Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

DELAWARE MEDICAID FRAUD CONTROL UNIT: 2015 ONSITE REVIEW

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EXECUTIVE SUMMARY: DELAWARE MEDICAID FRAUD CONTROL UNIT: 2015 ONSITE REVIEW
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WHY WE DID THIS STUDY

The Office of Inspector General (OIG) administers the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, annually recertifies the Units, and oversees the Units' performance in accordance with the requirements of the grant. As part of this oversight, OIG conducts periodic reviews of all Units and prepares public reports based on these reviews. The reviews assess the Units' performance in accordance with the 12 MFCU performance standards and their compliance with applicable Federal requirements.

HOW WE DID THIS STUDY

We conducted an onsite review of the Delaware Unit in June 2015. We based our review on an analysis of data from seven sources: (1) policies, procedures, and documentation related to the Unit's operations, staffing, and caseload for fiscal years (FYs) 2012 through 2014; (2) financial documentation for FYs 2012 through 2014; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with Unit management; (6) a sample of files for cases that were open at any time in FYs 2012 through 2014; and (7) observation of Unit operations.

WHAT WE FOUND

For FYs 2012 through 2014, the Delaware Unit reported 28 convictions, 47 civil judgments and settlements, and combined criminal and civil recoveries of $5 million. We identified areas where the Unit should improve its operations. Specifically, the absence of final written policies and procedures may have contributed to the lack of adherence to certain performance standards and noncompliance with certain Federal regulations. The Unit did not report any sentenced individuals to OIG within required timeframes and did not report any adverse actions to the National Practitioner Data Bank (NPDB). Forty-four percent of case files open longer than 90 days lacked documentation of supervisory reviews. The Unit investigated two sampled cases that were not eligible for Federal funding. The Unit stored some case files in a location accessible to non-Unit staff. Only a small portion of Unit fraud referrals came from the State Medicaid agency; however, the Unit worked to increase the number and quality of referrals. Finally, the Unit's memorandum of understanding (MOU) with the State Medicaid agency did not reflect current practice.

WHAT WE RECOMMEND

We recommend that the Delaware Unit: (1) ensure that it reports convictions to OIG within 30 days of sentencing; (2) ensure that it reports adverse actions to the NPDB; (3) ensure that it conducts and documents supervisory reviews of case files open longer than 90 days; (4) repay Federal matching funds spent on cases ineligible for Federal funding; (5) secure its case files; and (6) revise its MOU with the State Medicaid agency to reflect current practice. The Unit concurred with all six recommendations.

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OBJECTIVE

To conduct an onsite review of the Delaware 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] Pursuant to Title XIX of the SSA, each State must maintain a certified Unit unless the Secretary of Health and Human Services 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 (States) have created such Units.[3] In fiscal year (FY) 2014, combined Federal and State grant expenditures for the Units totaled $235 million.[4, 5] That year, the 50 Units employed 1,958 individuals.[6]

To carry out its duties and responsibilities in an effective and efficient manner, each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.[7] Unit staff review complaints provided by the State Medicaid agency and other sources and determine their potential for criminal prosecution and/or civil action. In FY 2014, the 50 Units collectively obtained 1,318 convictions and 874 civil settlements and

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[1] Social Security Act (SSA) § 1903(q). Regulations at 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.

[2] SSA § 1902(a)(61).

[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.

[4] All FY references in this report are based on the Federal FY (October 1 through September 30).

[5] Office of Inspector General (OIG), *MFCU Statistical Data for Fiscal Year 2014*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.htm on March 17, 2015.

[6] Ibid.

[7] SSA § 1903(q)(6); 42 CFR § 1007.13.

judgments.[8] That year, the Units reported recoveries of approximately $2 billion.[9]

Units are required to have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority.[10] In Delaware and 43 other States, the Units are located within offices of State Attorneys General; in the remaining 6 States, the Units are located in other State agencies.[11, 12]

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 (i.e., a memorandum of understanding (MOU)) that describes the Unit's relationship with that agency.[13]

Oversight of the MFCU Program

The Secretary of Health and Human Services delegated to OIG the authority both to certify the Units on an annual basis and to administer grant awards to reimburse States for a percentage of their costs of operating certified Units.[14] All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.[15] To receive Federal reimbursement, each Unit must submit an initial application to OIG.[16] OIG reviews the application and notifies the Unit if the application is approved and the Unit is certified. Approval and certification are for a 1-year period; the Unit must be recertified each year thereafter.[17] In addition to annual recertification, OIG performs periodic onsite reviews of the Units.

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[8] OIG, *MFCU Statistical Data for Fiscal Year 2014*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.htm on March 17, 2015.

[9] Ibid.

[10] SSA § 1903(q)(1).

[11] OIG, *Medicaid Fraud Control Units*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp on February 25, 2015.

[12] Among those States with a Unit, 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 employ an Office of Medicaid Inspector General that conducts and coordinates activities to combat fraud, waste, and abuse for the State agency.

[13] SSA § 1903(q)(2); 42 CFR § 1007.9(d).

[14] 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 Federal Financial Participation.

[15] SSA § 1903(a)(6)(B).

[16] 42 CFR § 1007.15(a).

[17] 42 CFR § 1007.15(b) and (c).

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.[18] OIG developed and issued 12 performance standards to define further the criteria it applies in assessing whether a Unit is effectively carrying out statutory functions and meeting program requirements. Examples of standards include maintaining an adequate caseload through referrals from various sources, maintaining an annual training plan for all professional disciplines, and establishing policy and procedure manuals to reflect the Unit's operations.[19] See Appendix A for a description of each of the 12 performance standards.

Delaware Unit

The Delaware Unit expended $1,944,099 in combined State and Federal funds in FY 2014.[20] At the time of our review, the Unit's 17 employees were located in a single office. The Unit's management is composed of a director, a deputy director, and a supervisory investigator. The Unit also employs 6 investigators, 3 attorneys, 2 administrative specialists, 1 auditor, 1 nurse analyst, and 1 paralegal. Three months after the completion of our onsite review, the Unit director assumed a different position and another individual was appointed acting director.[21] In November 2015, this individual became the permanent director.

Referrals. The Unit tracks and reviews referrals as they are received. The Unit receives referrals from a variety of sources including, but not limited to, the Delaware Medicaid program (Division of Medicaid and Medical Assistance), the Delaware Division of Long Term Care Residents Protection, State and local police departments, and the Unit's hotline. An investigator screens incoming referrals regarding patient abuse or neglect, financial exploitation, or drug diversion; a supervisory investigator or Unit director screens fraud referrals. Staff make a recommendation to the Unit director to either open an

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[18] SSA § 1902(a)(61).

[19] The performance standards referred to in this report were published on June 1, 2012, and were in effect for the majority of our review period. 77 Fed. Reg. 32645 (June 1, 2012). Previous performance standards, established in 1994, are found at 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Performance%20Standards.pdf on April 27, 2015.

[20] OIG, *MFCU Statistical Data for Fiscal Year 2014*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.htm on March 17, 2015.

[21] All references to Unit director in this report are to the individual who was the Unit director during our onsite review in June 2015.

investigation or close the referral. The Unit director reviews this recommendation and makes the final decision. Appendix B depicts Unit referrals by referral source, for FYs 2012 through 2014.

Investigations and Prosecutions. The Unit director and supervisory investigator discuss newly opened cases and assign an attorney and investigator. Unit attorneys prosecute all Unit cases. Cases that are deemed to lack prosecutorial merit are referred to appropriate State administrative agencies (e.g., the Division of Professional Regulation). See Appendix C for details on investigations opened and closed by provider category.

Previous Review

A 2009 OIG onsite review of the Unit found that the Unit was in full compliance with all applicable Federal rules and regulations that govern the grant and the 12 performance standards.

METHODOLOGY

We conducted the onsite review in June 2015. We based our review on an analysis of data from seven sources: (1) policies, procedures, and documentation related to the Unit's operations, staffing, and caseload for FYs 2012 through 2014; (2) financial documentation for FYs 2012 through 2014; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with Unit management; (6) a sample of files for cases that were open at any time in FYs 2012 through 2014; and (7) observation of Unit operations. Appendix D provides details of our methodology.

Standards

These reviews are conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

The Delaware Unit reported that it obtained 28 criminal convictions and 47 civil judgments and settlements during FYs 2012 through 2014. We found that the lack of final written policies and procedures may have been a factor in the Unit's nonadherence to certain performance standards and noncompliance with Federal regulations.

For FYs 2012 through 2014, the Delaware Unit reported 28 criminal convictions, 47 civil judgments and settlements, and combined criminal and civil recoveries of $5 million

For FYs 2012 through 2014, the Unit reported 28 criminal convictions and 47 civil judgments and settlements. See Table 1 for the Unit's yearly criminal convictions and civil judgments and settlements. Of the Unit's 28 convictions over the 3-year period, 16 involved patient funds, 9 involved patient abuse and neglect, and 3 involved provider fraud.

Table 1: Delaware MFCU Criminal Convictions and Civil Judgments and Settlements, FYs 2012–2014

Outcomes	FY 2012	FY 2013	FY 2014	3-Year Total
Criminal Convictions	9	8	11	28
Civil Judgments and Settlements	14	8	25	47

Source: OIG analysis of Unit-submitted documentation, 2015.

For the same period, the Unit reported combined criminal and civil recoveries of $5 million. See Table 2 for the Unit's yearly recoveries and expenditures. During the 3-year review period, "global" cases produced 88 percent of the recoveries.[22]

[22] "Global" cases are civil false claims actions involving the U.S. Department of Justice and other State MFCUs. The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases.

Table 2: Delaware MFCU Recoveries and Expenditures, FYs 2012–2014*

Type of Recovery	FY 2012	FY 2013	FY 2014	3-Year Total
Global Civil	$2,009,957	$994,951	$1,842,817	$4,847,725
Nonglobal Civil	$0	$0	$0	$0
Criminal	$256,364	$273,958	$106,816	$637,139
Total Recoveries	**$2,266,321**	**$1,268,909**	**$1,949,634**	**$5,484,864**
Total Expenditures	$1,809,257	$1,877,814	$1,944,099	$5,631,171

Source: OIG analysis of Unit-submitted documentation, 2015.

* Due to rounding, dollar figures for each category of recoveries do not always sum to the total recoveries.

The Unit reported no recoveries from nonglobal civil cases during the 3-year review period. The Unit has the authority to pursue such cases through their State False Claims Act;[23] however, only 4 of the Unit's 348 nonglobal cases open during the review period were civil cases. The Unit director reported that during the last 2 years, the Unit has placed more emphasis on prosecuting civil cases.

Prior to November 2015, the Unit lacked final written policies and procedures specific to its operations

The Unit director reported that the Unit's policies and procedures manual was in draft status for the entire review period (FYs 2012 through 2014). In our review, we found that the manual contained numerous placeholders and bracketed comments indicating incomplete areas of text. Performance Standard 3 states that a Unit should have written policies and procedures for its operations and should ensure that staff are familiar with, and adhere to, these policies and procedures.

The Unit provided a 2004 "File Processing Manual" that addressed some aspects of conducting investigations (e.g., referrals, arrest warrants, closings). However, the manual was outdated in that it referred to office locations that were no longer in operation and procedures that were no longer current Unit practice. For example, the manual referred to the establishment of master, investigator, and prosecutor files for each case. The Unit director reported that this practice had ended in 2013; the draft policies and procedures manual referred only to the establishment of a master case file. In addition

[23] Del. Code tit. 6, §§ 1201-1211.

to the 2004 manual, between 2010 and 2015 the Unit director provided staff with directives on various topics (e.g., evidence room security, document management). For items related to personnel, travel, and use of State resources, the Unit used the Delaware Department of Justice's manual.

The lack of Unit-specific final policies and procedures related to operations may have contributed to the Unit's nonadherence to certain performance standards and noncompliance with Federal regulations. Below we note where the impact of the lack of final policies and procedures may have been significant. Subsequent to the onsite review, on November 23, 2015, the Unit issued an official policies and procedures manual to staff.

The Unit did not report any sentenced individuals to OIG within required timeframes

The Unit obtained 28 convictions during the review period but reported only 2 of these individuals to OIG for program exclusion, according to Unit data. Performance Standard 8(f) states that when an individual is sentenced, the Unit should report the conviction to OIG within 30 days of sentencing for the purposes of program exclusion. The Unit did not report either of the two individuals within 30 days of sentencing.[24] The Unit's draft policies and procedures manual states, "For cases involving fraud where a conviction was obtained, the prosecuting [attorney] shall send the sentencing order to OIG." However, the requirement to report convictions extends to any type of case, not just those involving fraud. In May 2015, subsequent to OIG notifying the Unit of the onsite review, the Unit reported that it submitted the remaining 26 convictions to OIG and that it had clarified its process for reporting convictions.

The Unit did not report any adverse actions to the National Practitioner Data Bank

The National Practitioner Data Bank (NPDB) seeks 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 other adverse actions. Pursuant to Federal

[24] The Unit indicated that one individual was reported nearly 2 months after sentencing and the other was reported more than 5 months after sentencing.

regulations, Units must report any adverse actions[25] stemming from prosecutions of healthcare providers, to the NPDB.[26] Delays in reporting individuals to the NPDB could result in payments to providers with adverse actions. The Unit's registration with the NPDB was not current during the review period, and the Unit had not reported any adverse actions since 2007. We note that the Unit did not address the reporting of adverse actions to the NPDB in its draft policies and procedures. In May 2015, the Unit renewed its registration with the NPDB.

Forty-four percent of case files open longer than 90 days lacked documentation of periodic supervisory reviews

Forty-four percent of the Unit's case files open longer than 90 days lacked documentation of periodic supervisory reviews.[27] Performance Standards 5(b) and 7(a) state that supervisors should periodically review the progress of cases, ensure that each stage of an investigation and prosecution is completed within an appropriate timeframe, and note in the case file that the reviews take place. The Unit's policy for supervisory reviews, as written in the draft policies and procedures manual, states that on a quarterly basis, the director or deputy director sets a due date for investigators and attorneys to prepare case summaries. Case summaries should include a brief summary of the facts of the case, the investigative steps taken, and plans for investigation and prosecution. Completed case summaries are to be sent to the chief investigator and the administrative assistant. The administrative assistant is to place a copy in the case file and provide a hard copy to the director for review.

The 44 percent of case files open longer than 90 days that lacked documentation of periodic supervisory reviews included (1) case files with one or more gaps of more than 90 days between

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[25] SSA § 1128E(g)(1); 45 CFR § 60.3. Examples of adverse actions include criminal convictions; civil judgments (but not civil settlements); exclusions; and other negative actions or findings.

[26] Units must report adverse actions to the NPDB within 30 calendar days of the date the final adverse action was taken. 45 CFR § 60.5. In addition to Federal regulations, the Performance Standards also require the Unit to report to NPDB. Performance Standard 8(g) states that the Unit should report "qualifying cases to the Healthcare Integrity & Protection Databank (HIPDB), the National Practitioner Data Bank, or successor data bases." We reviewed the reporting of adverse actions under NPDB requirements, because the HIPDB and the NPDB were merged during our review period (FYs 2012 through 2014). 78 Fed. Reg. 20473 (April 5, 2013).

[27] Appendix E contains the point estimate and 95-percent confidence interval for the statistic in this finding.

supervisory reviews, (2) case files in which the last or most recent supervisory review occurred more than 90 days prior to case closure or, for open cases, the date of our onsite review, and (3) case files with no documented supervisory reviews. The Unit director attributed the lack of documentation of supervisory reviews to several factors. The due dates for the quarterly case summaries are set to coincide with the dates of quarterly meetings with the State Medicaid agency program integrity unit. From June 2012 through February 2013, the Unit director was detailed away from Unit director duties to a temporary appointment in the Office of Attorney General. During this time, a Unit attorney served as acting Unit director. The Unit director explained that the acting director did not continue the quarterly meetings with the State Medicaid agency or ensure that case summaries were submitted during this time. In addition, the Unit did not meet with the State Medicaid agency during the second quarter of 2015 due to staff changes in the program integrity unit. Therefore, the Unit did not generate case summaries during this quarter.

Subsequent to the onsite review, the Unit revised its policy for conducting and documenting supervisory reviews of cases. The November 2015 policies and procedures manual states that investigative staff will provide summaries for administrative staff to check against open case lists and that all case summaries will be reviewed and signed by the Unit director.

The Unit investigated two sampled cases that were not eligible for Federal funding

In our review of a sample of cases we found that the Unit investigated two cases that were not eligible for Federal matching funds. In the first case, the Unit investigated a matter alleging Medicaid eligibility fraud that did not involve conspiracy with a provider. Unless a recipient is alleged to have engaged in a conspiracy with a provider, Federal funds are not available for Unit investigations of recipient fraud.[28] In the second case, the Unit investigated alleged mishandling of guardianship paperwork for a nursing home resident that resulted in a nursing facility not receiving payment for services rendered. The case did not appear to involve provider fraud. The Unit opened this case as a patient funds case. In less than 3 months, the Unit determined that patient funds were not at risk. Once the

[28] 42 CFR § 1007.19(e)(5) and *OIG State Fraud Transmittal 2013-1, MFCU Authority in Personal Care Waiver Cases* (Mar. 18, 2013).

Unit determined that there was no misappropriation of patient funds, and thus insufficient potential for criminal prosecution, the case became ineligible for Federal funding.[29] However, the case remained open for 3 years and 5 months.

The Unit stored some case files in a location accessible to non-Unit staff

Federal regulation and OIG policy require Units to "safeguard the privacy rights of all individuals and [to] provide safeguards to prevent the misuse of information" under the Unit's control.[30] This includes securing case files containing potentially sensitive personally identifiable information about witnesses, victims, suspects, and informants. During our onsite review, we observed that some case files were stored in an unlocked file cabinet in an office, and Unit staff confirmed that the file cabinet is not routinely locked. Finally, non-Unit staff (e.g., other Office of Attorney General staff, janitors) are issued keycards providing access to the same areas to which the Unit staff has access.

Only a small portion of Unit fraud referrals came from the State Medicaid agency; however, the Unit worked to increase the number and quality of referrals

The Unit reported that only 10 of the 305 fraud referrals (3 percent) received by the Unit during the 3-year review period came from the State Medicaid agency's program integrity unit. Performance Standard 4 states that the Unit should take steps to ensure that it maintains an adequate volume and quality of referrals from the State Medicaid agency and other sources.

The Unit reported three activities it had already taken to increase the number and quality of referrals. First, staff from the entire Unit—including attorneys, investigators, analysts, and management—participate in quarterly meetings with the State Medicaid agency's program integrity unit and managed care organizations. Topics discussed at these meetings include open cases, fraud trends, policy issues, and training. Unit staff believe that discussion among individuals from the variety of disciplines and organizations represented at these meetings will lead to more and higher quality referrals. Second, the Unit participated in the Request for Proposal

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[29] 42 CFR § 1007.11(b).

[30] 42 CFR § 1007.11(f); *OIG State Fraud Policy Transmittal No. 99-02, Public Disclosure Requests and Safeguarding of Privacy Rights* (Dec. 22, 1999).

process for managed care contracts. The Unit provided input on several contract provisions, including (1) the process for reporting and investigating suspected fraud, and (2) definitions for terms such as "fraud" and "critical incident" (e.g., abuse or neglect occurring in nursing facilities). Third, the Unit director reported that in 2013 the Unit revised its referral form. The Unit director believed this revision will produce higher quality, actionable referrals.

The Unit's MOU with the State Medicaid agency did not reflect current practice

Performance Standard 10(a) requires the Unit to document that it has reviewed its MOU with the State Medicaid agency at least every 5 years, and has renegotiated the MOU as necessary, to ensure that it reflects current practice, policy, and legal requirements. Although the Unit's MOU with the State Medicaid agency has been renewed in the past 5 years, officials from both the Unit and the State Medicaid agency told us that they believed that the MOU should be renegotiated to more clearly define certain areas (e.g., managed care referrals, expectations related to content and contributions at quarterly meetings) to reflect current practice. We note that the MOU does not incorporate by reference the Centers for Medicare & Medicaid Services' *Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit*, as required by Performance Standard 10(e).

CONCLUSION AND RECOMMENDATIONS

Our review of the Delaware Unit identified areas where the Unit should improve its operations. Specifically, the Unit's policies and procedures for its operations were in draft status for the entire review period. The lack of final written policies and procedures might have contributed to the lack of adherence to certain performance standards and Federal regulations. The Unit reported only 2 of 28 convictions to the OIG, neither of which was reported within the required timeframe, and did not report any adverse actions to the NPDB.

Other areas needing improvement relate to case files. Forty-four percent of case files lacked documentation of supervisory reviews. In addition, the Unit investigated two cases that were not eligible for Federal funding. Moreover, the Unit stored some case files in a location accessible to non-Unit staff.

Further, officials from both the Unit and the State Medicaid agency reported the need to revise the existing MOU to reflect current practice. Finally, the Unit received only a small portion of referrals from the State Medicaid agency; however, the Unit has taken steps to increase the number and quality of referrals. In lieu of a recommendation, we will monitor the impact of these measures on referral volume and quality.

We recommend that the Delaware Unit:

Ensure that it reports convictions to OIG within 30 days of sentencing

The Unit should establish and follow a policy to report convictions in a timely manner.

Ensure that it reports adverse actions to the NPDB

The Unit should maintain its registration with the NPDB and ensure that it reports all adverse actions generated by investigations or prosecutions of healthcare providers to the NPDB as specified in Federal regulations.

Ensure it conducts and documents supervisory reviews of Unit case files open longer than 90 days

The Unit should conduct periodic supervisory reviews of case files consistent with the Unit's newly implemented written policy. These reviews should be documented in the case files.

Repay Federal matching funds spent on the cases that were not eligible for Federal funding

The Unit should work with OIG to identify the staff hours and expenditures associated with the two ineligible cases and repay those Federal matching funds. As for the patient funds case, the investigative costs the Unit incurred while determining whether there was substantial potential for criminal prosecution are allowable.

Secure case files

The Unit should store all case files and other documentation containing personally identifiable information in a locked room or in locked storage cabinets.

Revise the MOU with the State Medicaid agency to reflect current practice

The Unit should revise its MOU with the State Medicaid Agency so that the MOU reflects current practice. The MOU should be revised to more clearly define certain areas (e.g., managed care referrals, expectations related to content and contributions at quarterly meetings) and include the revised referral form. Further, the MOU should be revised to incorporate by reference the Centers for Medicare & Medicaid Services' *Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit.*

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Delaware Unit concurred with all six of our recommendations.

Regarding the first recommendation, the Unit stated that it has reported all convicted individuals not previously reported to OIG. In addition, the Unit stated that it updated its policies and procedures manual to reflect the requirement that all Unit-obtained convictions are to be reported to OIG within 30 days of sentencing.

Regarding the second recommendation, the Unit stated that it has reported all individuals not previously reported to the NPDB. In addition, the Unit stated that it has updated its policies and procedures manual to reflect the requirement that the Unit report adverse actions to the NPDB. We suggest that the Unit include language in its policies and procedures manual to reflect the timeframes specified in 45 CFR § 60.5.

Regarding the third recommendation, the Unit stated that it has updated its policies and procedures manual to state that the Unit will set quarterly dates for submission of case summaries. The Director will review and sign all quarterly case summaries. Unit staff will ensure that case files contain a signed case summary for each quarter.

Regarding the fourth recommendation, the Unit stated that it has instructed all staff on the scope of the Unit's jurisdiction. The Unit is working with OIG to identify Unit costs associated with the two ineligible cases and repay grant funds.

Regarding the fifth recommendation, the Unit stated that it has instructed staff to lock filing cabinets to prevent misuse of sensitive information in case files.

Regarding the sixth recommendation, the Unit stated that it has provided a draft revised MOU to the State Medicaid agency and requested a deadline of April 1, 2016, for a final, signed version of the MOU.

The Unit's comments are provided in Appendix F.

APPENDIX A

2012 Performance Standards[31]

1. A UNIT CONFORMS WITH ALL APPLICABLE STATUTES, REGULATIONS, AND POLICY DIRECTIVES, INCLUDING:
A. Section 1903(q) of the Social Security Act, containing the basic requirements for operation of a MFCU;
B. Regulations for operation of a MFCU contained in 42 CFR part 1007;
C. Grant administration requirements at 45 CFR part 92 and Federal cost principles at 2 CFR part 225;
D. OIG policy transmittals as maintained on the OIG Web site; and
E. Terms and conditions of the notice of the grant award.
2. 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.
A. The Unit employs the number of staff that is included in the Unit's budget estimate as approved by OIG.
B. The Unit employs a total number of professional staff that is commensurate with the State's total Medicaid program expenditures and that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
C. The Unit employs an appropriate mix and number of attorneys, auditors, investigators, and other professional staff that is both commensurate with the State's total Medicaid program expenditures and that allows the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
D. The Unit employs a number of support staff in relation to its overall size that allows the Unit to operate effectively.
E. To the extent that a Unit maintains multiple office locations, such locations are distributed throughout the State, and are adequately staffed, commensurate with the volume of case referrals and workload for each location.
3. A UNIT ESTABLISHES WRITTEN POLICIES AND PROCEDURES FOR ITS OPERATIONS AND ENSURES THAT STAFF ARE FAMILIAR WITH, AND ADHERE TO, POLICIES AND PROCEDURES.
A. The Unit has written guidelines or manuals that contain current policies and procedures, consistent with these performance standards, for the investigation and (for those Units with prosecutorial authority) prosecution of Medicaid fraud and patient abuse and neglect.
B. The Unit adheres to current policies and procedures in its operations.
C. Procedures include a process for referring cases, when appropriate, to Federal and State agencies. Referrals to State agencies, including the State Medicaid agency, should identify whether further investigation or other administrative action is warranted, such as the collection of overpayments or suspension of payments.
D. Written guidelines and manuals are readily available to all Unit staff, either online or in hard copy.
E. Policies and procedures address training standards for Unit employees.
4. A UNIT TAKES STEPS TO MAINTAIN AN ADEQUATE VOLUME AND QUALITY OF REFERRALS FROM THE STATE MEDICAID AGENCY AND OTHER SOURCES.
A. The Unit takes steps, such as the development of operational protocols, to ensure that the State Medicaid agency, managed care organizations, and other agencies refer to the Unit all suspected provider fraud cases. Consistent with 42 CFR 1007.9(g), the Unit provides timely written notice to the State Medicaid agency when referred cases are accepted or declined for investigation.

[31] 77 Fed. Reg. 32645 (June 1, 2012).

B. The Unit provides periodic feedback to the State Medicaid agency and other referral sources on the adequacy of both the volume and quality of its referrals.
C. The Unit provides timely information to the State Medicaid or other agency when the Medicaid or other agency requests information on the status of MFCU investigations, including when the Medicaid agency requests quarterly certification pursuant to 42 CFR 455.23(d)(3)(ii).
D. For those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases, the Unit takes steps, such as the development of operational protocols, to ensure that pertinent agencies refer such cases to the Unit, consistent with patient confidentiality and consent. Pertinent agencies vary by State but may include licensing and certification agencies, the State Long Term Care Ombudsman, and adult protective services offices.
E. The Unit provides timely information, when requested, to those agencies identified in (D) above regarding the status of referrals.
F. The Unit takes steps, through public outreach or other means, to encourage the public to refer cases to the Unit.
5. 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.
A. Each stage of an investigation and prosecution is completed in an appropriate timeframe.
B. Supervisors approve the opening and closing of all investigations and review the progress of cases and take action as necessary to ensure that each stage of an investigation and prosecution is completed in an appropriate timeframe.
C. Delays to investigations and prosecutions are limited to situations imposed by resource constraints or other exigencies.
6. 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.
A. The Unit seeks to have a mix of cases from all significant provider types in the State.
B. For those States that rely substantially on managed care entities for the provision of Medicaid services, the Unit includes a commensurate number of managed care cases in its mix of cases.
D. As part of its case mix, the Unit maintains a balance of fraud and patient abuse and neglect cases for those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases.
C. The Unit seeks to allocate resources among provider types based on levels of Medicaid expenditures or other risk factors. Special Unit initiatives may focus on specific provider types.
E. As part of its case mix, the Unit seeks to maintain, consistent with its legal authorities, a balance of criminal and civil fraud cases.
7. 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.
A. Reviews by supervisors are conducted periodically, consistent with MFCU policies and procedures, and are noted in the case file.
B. Case files include all relevant facts and information and justify the opening and closing of the cases.
C. Significant documents, such as charging documents and settlement agreements, are included in the file.
D. Interview summaries are written promptly, as defined by the Unit's policies and procedures.
E. The Unit has an information management system that manages and tracks case information from initiation to resolution.
F. The Unit has an information management system that allows for the monitoring and reporting of case information, including the following:
1. The number of cases opened and closed and the reason that cases are closed.

2. The length of time taken to determine whether to open a case referred by the State Medicaid agency or other referring source.
3. The number, age, and types of cases in the Unit's inventory/docket
4. The number of referrals received by the Unit and the number of referrals by the Unit to other agencies.
5. The number of cases criminally prosecuted by the Unit or referred to others for prosecution, the number of individuals or entities charged, and the number of pending prosecutions.
6. The number of criminal convictions and the number of civil judgments.
7. The dollar amount of overpayments identified.
8. The dollar amount of fines, penalties, and restitution ordered in a criminal case and the dollar amount of recoveries and the types of relief obtained through civil judgments or prefiling settlements.
8. A UNIT COOPERATES WITH OIG AND OTHER FEDERAL AGENCIES IN THE INVESTIGATION AND PROSECUTION OF MEDICAID AND OTHER HEALTH CARE FRAUD.
A. The Unit communicates on a regular basis with OIG and other Federal agencies investigating or prosecuting health care fraud in the State.
B. The Unit cooperates and, as appropriate, coordinates with OIG's Office of Investigations and other Federal agencies on cases being pursued jointly, cases involving the same suspects or allegations, and cases that have been referred to the Unit by OIG or another Federal agency.
C. The Unit makes available, to the extent authorized by law and upon request by Federal investigators and prosecutors, all information in its possession concerning provider fraud or fraud in the administration of the Medicaid program.
D. For cases that require the granting of "extended jurisdiction" to investigate Medicare or other Federal health care fraud, the Unit seeks permission from OIG or other relevant agencies under procedures as set by those agencies.
E. For cases that have civil fraud potential, the Unit investigates and prosecutes such cases under State authority or refers such cases to OIG or the U.S. Department of Justice.
F. The Unit transmits to OIG, for purposes of program exclusions under section 1128 of the Social Security Act, all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders.
G. The Unit reports qualifying cases to the Healthcare Integrity & Protection Databank, the National Practitioner Data Bank, or successor data bases.
9. A UNIT MAKES STATUTORY OR PROGRAMMATIC RECOMMENDATIONS, WHEN WARRANTED, TO THE STATE GOVERNMENT.
A. The Unit, when warranted and appropriate, makes statutory recommendations to the State legislature to improve the operation of the Unit, including amendments to the enforcement provisions of the State code.
B. The 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. The Unit monitors actions taken by the State legislature and the State Medicaid or other agencies in response to recommendations.
10. A UNIT PERIODICALLY REVIEWS ITS MEMORANDUM OF UNDERSTANDING (MOU) WITH THE STATE MEDICAID AGENCY TO ENSURE THAT IT REFLECTS CURRENT PRACTICE, POLICY, AND LEGAL REQUIREMENTS.
A. The MFCU documents that it has reviewed the MOU at least every 5 years, and has renegotiated the MOU as necessary, to ensure that it reflects current practice, policy, and legal requirements.
B. The MOU meets current Federal legal requirements as contained in law or regulation, including 42 CFR 455.21, "Cooperation with State Medicaid fraud control units," and 42 CFR 455.23, "Suspension of payments in cases of fraud."
C. The MOU is consistent with current Federal and State policy, including any policies issued by OIG or the Centers for Medicare & Medicaid Services (CMS).
D. Consistent with Performance Standard 4, the MOU establishes a process to ensure the receipt of an adequate volume and quality of referrals to the Unit from the State Medicaid agency.

E. The MOU incorporates by reference the *CMS Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit*.
11. A UNIT EXERCISES PROPER FISCAL CONTROL OVER UNIT RESOURCES.
A. The Unit promptly submits to OIG its preliminary budget estimates, proposed budget, and Federal financial expenditure reports.
B. The Unit maintains an equipment inventory that is updated regularly to reflect all property under the Unit's control.
C. The Unit maintains an effective time and attendance system and personnel activity records.
D. The Unit applies generally accepted accounting principles in its control of Unit funding.
E. The Unit employs a financial system in compliance with the standards for financial management systems contained in 45 CFR 92.20.
12. A UNIT CONDUCTS TRAINING THAT AIDS IN THE MISSION OF THE UNIT.
A. The Unit maintains a training plan for each professional discipline that includes an annual minimum number of training hours and that is at least as stringent as required for professional certification.
B. The Unit ensures that professional staff comply with their training plans and maintain records of their staff's compliance.
C. Professional certifications are maintained for all staff, including those that fulfill continuing education requirements.
D. The Unit participates in MFCU-related training, including training offered by OIG and other MFCUs, as such training is available and as funding permits.
E. The Unit participates in cross-training with the fraud detection staff of the State Medicaid agency. As part of such training, Unit staff provide training on the elements of successful fraud referrals and receive training on the role and responsibilities of the State Medicaid agency.

APPENDIX B

Table B-1: Unit Referrals by Referral Source for FYs 2012 Through 2014

	FY 2012			FY 2013			FY 2014		
Referral Source	**Fraud**	**Abuse & Neglect**	**Patient Funds**	**Fraud**	**Abuse & Neglect**	**Patient Funds**	**Fraud**	**Abuse & Neglect**	**Patient Funds**
State Medicaid agency	6	0	0	2	0	0	2	0	0
Medicaid agency – other	0	0	0	0	0	0	1	0	0
State survey and certification agency	0	0	0	0	0	0	0	0	0
Other State agencies[32]	4	220	48	5	140	35	0	135	34
Licensing Board	2	0	0	0	2	0	0	6	0
Law enforcement	4	7	9	0	8	0	1	7	1
Office of Inspector General	0	0	0	0	0	0	0	0	0
Prosecutors	7	0	2	0	0	0	1	5	0
Providers	0	0	0	0	0	0	0	0	0
Provider associations	0	0	0	0	0	0	0	0	0
Private health insurer	0	0	0	0	0	0	0	0	0
Long-term-care ombudsman	0	0	0	0	0	0	0	0	0
Adult protective services	0	0	0	0	0	0	0	0	0
Private citizens	116	7	1	77	2	0	64	1	0
MFCU hotline	0	1	0	3	0	0	2	1	0
Other	1	1	0	4	2	0	3	0	0
Total	**140**	**236**	**60**	**91**	**154**	**35**	**74**	**155**	**35**
Annual Total			**436**			**280**			**264**

Source: OIG analysis of Unit-submitted documentation, FYs 2012–2014, 2015.

[32] The Unit reported that referrals from the Delaware Division of Long Term Care Residents Protection make up the majority of these referrals.

APPENDIX C

Investigations Opened and Closed by Provider Category for FYs 2012 Through 2014

Table C-1: Fraud Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
Facilities	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Hospitals	0	0	1	0	1	0
Nursing facilities	3	0	2	1	0	1
Other long-term-care facilities	0	1	0	0	0	0
Substance abuse treatment centers	0	0	0	0	0	0
Other	0	0	0	0	2	1
Subtotal	**3**	**1**	**3**	**1**	**3**	**2**
Practitioners	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Doctors of medicine or osteopathy	5	3	2	1	6	4
Dentists	0	0	2	0	0	1
Podiatrists	0	0	0	0	0	0
Optometrists/opticians	0	0	0	1	0	0
Counselors/psychologists	0	0	2	0	1	1
Chiropractors	0	0	0	0	0	0
Other	3	0	2	1	1	0
Subtotal	**8**	**3**	**8**	**3**	**8**	**6**
Medical Support	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Pharmacies	6	1	3	1	4	0
Pharmaceutical manufacturers	34	12	37	8	29	20
Suppliers of durable medical equipment and/or supplies	10	1	17	0	19	3
Laboratories	5	0	9	1	11	1
Transportation services	0	1	1	0	0	0
Home health care agencies	0	0	0	0	0	0
Home health care aides	0	0	0	0	0	0
Nurses, physician assistants, nurse practitioners, certified nurse aides	3	2	0	0	1	0
Radiologists	0	0	0	0	0	0
Medical support—other	7	1	7	0	9	2
Subtotal	**65**	**18**	**74**	**10**	**73**	**26**

Table C-1 (Continued): Fraud Investigations

Program Related	Opened	Closed	Opened	Closed	Opened	Closed
Managed care	0	0	0	0	0	0
Medicaid program administration	0	0	0	0	0	0
Billing company	0	0	0	0	0	0
Other	0	0	0	1	0	0
Subtotal	**0**	**0**	**0**	**1**	**0**	**0**
Total Provider Categories	**76**	**22**	**85**	**15**	**84**	**34**

Source: OIG analysis of Unit-submitted documentation, 2015.

Table C-2: Patient Abuse and Neglect Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing facilities	0	2	0	0	0	2
Other long-term-care facilities	0	0	0	0	0	0
Nurses, physician's assistants, nurse practitioners, certified nurse aides	16	14	18	9	25	27
Home health aides	0	0	0	0	1	0
Other	30	29	30	25	60	43
Total	**46**	**45**	**48**	**34**	**86**	**72**

Source: OIG analysis of Unit-submitted documentation, 2015.

Table C-3: Patient Funds Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Nondirect care	16	12	7	9	6	8
Nurses, physician's assistants, nurse practitioners, certified nurse aides	1	0	1	0	3	1
Home health aides	1	0	0	1	0	0
Other	12	2	4	8	5	6
Total	**30**	**14**	**12**	**18**	**14**	**15**

Source: OIG analysis of Unit-submitted documentation, 2015.

APPENDIX D

Detailed Methodology

We used data collected from the seven sources below to describe the caseload and assess the performance of the Delaware Unit.

Data Collection

Review of Unit Documentation. Prior to the onsite visit, we analyzed information from several sources regarding the Unit's investigation of Medicaid cases, including information about the number of referrals the Unit received, the number of investigations the Unit opened and closed, the outcomes of those investigations, and the Unit's case mix. We also collected and analyzed information about the number of cases that the Unit referred for prosecution and the outcomes of those prosecutions. We gathered this information from several sources, including the Unit's quarterly status reports, its annual reports, its recertification questionnaire, its policy and procedures manuals, and its MOU with the State Medicaid agency. Additionally, we confirmed with the Unit director that the information we had was current as of May 2015.

Review of Unit Financial Documentation. We reviewed the Unit's control over its fiscal resources to identify any internal control issues or other issues involving use of resources. Prior to the onsite review, we reviewed the Unit's financial policies and procedures; its response to an internal control questionnaire; and documents (such as financial status reports) related to MFCU grants.

We reviewed three purposive samples to assess the Unit's internal control of fiscal resources. All three samples were limited to the review period of FYs 2012 through 2014. The three samples included the following:

1. To assess the Unit's expenditures, we selected a purposive sample of 24 items from the Unit's 2,460 expenditure transactions. We selected routine and nonroutine transactions representing a variety of budget categories and payment amounts.
2. To assess the Unit's travel expenditures, we selected a purposive sample of 24 items from the Unit's 772 travel transactions. We selected eight travel related transactions for each FY. We selected a variety of travel expenditure categories such as hotel stays, airfare, conference expenses, rental cars, and meals.

3. To assess employees' time and effort, we selected a sample of three pay periods, one from each FY. We then requested and reviewed documentation (e.g., time card records) to support the time and effort of Unit staff during the selected pay periods.

We also reviewed a purposive sample of the Unit's supply inventory, including vehicles. Specifically, we selected and verified a purposive sample of 18 items from the current inventory list of 112 items. To ensure a variety in our inventory sample, we included larger items such as computers and vehicles as well as a mix of other items such as radios and cameras.

Interviews with Key Stakeholders. In May and June 2015, we interviewed key stakeholders, including officials in the United States Attorney's Office (Criminal and Civil Divisions), the Federal Bureau of Investigation, the State Attorney General's Office, and State Agencies that interacted with the Unit (i.e., Adult Protective Services, Delaware State Police, Division of Long Term Care Residents Protection, Division of Medicaid and Medical Assistance Program Integrity Unit, Division of Professional Regulation, and Long Term Care Ombudsman). We also interviewed a supervisor from OIG's Region III office who works regularly with the Unit. We focused these interviews on the Unit's relationship and interaction with OIG and other Federal and State authorities, and we identified opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management.

Survey of Unit Staff. In April and May 2015, we conducted an online survey of all 14 nonmanagerial Unit staff within each professional discipline (e.g., attorneys, investigators) as well as support staff. We received completed surveys from 12 of 14 staff, or 86 percent. The survey focused on operations of the Unit, opportunities for improvement, and practices that contributed to the effectiveness and efficiency of Unit operations and/or performance. The survey also sought information about the Unit's compliance with applicable laws and regulations.

Onsite Interviews with Unit Management. We conducted structured interviews with the Unit's management during our onsite review. We interviewed the Unit's director, deputy director, and chief investigator. We asked these individuals to provide information related to (1) the Unit's 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, and (4) clarification regarding information obtained from other data sources.

Onsite Review of Case Files and Other Documentation. We requested that the Unit provide us with a list of cases that were open at any point during FYs 2012 through 2014. The Unit provided a list of 876 cases that were open during the review period. For each of these 876 cases, the Unit provided data including: the current status of the case; whether the case was criminal, civil, or global; and the date on which the case was opened. From this list of cases, we excluded 528 cases that were categorized as "global," leaving a population of 348 cases that were open at any point during the review period.

We then selected a simple random sample of 100 cases from the population of open cases. We determined that 87 of these 100 sample cases were open longer than 90 days, and therefore required periodic supervisory review. Based on the percentage of cases in our sample that were open longer than 90 days, we estimated the subpopulation of all cases open longer than 90 days. We estimate this subpopulation is composed of approximately 303 case files within the 348 submitted. Table D-1 provides the sample size, the estimated subpopulation, and the 95-percent confidence interval for the estimate of the number of case files that were open longer than 90 days.

Table D-1: Estimate of Subpopulation Size

Subpopulation Description	Sampled Case Files	Estimated Number of Case Files	95-percent Confidence Interval
Case files open longer than 90 days	87	303	278–321

Source: OIG analysis of case files, 2015.

We reviewed the 87 sample cases to determine whether documentation for all required supervisory reviews was present. Using the results of our review, we reported an estimate of the number of case files that did not contain documentation of supervisory review for the above subpopulation. The point estimate and its 95-percent confidence intervals are in Appendix E.

From the initial sample of 100 case files, we selected a further simple random sample of 50 files for an OIG investigator to conduct an indepth review of selected issues, such as the timeliness of investigations and case development. We did not estimate any

population or subpopulation proportions from this additional sample of 50 case files.

Onsite Review of Unit Operations. During our June 2015 site visit, we observed the Unit's offices and meeting spaces; the security of data and case files; location of select equipment; and the general functioning of the Unit. We also determined whether the Unit referred sentenced individuals to OIG for program exclusion and whether the Unit reported adverse actions to the NPDB.

Data Analysis

We analyzed data to identify any opportunities for improvement and 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.[33] We based our findings on data analysis, statements from Unit staff, and our own judgment.

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

APPENDIX E

Table E-1: Point Estimate and 95-Percent Confidence Interval Based on Reviews of Case Files

Estimate Characteristic	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Case files open longer than 90 days that did not contain documentation of periodic supervisory review	87	43.7%	34.3%	53.1%

Source: OIG analysis of case files, 2015.

APPENDIX F
Unit Comments

MATTHEW P. DENN
ATTORNEY GENERAL

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January 19, 2016

Suzanne Murrin
Deputy Inspector General
Office of Inspector General
Office of Evaluations and Inspections
Room 5660, Cohen Building
330 Independence Avenue, SW
Washington, DC 20201

Re: Delaware MFCU 2015 Onsite Review (OEI-07-15-00240)

Dear Ms. Murrin:

This letter represents the invited comments of the Delaware Medicaid Fraud Control Unit (MFCU) to your report dated December 23, 2015. The Delaware MFCU would like to express its appreciation to the onsite review team for the professionalism of your staff during the onsite review process, and we thank you for the opportunity to comment on the recommendations of the review team.

Your report made six recommendations. The MFCU concurs with each recommendation, as explained more fully below.

Recommendation #1: Ensure that convictions are reported to OIG within 30 days of sentencing.

Unit Comment: The Unit concurs with this recommendation. Unit management recognized the failure to timely report convictions prior to the end of the onsite review period. All individuals not previously reported to OIG within the proper timeframe of the onsite review period have since been reported to OIG. The Unit is now up-to-date with its reporting requirement. To address the issue for future reporting, the MFCU policies and procedures manual dated November 23, 2015 memorializes the procedure by which all convictions obtained by the Unit are to be reported to OIG within thirty days of sentencing.

Recommendation #2: Ensure that adverse actions are reported to the National Practitioner Data Bank.

Unit Comment: The Unit concurs with this recommendation. Unit management recognized the failure to report any adverse actions to the National Practitioner Data Bank (NPDB) prior to the end of the onsite review period. The Unit renewed its registration with

NPDB in May 2015. All individuals not previously reported to the NPDB within the proper timeframe of the onsite review period have since been reported to the NPDB. Similar to the action taken in recommendation one, the Unit memorialized the procedure by which the Unit reports adverse actions to the NPDB in its policies and procedures manual dated November 23, 2015.

Recommendation #3: Ensure that supervisory reviews of Unit case files open longer than 90 days are conducted and documented.

Unit comment: The Unit concurs with this recommendation. As was explained by the Unit Director, prior to October 22, 2015 the quarterly case summaries were tied to meetings with the State Medicaid program integrity unit. Moreover, the Unit Director cited temporary management assignments as an explanation for why the review team may not have found evidence of supervisory review. On October 22, 2015, current Unit management revamped the quarterly case submission process. The October 22, 2015 policy was codified in the November 23, 2015 Policies and Procedures manual and no longer ties quarterly case submissions with quarterly State Medicaid agency meetings, consistent with the recommendation. Policies and Procedures dictate that the Unit will set up quarterly dates for submission of quarterly case summaries. The Unit Director will review and sign all quarterly case summaries, and Unit staff will ensure that each open master file will have a signed quarterly case summary for each quarter. Master files have been re-organized to ensure that quarterly case summaries are easily accessible for review. Notably, the current Unit Director has reviewed and signed all fourth quarter case summaries for 2015 and all first quarter case summaries for 2016. Those case summaries are documented in the case files.

Recommendation #4: Repay Federal matching funds spent on the cases that were not eligible for Federal Funding.

Unit comment: The Unit concurs with this recommendation. In light of this recommendation, the Unit has instructed all staff, particularly intake investigators, on the scope of Unit jurisdiction. The Unit has submitted a memo to OIG noting the staff hours, fringe and indirect costs spent working on these two cases. To the extent investigative or attorney activity on these cases involved determining whether a viable patient funds allegation existed, that activity was not included in the memo. The memo solely addressed any activity that was outside the scope of Unit jurisdiction, as outlined in the report.

Recommendation #5: Secure case files.

Unit comment: The Unit concurs with this recommendation. Unit staff maintains keys for the case files and have been instructed to lock filing cabinets to prevent misuse of sensitive information under the Unit's control.

Recommendation #6: Revise the MOU with the State Medicaid agency to reflect current practice.

Unit comment: The Unit concurs with this recommendation. On November 30, 2015, Unit management had a teleconference with the State Medicaid agency PIU Director and Systems Utilization and Review Unit Administrator to discuss revisions to the MOU. The Unit and agency agreed to update the MOU. As of the date of this submission, the Unit sent a draft revised MOU to the State Medicaid agency. The agency provided a deadline of April 1, 2016 for a final, signed version of the MOU.

While no specific recommendations were made with respect to the finding that only a small portion of Unit fraud referrals came from the State Medicaid agency, the Unit has made significant efforts to improve the referral process with the State Medicaid agency. Notable strides include the Unit soliciting referrals from the agency, the Unit stressing the importance of maintaining quarterly meetings between the Unit and the Systems Utilization and Review Unit of the State Medicaid agency's Program Integrity Unit, and re-instating monthly Unit and PIU manager meetings. The Unit is also working with the Medicaid agency to provide cross-training between the Unit and the agency. Finally, in early 2016, Unit managers will be attempting to set-up meetings with the Medicaid agency's subject matter experts to open a dialogue in the hopes of soliciting more referrals from the various provider disciplines.

Thank you again for the opportunity to formally comment and report on the significant advances the MFCU has made since the onsite review. The Unit greatly appreciates the guidance and insight provided by the review team. We look forward to working with OIG/HHS as we pursue the mission of this Unit to investigate and prosecute Medicaid fraud and patient abuse and neglect.

Sincerely,

Kate S. Keller
Director
Medicaid Fraud Control Unit
Delaware Department of Justice

cc: Jordan Clementi
(Via Email)

ACKNOWLEDGEMENTS

This report was prepared under the direction of Brian T. Whitley, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office.

Tricia Fields served as the project leader for this study. Other Office of Evaluation and Inspections staff who conducted the study include Teresa Dailey and Dennis J. Tharp. Other Office of Evaluation and Inspections staff who contributed to this study include Conswelia McCourt and Michala Walker. Office of Investigations staff also participated in the review. Central office staff who contributed include Jordan R. Clementi, Kevin Farber, Lonie Kim, Joanne Legomsky, and Andrew VanLandingham.

Office of Inspector General

http://oig.hhs.gov

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