeting this standard, the Unit must meet, but is not limited to, the following requirements:

   a. The Unit professional staff must consist of permanent employees working full-time on Medicaid fraud and patient abuse matters.

   b. The Unit must be separate and distinct from the single State Medicaid agency.

   c. The Unit must have prosecutorial authority or an approved formal procedure for referring cases to a prosecutor.

   d. The Unit must submit annual reports, with appropriate certifications, on a timely basis.

   e. The Unit must submit quarterly reports on a timely basis.

   f. The Unit must comply with the Americans with Disabilities Act, the Equal Employment opportunity requirements, the Drug Free workplace requirements, Federal lobbying restrictions, and other such rules that are made conditions of the grant.

2. **A Unit should maintain staff levels in accordance with staffing allocations approved in its budget.** In meeting this standard, the following performance indicators will be considered:

   a. Does the Unit employ the number of staff that was included in the Unit's budget as approved by [the Office of Inspector General (OIG)]?

   b. Does the Unit employ the number of attorneys, auditors, and investigators that were approved in the Unit's budget?

   c. Does the Unit employ a reasonable size of professional staff in relation to the State's total Medicaid program expenditures?

   d. Are the Unit office locations established on a rational basis and are such locations appropriately staffed?

3. **A Unit should establish policies and procedures for its operations, and maintain appropriate systems for case management and case tracking.** In meeting this standard, the following performance indicators will be considered:

   a. Does the Unit have policy and procedure manuals?

   b. Is an adequate, computerized case management and tracking system in place?

4. **A Unit should take steps to ensure that it maintains an adequate workload through referrals from the single State agency and other sources.** In meeting this standard, the following performance indicators will be considered:

   a. Does the Unit work with the single State Medicaid agency to ensure adequate fraud referrals?

   b. Does the Unit work with other agencies to encourage fraud referrals?

   c. Does the Unit generate any of its own fraud cases?

   d. Does the Unit ensure that adequate referrals of patient abuse complaints are received from all sources?

5. **A Unit's case mix, when possible, should cover all significant provider types.** In meeting this standard, the following performance indicators will be considered:

   a. Does the Unit seek to have a mix of cases among all types of providers in the State?

   b. Does the Unit seek to have a mix of Medicaid fraud and Medicaid patient abuse cases?

   c. Does the Unit seek to have a mix of cases that reflect the proportion of Medicaid expenditures for particular provider groups?

   d. Are there any special Unit initiatives targeting specific provider types that affect case mix?

   e. Does the Unit consider civil and administrative remedies when appropriate?

6. **A Unit should have a continuous case flow, and cases should be completed in a reasonable time.** In meeting this standard, the following performance indicators will be considered:

   a. Is each stage of an investigation and prosecution completed in an appropriate time frame?

   b. Are supervisors approving the opening and closing of investigations?

   c. Are supervisory reviews conducted periodically and noted in the case file?

7. **A Unit should have a process for monitoring the outcome of cases.** In meeting this standard, the following performance indicators will be considered:

   a. The number, age, and type of cases in inventory.

   b. The number of referrals to other agencies for prosecution.

   c. The number of arrests and indictments.

   d. The number of convictions.

   e. The amount of overpayments identified.

f. The amount of fines and restitution ordered.

g. The amount of civil recoveries.

h. The numbers of administrative sanctions imposed.

8. **A Unit will cooperate with OIG and other Federal agencies, whenever appropriate and consistent with its mission, in the investigation and prosecution of health care fraud.** In meeting this standard, the following performance indicators will be considered:

   a. Does the Unit communicate effectively with OIG and other Federal agencies in investigating or prosecuting health care fraud in their State?

   b. Does the Unit provide OIG regional management, and other Federal agencies, where appropriate, with timely information concerning significant actions in all cases being pursued by the Unit?

   c. Does the Unit have an effective procedure for referring cases, when appropriate, to Federal agencies for investigation and other action?

   d. Does the Unit transmit to OIG, for purposes of program exclusions under section 1128 of the Social Security Act, reports of convictions, and copies of Judgment and Sentence or other acceptable documentation within 30 days or other reasonable time period?

9. **A Unit should make statutory or programmatic recommendations, when necessary, to the State government.** In meeting this standard, the following performance indicators will be considered:

   a. Does the Unit recommend amendments to the enforcement provisions of the State's statutes when necessary and appropriate to do so?

   b. Does the Unit provide program recommendations to single State agency when appropriate?

   c. Does the Unit monitor actions taken by State legislature or State Medicaid agency in response to recommendations?

10. **A Unit should periodically review its memorandum of understanding (MOU) with the single State Medicaid agency and seek amendments, as necessary, to ensure it reflects current law and practice.** In meeting this standard, the following performance indicators will be considered:

    a. Is the MOU more than 5 years old?

    b. Does the MOU meet Federal legal requirements?

    c. Does the MOU address cross-training with the fraud detection staff of the State Medicaid agency?

d. Does the MOU address the Unit's responsibility to make program recommendations to the Medicaid agency and monitor actions taken by the Medicaid agency concerning those recommendations?

11. The Unit director should exercise proper fiscal control over the Unit resources.
In meeting this standard, the following performance indicators will be considered:

a. Does the Unit director receive on a timely basis copies of all fiscal and administrative reports concerning Unit expenditures from the State parent agency?

b. Does the Unit maintain an equipment inventory?

c. Does the Unit apply generally accepted accounting principles in its control of Unit funding?

12. A Unit should maintain an annual training plan for all professional disciplines.
In meeting this standard, the following performance indicators will be considered:

a. Does the Unit have a training plan in place and funds available to fully implement the plan?

b. Does the Unit have a minimum number of hours training requirement for each professional discipline, and does the staff comply with the requirement?

c. Are continuing education standards met for professional staff?

d. Does the training undertaken by staff aid to the mission of the Unit?

APPENDIX B

Fraud Investigations Opened and Closed by Provider Category, Fiscal Years 2008 to 2010

Provider Category	Fiscal Year (FY) 2008		FY 2009		FY 2010	
Facilities	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Hospitals	62	39	30	45	23	24
Nursing facilities	48	67	38	48	16	19
Other long-term care facilities	2	1	2	1	2	2
Substance abuse treatment centers	2	6	0	2	4	4
Other	6	33	7	6	16	10
Practitioners	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Doctors of medicine or osteopathy	13	29	11	18	12	8
Dentists	3	6	8	6	5	7
Counselors/psychologists	3	2	5	4	5	3
Other	1	2	3	0	1	1
Medical Support	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Pharmacies	22	28	22	13	18	15
Pharmaceutical manufacturers	59	5	39	6	73	35
Durable medical equipment and/or suppliers	25	26	5	5	17	5
Laboratories	3	0	2	1	10	3
Transportation services	12	9	17	4	7	15
Home health care agencies	30	25	44	22	21	24
Home health care aides	6	2	22	5	15	13
Nurses, physician assistants, nurse practitioners, certified nurse aides	26	12	28	37	16	27
Radiologist	0	0	3	0	3	1
Medical support—other	37	11	37	50	2	13
Program Related	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Managed care	5	2	1	1	2	4
Billing company	1	0	0	2	0	0
Other	10	6	18	12	11	11
Total All Provider Categories	**376**	**311**	**342**	**288**	**279**	**244**

Source: New York Medicaid Fraud Control Unit, 2011.

Patient Abuse and Neglect Investigations Opened and Closed by Provider Category, FYs 2008 to 2010

Provider Category	FY 2008		FY 2009		FY 2010	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing facility	2	4	5	0	3	2
Nondirect care	1	1	4	2	3	2
Other long-term care	1	0	1	0	1	1
Nurses, physician assistants, nurse practitioners, certified nurse aides	35	45	50	39	29	40
Home health care aides	0	0	0	0	0	0
Other	6	3	3	8	1	2
Total	**45**	**53**	**63**	**49**	**37**	**47**

Source: New York Medicaid Fraud Control Unit, 2011.

APPENDIX C

Confidence Interval Estimates Based on Case File Review

We estimated the following 3 population values for all 1,887 case files from the results of our review of the 94 case files selected in our simple random sample. The table below includes the estimate descriptions, sample sizes, point estimates, and 95-percent confidence intervals for these 3 estimates.

Confidence Intervals for Key Case File Review Data

Data	Estimate Description	Point Estimate	95-Percent Confidence Interval
Case files missing an opening memorandum	94	9.6%	4.5%–17.4%
Case files missing a closing memorandum	57*	7.0%	1.9%–17.0%
Case files missing documentation indicating at least one supervisory review	94	47.9%	37.5%–58.4%

* Of the 94 cases reviewed, 57 were closed between fiscal years 2008 and 2010.

Source: Office of Inspector General analysis of Medicaid Fraud Control Unit case files, 2011.

APPENDIX D

Unit Comments

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May 18, 2012

Stuart Wright
Deputy Inspector General for Evaluation and Inspections
Office of Inspector General
Department of Health and Human Services
Washington, DC 20201

Re: New York State Medicaid Fraud Control Unit (OEI-02-11-00440)

Dear Mr. Wright:

We appreciate the opportunity to receive and respond to the HHS-OIG Onsite Review of the New York State Medicaid Fraud Control Unit for the Review Period 2007-10. As new management in the New York MFCU and a new administration in the New York State Office of the Attorney General at the time of the Onsite Review, we have taken this review and interaction with HHS-OIG as an exercise in identifying our best practices and areas for improved practices.

We also appreciate the diligence shown by the HHS-OIG Onsite Review team and the positive communication which facilitated our analysis and response to the on-site report.

HHS-OIG has requested that the New York MFCU respond with comments to the Onsite Review, including whether we concur with the recommendations and statements of specific actions or alternative actions, with timelines. In addition, HHS-OIG has requested the reasons for any disagreement with the recommendations.

In the response below, we have set forth the summary recommendations from the Onsite Review and our response, in which we set forth our analysis of the circumstances leading to the recommendation.

Seek to expand staff sizes to reflect the number of staff approved in the Unit's budget

The Unit should seek to maintain staff levels in accordance with staffing allocations requested by the Unit and approved by OIG.

Response:

We entirely concur with the HHS-OIG finding that funding and staffing for NY MFCU during 2008-2010 decreased and that such decrease was contrary to the Unit's mission.

Analysis:

Although the current administration can neither recreate nor endorse all of the budgetary decision-making during the Review Period that led to the net decrease in staffing, clearly the sudden financial crisis shortly after the beginning of the Review Period, the subsequent New York State budgetary constraints, and decisions made based on those factors, had a role in the net staffing decrease. At the very beginning of the Review Period, the Unit was aggressively recruiting staff, for example nearly doubling the attorney staffing in the Civil Enforcement Division. The effects of the budgetary constraints were exacerbated in early 2011 by a large number of staff retirements, which led to the historically-low staffing number of 283 at the time of the Onsite Review. Some of those staffers were "first generation" MFCU employees who commenced their careers with the establishment of the NY MFCU – the Nation's first -- in the late 1970s. Anecdotal information suggests that several of those staffers had deferred retirement due to the economic uncertainty of potential private employment, and others deferred with unrealistic hopes that an improving economy would lead to a substantially improved compensation system to offset nearly four years without any form of raises, including cost-of-living raises received in other State agencies. Therefore, the net decrease is partially an effect of the national economy and individual decisions made by staff based on economic perceptions.

Plan:

Attorney General Eric T. Schneiderman announced, as one of his earliest acts upon taking office in 2011, a commitment to increasing the MFCU budget, which he accomplished that year, and a commitment to increasing MFCU staffing. We are pleased to report that MFCU recruitment efforts in 2011 reversed the low-point seen at the time of the Onsite Review, and has led to a net increase of staff to 302 as of April 23, 2012, with an additional 12 employees scheduled to join the staff by the beginning of July.

This expansion occurred despite continued attrition due to retirements. Our vigorous recruitment efforts are continuing.

Establish annual training plans and increase the number of training opportunities available to staff

The Unit should develop formal training plans that indicate the type and duration of training expected each year for employees in each professional discipline. The Unit should also provide additional training opportunities and consider reinstituting the annual training conferences.

Response:

We agree that the Unit lacked an annual training plan for each discipline during the Review Period. We also agree that no multi-discipline training conferences were held during the Review Period and that state budget constraints prevented funds from being expended for this purpose.

Analysis:

As HHS-OIG's notes to the finding indicate, the critique of the training plan during the Review Period does not indicate that staffers were not competent to perform their duties. All staffers maintained any professional accreditation during the Review Period. (For example, New York requires attorneys to receive at least 24 credit hours of continuing legal education every two years.) Rather, the standard reflects best practices for MFCUs, which we fully endorse.

We refer to the comments above as to the current administration's understanding of the budgetary decisions made by the prior administration during the Review Period. We note, however, that multi-day training programs encompassing over 250 professional staff of the Unit are very expensive and administratively burdensome and essentially shut down the Unit for the days such training occurs. The resulting "classes" of 100 or more participants were not optimal instructional formats. Nor do we believe that model is viable for a unit this size even in better budgetary conditions. We expect future multi-discipline training programs to take place in smaller groupings so that the trainers and the students have greater interaction.

Despite the decrease in large scale training, MFCU conducted several training programs during the Review Period that we believe exceeded programs for comparable disciplines in other agencies. For example, all auditor-investigators were required to attend a multi-day seminar in the fall of 2008; all investigators were required to attend a multi-day seminar in the fall of 2008. All MFCU attorneys were required to attend a multi-day seminar in the fall of 2007 with 14 hours of credit in criminal law and practice, a training program on negotiation in 2008, and a multi-day seminar in December 2008 with 15.5 hours of credit in MFCU-specific subjects.

In addition, many staffers attended training seminars conducted by NAMFCU and other agencies, with priority given to staff newly-hired in 2007-08. All investigators maintained their certifications and several received advanced certifications; each armed investigator maintained

firearms proficiency annually; all investigative trainees attended rigorous six-month police academy programs.

We note that although formal, large-scale training sessions were concentrated in 2007 and 2008, such sessions encompassed the vast majority of professional staff in the Unit during the Review Period. Indeed, only two professional staffers, a highly experienced attorney already on staff of the Attorney General's Office and an experienced investigator, joined the Unit between the 2008 conferences and the end of the Review Period.

We further note that MFCU had been at the forefront of training throughout its existence and cessation of the outmoded conference format would be a cause for comment by staff used to that format. Despite this, during the Review Period, many staffers took advantage of other forms of training that were encouraged, including continuing legal education, courses offered by federal and state agencies, "webinars" and small-scale, self-developed training programs. The vast majority of the topics focused on subjects relevant to the investigation and prosecution of fraud, as well as resident abuse and neglect. Therefore we believe that some of the staff comments reflect a subjective view of the training format. Most staffers eagerly took advantage of the new opportunities.

Plan:

The Unit has re-committed to training. An annual training plan has already been promulgated and implemented based on a "credit-hour" model to give the Unit more flexibility in uncertain budget times. A training committee with participants from each discipline has been established. Even prior to implementation of the new Training Plan, Unit staff commenced separate training sessions for both new and experienced attorneys, and all new investigative trainees were sent to police academy training. We expect substantial progress towards the goals of the new Training Plan, and a re-assessment of that plan, during the remainder of 2012 and 2013.

Ensure that the MOU, policies, and procedures of the Unit reflect current practices

The Unit should update its MOU with the State Agency so that it addresses recent changes, such as the establishment of the Medicaid Inspector General and the State false claims act. The Unit should also develop up-to-date policies and procedures manuals for each professional discipline and for the maintenance of case files.

We address the two aspects of this finding and related comments separately.

Memorandum of Understanding

Response:

We agree that the existing Memorandum of Understanding (MOU) between the Unit and the Department of Health should be updated to reflect the current configuration of the Department of Health, including the Office of Medicaid Inspector General, and changes in law and policy.

Analysis:

The Unit leadership change noted in the Onsite Review occurred in the prior Attorney General administration, along with two changes in gubernatorial administrations overseeing the Department of Health, and we cannot replicate the circumstances under which the MOU was not updated. However, MFCU and OMIG established a good working relationship and protocols for handling matters that are not expressly addressed in the MOU.

Plan:

MFCU is prepared to move forward with a new MOU and the current MFCU administration has picked up the process with the Department and OMIG. We anticipate a need to formalize interagency practices already functioning, amend the MOU to address enhanced timely access to controlled substance prescription information under the Attorney General's pending legislation modernizing New York's Prescription Monitoring Program, the trend towards Medicaid Managed Care, and a need to improve the Department's communication to the Unit of advice or policy statements made to providers. MFCU expects that there will be an updated MOU in place by July 1st.

Procedures Manuals

Response:

We concur with the recommendation. As indicated in the Report, MFCU administration recognized at the time of the review that the existing manuals need to be updated. The manuals described in the finding reflect an outdated commitment to paper documents, and the process

used to create the manuals apparently made updating the material more difficult than necessary. We anticipate more-readily updatable electronically-maintained MFCU manuals in 2012.

Analysis:

Although there are no stand-alone "manuals" in an updated form that meet the standard, the paper-based manuals referenced in the Report were by no means the sole source of information for staff during the Review Period. For example, one reason the MFCU Attorney Manual was not updated is that approximately half of its material was superseded by a manual (first promulgated in 2006 and currently being updated) governing grand jury practice by all prosecutors in the Attorney General's Office. That grand jury manual is promulgated in electronic form on MFCU's intranet and was never physically part of the MFCU "Attorney Manual". In addition, many statements of MFCU policy and practice were conveyed by memoranda in electronic form that are re-transmitted to new staffers. [1]

Similarly, since at least 2003, many of the paper-based forms found in the 2001 Attorney Manual were superseded by computer-based templates on MFCU's computer system, which are frequently updated. Therefore, while the Onsite Review is accurate that the "manuals" themselves are outdated, much of the most relevant material has been maintained in electronic formats.

However, we agree those materials should have been collated in a manner that facilitated ready-reference.

Policy and procedure manuals are useful tools. They are not substitutes, however, for dynamic analysis of situations. In this context, we refer to the following comment in the report:

> *In addition, one staff member expressed what it was like to be a new employee: "I know that I felt absolutely clueless about any policy and procedures for quite some time, and still run into situations where I [am] expected to know something but have not been told the way things normally work."*

We cannot fully address this anonymous staffer's experience, but the comment suggests a somewhat artificial view of "policy" and "procedure." Although the Unit has 302 staffers, the ratio of line staff to direct supervisors is approximately 5:1, and even lower when team-leading staff are counted. Teaching "the way things normally work" to a new employee cannot consist of

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[1] In addition, the Office of the Attorney General has always maintained policy statements furnished to all OAG employees as to ethics, professional responsibility, overall office policy, human resources issues, and similar matters to be expected in an office of this size, which were never repeated as a MFCU "manual."

a wholly paper-based process of "policy and procedure" in complex investigations, and taking the initiative to appropriately seek guidance is the responsibility of all staffers.

Plan:

The Unit has been completely revamping its approach to maintaining policy statements and accessing those statements, which will result in electronic "manuals" with the ease of use and updatability of modern web-based systems. The structure is being tested now. We anticipate the base project to be completed by August 2012 with continuous maintenance thereafter.

Ensure greater consistency in how case files are maintained and increase the frequency of supervisory reviews Unit supervisors should periodically review case files to ensure they include all necessary documentation. Additionally, supervisors should include notation of such reviews in the case files, to ensure timely investigation, prosecution, and closure of cases.

Response:

We concur that case file policy should be better articulated and supervisory review better documented.

Analysis:

Most of the files which lacked documentation of interim supervisory review would have demonstrated such review had the Unit culled for the HHS-OIG team all e-mail messages concerning the matters as part of the formal case file.

However, the Unit did not cull those emails, as we did not perceive the extent to which we were documenting decisions exclusively by email. HHS-OIG's exit interview gave valuable insight into this weakness in our internal process.

The Review Period was a time of incomplete transition between heavy reliance on traditional paper files and increasing reliance on electronic records. New practices at the Unit are intended to address the persistence of "paper" in an electronic age without over-committing to formats that may become outmoded if not sufficiently flexible.

Plan:

Thanks to the HHS-OIG insight, the Unit immediately commenced an examination of this process and created several innovative new approaches to electronic files, with the goal of achieving completely electronic files for new matters. Our Electronic Investigative Support Group created a user-friendly "macro" that automatically establishes an electronic file system for new cases on our computer network. That system accepts newly-created internal electronic documents, scanned paper documents, and e-mail, as well as documents produced or delivered by third-parties. The system will integrate with the electronic document search software that we now utilize for investigative work.

In development prior to the Onsite Review, but reflecting the same concerns, the Unit created a new position -- Chief of Criminal Investigations -- an attorney to foster the criminal investigative process by enhancing internal and external communications.

We have also instructed supervisors and staff to memorialize, in a simplified manner, discussions with significant case implications, and to file such notes electronically.

Given that we investigate third-parties who often rely on the inefficiency of paper to conceal fraud, and interact with agencies with different practices, we are unlikely to achieve a completely "paperless" environment in the near-term, but we intend to have all support staff proficient on the new model by August, 2012, and the entire staff proficient by year end 2012.

Establish written policies and procedures for controls over purchase cards, reconciliation of accounting records, and the sale and transfer of vehicles

The Unit should develop and disseminate written policies and procedures for purchase cards to ensure that staff responsible for acquiring cards are not the same staff responsible for paying them. The Unit should also develop an electronic means of maintaining accounting records. Finally, the Unit should develop policies and procedures for decommissioning its vehicles in accordance with Federal regulations.

Response:

We concur with these recommendations.

Analysis:

We appreciate HHS-OIG's note that no major concerns were identified as part of this recommendation. The insight as to the purchase cards was valuable even though our Finance Department staff have properly performed their duties. As indicated in the report, the Unit had been expecting a new statewide accounting software platform, which has just recently been launched for all New York State agencies. We further appreciate the note that the Unit self-identified the vehicle transfer and sale issue caused by inter-agency disposition of vehicles during the Review Period.

Plan:

The Unit's Finance Department and the Chief Administrative Officer for MFCU are revising the handling of purchase cards; the Chief Administrative Officer now approves the issuance of such cards after initial processing by Finance. As noted in the report, the Unit has already adopted a solution to the vehicle disposition issue. Now that the new statewide accounting platform has been launched, we will plan a records maintenance system based on experience with the new platform's capabilities. We anticipate that an additional two fiscal quarters experience will give a baseline for establishing an electronic record system.

Although the number of referrals to the Unit increased, the number of cases the Unit opened and closed decreased

Response:

We agree with the statistical figures identified by the Onsite Review; however we analyze those figures and the reasons for the changes somewhat differently than the comments which suggest a direct linkage to staffing and budget. As described in our analysis of the budget and staffing recommendation above, those issues were real, but other factors had a larger effect on the statistics on case openings and closings. To the extent budget and staffing had a role in the statistics, we expect that the improvements described above will have a positive effect.

Analysis:

Although staffing and budget issues contributed to the overall statistics, we believe from MFCU data and practice changes that the gross numbers are primarily the effect of better screening of referrals. Practice prior to the Review Period had been to "open" all referrals as "cases", which frequently resulted in the nearly immediate "closing" of the "case" due to a lack of merit. During the Review Period, MFCU worked with referring agencies to improve the quality of referrals before cases were formally "opened." This improvement in quality led to cases being worked more intensely on the facts rather than being readily "closed."

Also during the Review Period, the Unit saw a great increase in False Claims Act "whistleblower" cases due to State Finance Law §89, which became effective in 2007 at the beginning of the Review Period. The number of these matters pending in the Unit quickly rose to over 200 at the beginning of the Review Period. As the procedure for these cases was entirely novel under New York law, and the matters were both complex and newly-filed, the Unit had to adapt practices and recruit staff to handle the matters. In addition, Unit staff had to spend considerable time on older matters that had previously been filed under seal in Federal courts, often with other states as parties, to which New York was then made a party under the FCA. Overall, the time-line for such complex matters is much longer than cases exclusively involving New York.

By the close of the Review Period, the Unit had succeeded in adapting to such matters, and during 2011 the Unit made a major reorganization of its Civil Enforcement Division to effectuate the lessons learned during the initial years of FCA practice. As is reflected in the number of convictions and amount of recoveries during the Review Period, the reduction in the number of cases opened and closed did not negatively affect the Unit's results and its ability to maintain a continuous case flow.

Conclusion

The New York MFCU appreciates the efforts of HHS-OIG and the insight provided by the Onsite Review. We appreciate and concur with the recommendations, which will be implemented to the extent not already accomplished as we recover from the budgetary impact of the financial crisis. As the statistics demonstrated, MFCU achieved unprecedented results despite such obstacles. New York MFCU remains committed to meeting and exceeding the standards for Medicaid Fraud Control Units.

Respectfully submitted,

/S/

Monica J. Hickey-Martin
Special Deputy Attorney General
Director, New York MFCU

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ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Meridith Seife, Deputy Regional Inspector General.

Vince Greiber served as the team leader for this study. Other Office of Evaluation and Inspections staff from the New York regional office who conducted the study include Hailey Davis. Central office staff who provided support include Thomas Brannon and Christine Moritz. Michael Henry of the San Francisco regional office also contributed to the report. Office of Audit Services staff who contributed to the report include Eileen Bechkes and Ryan Moul. Office of Investigations staff who contributed to the report include LaTonya Coates, Michael Mahabir, and Jason Weinstock.

Office of Inspector General

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