Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MASSACHUSETTS STATE MEDICAID FRAUD CONTROL UNIT: 2015 ONSITE REVIEW

Suzanne Murrin
Deputy Inspector General
For Evaluation and Inspections

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EXECUTIVE SUMMARY: MASSACHUSETTS STATE 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. These reviews assess the Unit's adherence to the 12 MFCU performance standards and compliance with applicable Federal statutes and regulations.

HOW WE DID THIS STUDY

We conducted an onsite review of the Massachusetts Unit in October 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; (2) financial documentation for fiscal years (FYs) 2012 through 2014; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) a sample of files for cases that were open in FYs 2012 through 2014; and (7) observation of Unit operations.

WHAT WE FOUND

The Unit was generally in compliance with applicable laws, regulations, and policy transmittals. For FYs 2012 through 2014, the Massachusetts Unit reported 49 criminal convictions, 72 civil judgments and settlements, and combined criminal and civil recoveries of $182 million. We noted that the Massachusetts Unit has developed successful partnerships with other agencies and clinical experts to investigate and prosecute pharmacy cases, and streamlined a number of administrative processes using a customized intranet.

We identified two areas where the Unit should improve its performance. Specifically, the Unit should better ensure that all case files contain documentation of periodic supervisory reviews, and report all convictions and adverse actions to Federal partners within required timeframes.

WHAT WE RECOMMEND

We recommend that the Massachusetts Unit monitor the implementation of its new policies and processes for (1) documenting periodic supervisory reviews results, and (2) ensuring that all convictions and adverse actions are reported to Federal partners within required timeframes. The Unit concurred with both of our recommendations.

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OBJECTIVE

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

BACKGROUND

The mission of MFCUs is to investigate and prosecute Medicaid provider fraud and patient abuse or neglect under State law.[1] The SSA requires each State to operate a MFCU, unless the Secretary of Health and Human Services (HHS) determines that operation of a Unit would not be cost-effective because minimal Medicaid fraud exists in a particular State and 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 MFCUs.[3]

Each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.[4] Unit staff review referrals of provider fraud and patient abuse or neglect to determine their potential for criminal prosecution and/or civil action. In fiscal year (FY) 2015, the 50 Units collectively reported 1,553 convictions, 795 civil settlements or judgments, and approximately $745 million in recoveries.[5, 6]

Units must meet a number of requirements established by the SSA and Federal regulations. For example, each Unit must:

- be a single, identifiable entity of State government, distinct from the single State Medicaid agency;[7]
- develop a formal agreement, such as a memorandum of understanding (MOU), which describes the Unit's relationship with the State Medicaid agency;[8] and

[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] SSA § 1903(q)(6); 42 CFR §1007.13.

[5] Office of Inspector General (OIG), *MFCU Statistical Data for Fiscal Year 2015*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm on April 13, 2016.

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

[7] SSA § 1903(q)(2); 42 CFR § 1007.5 and 1007.9(a).

[8] 42 CFR § 1007.9(d).

- have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority.[9]

MFCU Funding

Each MFCU is funded jointly by its State and the Federal government. Federal funding for the MFCUs is provided as part of the Federal Medicaid appropriation, but it is administered by OIG.[10] Each Unit receives Federal financial participation equivalent to 75 percent of its total expenditures, with State funds contributing the remaining 25 percent.[11] In FY 2015, combined Federal and State expenditures for the Units totaled $251 million, $188 million of which represented Federal funds.[12]

Administration and Oversight of the MFCU Program

The Secretary of HHS delegated to OIG the authority to administer the MFCU grant program.[13] To receive Federal reimbursement, each Unit must submit an initial application to OIG for approval and be recertified each year thereafter.

In annually recertifying the Units, OIG evaluates Unit compliance with Federal requirements and adherence to performance standards. The Federal requirements for Units are contained in the SSA, regulations, and policy guidance.[14] In addition, OIG has published 12 performance standards that it uses to assess whether a Unit is effectively performing its responsibilities.[15] The standards address topics such as staffing, maintaining adequate referrals, and cooperation with Federal authorities. Appendix A contains the Performance Standards.

OIG also performs periodic onsite reviews of the Units, such as this review of the Massachusetts MFCU. During these onsite reviews, OIG evaluates Units' compliance with laws, regulations, and policies, as well as adherence to the 12 performance standards. OIG also makes observations about best

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[9] SSA § 1903(q)(1).

[10] SSA § 1903(a)(6)(B).

[11] Ibid.

[12] Office of Inspector General (OIG), *MFCU Statistical Data for Fiscal Year 2015*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm on April 13, 2016.

[13] The SSA authorizes the Secretary of HHS to award grants to the Units; the Secretary delegated this authority to the OIG.

[14] On occasion, OIG issues policy transmittals to provide guidance and instructions to MFCUs.

[15] 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Performance%20Standards.pdf on May 22, 2015. On June 1, 2012, OIG published a revision of the performance standards at 77 Fed. Reg. 32645. Because our review covered FYs 2012 through 2014, we applied the standards published on June 1, 2012.

practices, provides recommendations to the Units, and monitors the implementation of the recommendations. These evaluations differ from other OIG evaluations as they support OIG's direct administration of the MFCU grant program. These evaluations are subject to the same internal quality controls as other OIG evaluations, including internal peer review.

OIG provides additional oversight including the collection and dissemination of performance data, training, and technical assistance.

Massachusetts MFCU

The Unit, a division of the Massachusetts Office of the Attorney General, investigates and prosecutes cases of Medicaid fraud and patient abuse or neglect. To investigate and prosecute such cases, the Unit employed 46 staff as investigators, attorneys, auditors, nurse investigators, paralegals, and administrative staff during the time of our onsite review.[16] The Massachusetts Unit had total expenditures of approximately $5.4 million in combined State and Federal funds in FY 2015.[17]

The Unit is broadly organized into two groups, investigators (which includes the Unit auditors) and attorneys. The investigators and auditors report to either an investigations supervisor, or directly to the Chief of Investigations. The three investigations supervisors also report to the Chief of Investigations. The Unit employs two Managing Assistant Attorneys General (AAGs). The attorneys report to one of the Managing AAGs, the Unit director, or the Unit Deputy Chief. The Chief of Investigations, the Managing AAGs, and the Deputy Chief all report to the Unit director. The second Managing AAG manages the Unit's global cases.

Referrals. The Unit receives referrals from a variety of sources, including the State Medicaid agency, a hotline, and private citizens. Appendix B depicts Unit referrals by referral source for FYs 2012 through 2014. For each referral received, Unit staff perform an initial review. The results of the initial review of each referral are discussed at a weekly management meeting. The Unit director and Chief of Investigations, in consultation with other Unit staff, decide whether to open a case based on each referral.

Periodic Supervisory Reviews. The Unit conducts periodic supervisory reviews on each open case. The Unit Policy and Procedures Manual requires supervisory review of each case at least quarterly, but according to the Unit director, the Unit strives to review each case monthly. During these reviews, the assigned investigator or attorney and appropriate supervisor discuss the

[16] In the Massachusetts Unit, four staff were designated as auditors at the time of our review. Although the title of each of these four staff was "Investigator" or "Senior Investigator," the Director explained that their duties fulfilled the auditor function.

[17] OIG, *MFCU Statistical Data for Fiscal Year 2015*, February 2016.

progress made on each case and plan the next steps for pursuing the case. The reviews are noted in the Unit's online tracking system.

The Chief of Investigations also meets with each investigator periodically to discuss progress on cases. The frequency of these case meetings ranges from weekly to monthly, depending on the experience of the investigator.

Appendix C contains details on opened and closed investigations.

Previous Onsite Review

In 2010, OIG published a report regarding its onsite review of the Massachusetts Unit.[18] OIG found that the Massachusetts Unit did not maintain interim investigative memoranda, which note the progress of investigations, in official case files. Our 2015 onsite review found no further evidence that the Unit did not document the progression of its investigations.

METHODOLOGY

Data Collection and Analysis

We conducted the onsite review in October 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; (2) financial documentation for FYs 2012 through 2014; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) a sample of files for cases that were open in FYs 2012 through 2014; and (7) observation of Unit operations. We also used these data sources to determine if any issues related to findings from the previous OIG onsite review persisted. Appendix D provides details of our methodology.

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.

[18] OIG, *Onsite Review of the Commonwealth of Massachusetts Medicaid Fraud Control Unit*, March 2010.

FINDINGS

Our review of the Massachusetts Unit found that it was generally in compliance with applicable laws, regulations, and policy transmittals. The Unit reported 49 criminal convictions and 72 civil judgements and settlements. It also reported combined criminal and civil recoveries of $182 million, and recovered more than $11 in combined Federal and State expenditures for every $1 spent in the review period.

We identified two areas where the Unit should improve its operations. Specifically, the Unit should better ensure that all case files contain documentation of periodic supervisory reviews, and report all convictions and adverse actions to Federal partners within required timeframes.

For FYs 2012 through 2014, the Massachusetts Unit reported 49 criminal convictions, 72 civil judgments and settlements, and combined criminal and civil recoveries of $182 million

For FYs 2012 through 2014, the Unit reported 49 criminal convictions and 72 civil judgments and settlements. See Table 1 for yearly convictions and civil judgments and settlements. Of the Unit's 49 convictions over the 3-year period, 42 involved provider fraud and 7 involved patient abuse and neglect.

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

Outcomes	FY 2012	FY 2013	FY 2014	3-Year Total
Criminal Convictions	11	17	21	49
Civil Judgments and Settlements	19	32	21	72

Source: OIG analysis of Unit-submitted documentation, 2016.

The Unit reported criminal and civil recoveries totaling $182 million for FYs 2012 through 2014. Sixty-eight percent of the Unit's recoveries were obtained from "global" settlements during the period of our review.[19] See Table 2 for the Massachusetts Unit's yearly recoveries and expenditures.

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

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

Type of Recovery	FY 2012	FY 2013	FY 2014	3-Year Total
Global Civil	$47,548,936	$26,209,559	$50,327,005	$124,085,500
Nonglobal Civil	$44,379,513	$2,514,310	$5,288,196	$52,182,018
Criminal	$227,034	$884,124	$4,639,474	$5,750,632
Total Recoveries	**$92,155,483**	**$29,607,993**	**$60,254,675**	**$182,018,150**
Total Expenditures	$5,456,458	$5,271,067	$5,470,721	$16,198,246

Source: OIG analysis of Unit-submitted documentation, 2016.

Eighteen percent of the case files lacked required documentation of periodic supervisory reviews; however, supervisors documented opening and closing of most cases

Eighteen percent of the case files that required periodic supervisory reviews lacked documentation of such reviews. Performance Standard 7(a) states that supervisory reviews should be conducted periodically and noted in the case file. Further, the Unit's policy requires a review of each case at least quarterly.[20] Pursuant to this policy, the Managing AAG or Chief of Investigations notes each supervisory review on the Unit's intranet. Periodic supervisory reviews ensure timely completion of cases and may identify potential issues during the investigation.

Although some case files lacked documentation of periodic supervisory reviews, most case files contained documentation of supervisory approval to open and close the cases. Eighty-eight percent of the Unit's case files included documentation of supervisory approval to open the cases. All of the Unit's closed cases included documentation of supervisory approval to close the case.[21] Performance Standard 5(b) states that Unit supervisors should approve the opening and closing of cases. The Unit's policy also requires that opening and closing documents be maintained in case files.[22] Supervisory approval to open cases indicates that Unit supervisors are monitoring the intake of cases, thereby facilitating progress in the

[20] "MA MFCU Policy and Procedures Manual," B-4 Supervisory Reviews, p. 12.

[21] All closed case files in our sample included documentation of supervisory approval to close the cases. However, we cannot be certain—because of sampling error—that all of the Unit's closed case files in the review period included this documentation. As a statistical matter, we are 95-percent confident that at least 96.2 percent of the closed cases in the population had documentation of supervisory approval to close the case.

[22] "MA MFCU Policy and Procedures Manual," B1-Case Opening Procedures and B2-Case Closing Procedures, p. 11.

investigation. Supervisory approval of case closures helps ensure the timely completion and resolution of cases.

During FY 2014 (toward the end of our review period), the Unit implemented a new, streamlined method of documenting periodic supervisory reviews and supervisory approvals to open and close cases through their intranet site. According to Unit staff, this new method greatly improved the process of documenting these reviews. However, because the new process was implemented near the end of the review period, few sampled cases were required to have periodic reviews. Therefore, we could not verify whether the new process resulted in documentation of more periodic supervisory reviews.

The Unit did not report all convictions and adverse actions to Federal partners within required timeframes

The Unit did not report all convictions to OIG for the purpose of program exclusion or all adverse actions to the National Practitioner Data Bank (NPDB) within the required timeframes. The Unit director explained that, for part of the review period, the Unit was using an old reporting process that did not result in all convictions being reported to OIG in a timely manner. However, in January 2013, the Unit instituted a new reporting process to address this issue. With regard to NPDB reporting, the Unit director explained that the Unit was not aware of the requirement to report adverse actions to NPDB within 30 days until September 2013. In March 2014, the Unit began tracking reporting of adverse actions to NPDB through the new process as well.

The Unit did not report all convictions to OIG within required timeframes.

The Unit did not report 21 of its 49 convictions to OIG within 30 days of sentencing as required by Federal regulations. Table 3 shows how many days after sentencing these convictions were reported to OIG. Performance Standard 8(f) states that the Unit should transmit to OIG reports of all convictions for the purpose of exclusion from Federal health care programs within 30 days of sentencing. Late reporting of convictions to OIG delays the initiation of the program exclusion process, which may result in improper payments to providers by Medicare or other Federal health care programs or possible harm to beneficiaries.

Table 3: Number of Convictions Reported to OIG After Required Timeframe

Federal Partner Reported To	Convictions Reported Within 31 to 60 Days After Sentencing	Convictions Reported Within 61 to 90 Days After Sentencing	Convictions Reported More Than 90 Days After Sentencing	Total Convictions Reported More Than 30 Days After Sentencing
OIG	8	2	11	**21**

Source: OIG analysis of Unit convictions and dates reported to OIG, 2016.

Unit management explained that many of the convictions that were reported late occurred prior to implementation of its new reporting process in January 2013. The new process provides multiple opportunities for tracking, documenting, and communicating about convictions. These opportunities include:

- submission of court activity reports by Unit attorneys after every court appearance. The court activity reports detail actions taken in court and indicate the next scheduled court event. These reports are submitted to the Unit director and the Unit's support staff. They ensure that the Unit's support staff who are responsible for reporting convictions to OIG have current court information on all active cases.
- preparation of biweekly reports by all Unit attorneys and investigators. The biweekly reports describe significant activities, including convictions, from the past two weeks, and significant activities expected in the next two weeks. These reports are reviewed at several levels, including supervisors, the Deputy Chief, and the Unit director.
- weekly meetings between Unit management and support staff to discuss a wide variety of issues, including conviction reporting.

The Unit director reported that 25 of the Unit's 29 convictions obtained since the implementation of the new process were reported in a timely manner. The new processes are documented in the Unit's policy and procedures manual.[23]

The Unit did not report most of its adverse actions to NPDB within required timeframes.

The Unit did not report 45 of its 49 convictions to NPDB within 30 days of the adverse action. Federal regulations require that Units report any adverse actions generated as a result of investigations or prosecutions of

[23] "MA MFCU Policy and Procedures Manual," D2-Court Activity Reports, p. 18 and F5-Bi-Weekly Reports, p. 24.

healthcare providers to the NPDB.[24] Performance Standard 8(g) also states that the Unit should report qualifying cases to NPDB.[25] The NPDB is intended to restrict the ability of physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice and adverse actions. If a Unit fails to report adverse actions to the NPDB, individuals may be able to find new healthcare employment with an organization that is not aware of their adverse actions.

Table 4: Number of Convictions Reported to NPDB After Required Timeframe

Federal Partner Reported To	Convictions Reported Within 31 to 60 Days After the Action	Convictions Reported Within 61 to 90 Days After the Action	Convictions Reported More Than 90 Days After the Action	Total Convictions Reported More Than 30 Days After the Action
NPDB	2	0	43	**45**

Source: OIG analysis of Unit convictions and dates reported to NPDB, 2016.

Unlike delays in reporting convictions to OIG for exclusion, delays in reporting adverse actions to NPDB occurred because the Unit was unaware of the requirement to report to NPDB within 30 days. According to the Unit director, the Unit learned of the NPDB reporting requirement in a September 2013 webinar OIG hosted. In March 2014, the Unit began including the reporting of adverse actions to NPDB in their new process for reporting convictions described above. The new reporting process provides multiple opportunities for documentation and communication help ensure the timely reporting of adverse actions to NPDB.

Other observation: The Unit has developed successful partnerships with other agencies and clinical experts to investigate and prosecute pharmacy cases

The Unit has developed successful partnerships with other agencies and effective methods of accessing specialized expertise in its investigation and prosecution of pharmacy cases, including cases involving the overprescription and/or abuse of opioids. The Unit developed these relationships in response to the recent rise in problems with opioid abuse in Massachusetts. In March 2014, Massachusetts' Governor declared a public

[24] 45 CFR § 60.5.

[25] 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." The HIPDB and the NPDB were merged during our review period (FYs 2012 through 2014); therefore, we reviewed the reporting of adverse actions under NPDB requirements. 78 Fed. Reg. 20473 (April 5, 2013). Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions. See SSA § 1128E(g)(1) and 45 CFR § 60.3.

health emergency related to opioid addiction; and in December 2015, the Massachusetts Medical Society called the opioid crisis the Society's top priority.[26]

Unit staff reported that their strong, cooperative relationship with the Drug Enforcement Administration's (DEA's) Diversion Program led to the Unit's successful prosecutions of cases involving drug diversion and illegal prescription of opioids. DEA has the ability to efficiently obtain original prescriptions from pharmacies, a time- and resource-intensive task that is necessary to investigate and prosecute illegal prescribing. The partnership also helps identify new cases; the Unit has opened several investigations based on DEA referrals of suspect pharmacies and prescribers. DEA performs pharmacy inspections, and therefore has ample information on prescribing doctors and their employees.

The Unit also cooperates with the Norfolk County Overdose Death Review Team, which performs periodic reviews of all deaths from opiate drug overdoses. A working group of staff from the county and other State police and licensing agencies conduct these reviews. The team reviews the prescription histories of county residents who die from overdoses of opiate drugs to identify providers and pharmacies who may be involved in abusive or illegal prescribing. Unit staff also identified their relationship with the Norfolk County working group as a rich source of referrals and investigative information. For example, the working group may identify abusive practices by a prescriber or pharmacy already under investigation by the Unit and provide information to the Unit that helps support their case.

Additionally, Unit staff reported that they gain access to specialized expertise on prescribing and the pharmaceutical industry by employing students from local pharmacy schools as interns. The pharmacy interns use their expertise to review pharmacy claims and identify recipients who receive Medicaid-paid prescription drugs, but who do not have claims for office visits or other healthcare services from the prescribers of those drugs. Unit staff reported that the interns contribute significantly to the Unit's pharmacy cases, but cost the Unit little in terms of budget and resources.

Other observation: The Unit has streamlined a number of administrative processes using its intranet

The Unit has streamlined several administrative processes through its intranet. Unit staff reported that the improvements to these processes have

[26] Massachusetts Medical Society, 2015 Interim Meeting: President's Report, December 4, 2015. Accessed online at http://www.massmed.org/Governance-and-Leadership/House-of-Delegates/Interim-Meeting/2015-Interim-Meeting--President-s-Report/#.VxEqx032bcs on April 15, 2016.

helped the Unit ensure timely progression of cases and effective investigation and prosecution of fraud and abuse.

The Unit tracks and documents periodic supervisory case reviews through the intranet site. Each manager has a folder on the intranet for each staff person supervised; reviews of the cases assigned to each staff person are noted in that person's folder. When a manager notes a case review, the intranet automatically sends an email to the Unit's support staff. The support staff then update the Unit's case management system to reflect the case review conducted.[27]

Another process the Unit has streamlined through its intranet is supervisory review and approval of opening and closing memos. When each case is opened and closed, the staff assigned to it draft a memorandum explaining why the case should be opened, or why it is ready to be closed. When Unit staff upload a draft memorandum to the intranet, it is automatically routed to the appropriate supervisor(s) for review. When each supervisor approves the memorandum, the intranet records those approvals.

The Unit has also streamlined a number of other administrative processes through the intranet, including: requesting criminal history information, requesting data from the State Medicaid agency, managing staff leave requests, and populating calendars with scheduled leave and court appearances. Finally, the intranet also provides links to useful resources, such as the Unit's Policy and Procedures Manual and administrative forms.

[27] The Unit implemented this process near the end of the review period; thus, our case file review results do not reflect any improvements in documentation of periodic reviews that resulted from the new process.

CONCLUSION AND RECOMMENDATIONS

Our review of the Massachusetts Unit found that it was generally in compliance with applicable laws, regulations and policy transmittals. The Unit reported obtaining 49 criminal convictions and 72 civil judgments and settlements during the review period. The Unit also reported combined criminal and civil recoveries of $182 million, and recovered more than $11 in combined Federal and State expenditures for every $1 spent in the review period. The Massachusetts Unit has developed successful partnerships and effective methods of accessing expertise to investigate and prosecute pharmacy cases, and streamlined a number of administrative processes using its customized intranet.

We identified two areas where the Unit should improve its operations. Specifically, the Unit should better ensure that all case files contain documentation of periodic supervisory reviews, and should report all convictions and adverse actions to Federal partners within required timeframes.

We recommend that the Massachusetts Unit:

Monitor implementation of its new policies and process for documenting periodic supervisory reviews

The Unit already has implemented new policies and a related process to ensure that periodic supervisory case reviews are documented. To ensure the new policies and related process are working as intended, the Unit could review a sample of its own case files to determine if the changes produce the required documentation. If the Unit finds that some reviews are not being documented, it should further revise to its process to ensure the documentation of all periodic supervisory reviews.

Monitor implementation of its new policies and process to ensure all convictions and adverse actions are being reported to Federal partners within required timeframes

The Unit already has implemented new policies and a related process to ensure that convictions are reported to OIG within 30 days and adverse actions are reported to NPDB within 30 days. To ensure the new policies and related process are working as intended, the Unit could periodically review its own reporting to determine if all convictions and adverse actions being reported to both OIG and NPDB in a timely manner. If these reviews indicate that some convictions or adverse actions are not being reported within required time frames, the Unit should further revise its processes to ensure the timeliness of all reporting to Federal partners.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Massachusetts Unit concurred with both of our recommendations.

Regarding the first recommendation, the Unit stated that it will continue to use its intranet to facilitate documentation of supervisory reviews. The Unit also will monitor the effectiveness of the system through periodic self-reviews.

Regarding the second recommendation, the Unit stated that it will monitor its policies and procedures that are intended to ensure compliance with adverse action reporting requirements and that it has added this as a discussion item to its weekly meetings with support staff.

The Unit's comments are provided in Appendix F.

APPENDIX A

2012 Performance Standards[28]

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.
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.

[28] 77 Fed. Reg. 32645, June 1, 2012.

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

Massachusetts State Medicaid Fraud Control 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**
Medicaid agency – PI/SURS[29]	69	0	0	18	0	0	0	0	0
Medicaid agency – other	0	0	0	24	0	0	65	0	0
Managed care organizations	0	0	0	0	0	0	1	0	0
State survey and certification agency	8	1,014	1	2	986	1	3	1,176	0
Other State agencies	12	0	0	2	0	0	4	0	0
Licensing board	0	0	0	0	0	0	4	0	0
Law enforcement	2	0	0	14	2	0	6	1	0
Office of Inspector General	5	2	0	2	0	0	2	0	0
Prosecutors	1	0	0	0	0	0	2	0	0
Providers	6	0	0	4	0	0	0	0	0
Provider associations	0	0	0	0	0	0	0	0	0
Private health insurer	1	0	0	2	0	0	0	0	0
Long-term-care ombudsman	0	0	0	0	0	0	0	0	0
Adult protective services	0	0	0	1	1	0	0	0	0
Private citizens	54	0	0	116	2	0	102	1	0
MFCU hotline	178	0	0	78	14	0	149	36	0
Self-generated	5	0	0	3	0	0	1	0	0
Other	12	0	0	6	0	0	5	0	1
Total	**353**	**1,016**	**1**	**272**	**1,005**	**1**	**344**	**1,214**	**1**
Annual Total			**1,370**			**1,278**			**1,559**

Source: OIG analysis of Unit-submitted documentation, 2016.

[29] The abbreviation "PI" stands for program integrity; the abbreviation "SURS" stands for Surveillance and Utilization Review Subsystem.

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	3	1	1	0	3	1
Nursing facilities	8	6	2	6	3	3
Other long-term-care facilities	0	0	0	0	0	0
Substance abuse treatment centers	0	0	0	0	0	0
Other	39	8	20	13	20	27
Subtotal	**50**	**15**	**23**	**19**	**26**	**31**
Practitioners	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Doctors of medicine or osteopathy	43	21	13	20	16	21
Dentists	28	24	11	10	11	15
Podiatrists	0	0	1	1	0	0
Optometrists/opticians	0	0	1	1	1	0
Counselors/psychologists	0	0	1	1	2	1
Chiropractors	2	3	0	0	0	0
Other	15	5	1	5	5	6
Subtotal	**88**	**53**	**28**	**38**	**35**	**43**
Medical Support	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Pharmacies	17	32	16	6	14	9
Pharmaceutical manufacturers	51	24	33	36	29	29
Suppliers of durable medical equipment and/or supplies	15	8	21	3	19	2
Laboratories	7	4	5	6	8	6
Transportation services	5	0	1	7	3	4
Home health care agencies	12	8	11	2	4	8
Home health care aides	20	16	16	17	11	13
Nurses, physician assistants, nurse practitioners, certified nurse aides	4	7	1	2	2	1
Radiologists	1	1	0	0	0	0
Medical support—other	0	0	0	0	0	0
Subtotal	**132**	**100**	**104**	**79**	**90**	**72**

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	0	0	0
Subtotal	**0**	**0**	**0**	**0**	**0**	**0**
Total Provider Categories	**270**	**168**	**155**	**136**	**151**	**146**

Source: OIG analysis of Unit-submitted documentation, 2016.

Table C-2: Patient Abuse and Neglect Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing facilities	256	201	52	103	35	78
Other long-term-care facilities	0	0	0	0	0	0
Nurses, physician's assistants, nurse practitioners, certified nurse aides	97	90	35	46	16	44
Home health aides	0	0	0	0	0	0
Other	6	4	1	3	1	3
Total	**359**	**295**	**88**	**152**	**52**	**125**

Source: OIG analysis of Unit-submitted documentation, 2016.

Table C-3: Patient Funds Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Nondirect care	0	0	0	0	0	0
Nurses, physician's assistants, nurse practitioners, certified nurse aides	0	0	0	0	0	0
Home health aides	0	0	0	0	0	0
Other	1	1	1	0	0	1
Total	**1**	**1**	**1**	**0**	**0**	**1**

Source: OIG analysis of Unit-submitted documentation, 2016.

APPENDIX D

Detailed Methodology

Data collected from the seven sources below was used to describe the caseload and assess the performance of the Massachusetts MFCU.

Data Collection

Review of Unit Documentation. Prior to the onsite visit, we analyzed information 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 statistical reports, its annual reports, its recertification questionnaire, its policy and procedures manuals, and its MOU with the State Medicaid agency. We requested any additional data or clarification from the Unit as necessary.

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 FY 2012 through FY 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 2,611 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 94 travel transactions. We selected a variety of travel expenditure categories related to both in-State and out-of-State travel, such as hotel stays, airfare, and conference expenses.
3. To assess employees' "time and effort"—i.e., their work hours spent on various MFCU tasks—we selected a sample of three pay periods, one from each fiscal year. We then requested and reviewed

documentation (e.g., time card records) to support the time and effort of the MFCU 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 31 items from the current inventory list of 495 items maintained in the Unit's Boston office. To ensure a variety in our inventory sample, we included expensive items such as computers and vehicles, as well as less-expensive items such as flash drives and computer monitors.

Interviews with Key Stakeholders. In August and September 2015, we interviewed key stakeholders, including officials in the United States Attorneys' Offices, the State Attorney General's Office, and other State agencies that interacted with the Unit (i.e., the Medicaid Program Integrity Unit, the Bureau of Health Care Quality and Safety, and the Division of Health Professions Licensure). We also interviewed supervisors from OIG's Region I offices who work regularly with the Unit. We focused these interviews on the Unit's relationship and interaction with OIG and other Federal and State authorities and opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management.

Survey of Unit Staff. In September 2015, we conducted an online survey of all 37 nonmanagerial Unit staff within each professional discipline (i.e., investigators, attorneys, and nurse investigators) as well as support staff. The response rate was 100 percent. Our questions 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 the onsite review in October 2015. We interviewed the Unit's director, Deputy Chief, Chief of Investigations, Managing AAGs, and Administrative Assistant. We asked these individuals to provide information related to (1) Unit operations, (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance, (3) opportunities for the Unit to improve its operations and/or performance, 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. This list of 1,635 cases included, but was not limited to, the current status of the case; whether the case was criminal, civil, or global; and the date on which the case was opened. Because

global cases are civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a group of State MFCUs, we exclude those cases from our review of a Unit's case files. Therefore, we excluded 387 cases that were categorized as "global." We also excluded four cases that were opened in 2015, after the end of the review period. After these exclusions, 1,244 case files remained.

From the 1,244 cases, we selected a simple random sample of 106 cases for review. From this initial sample of 106 case files, we selected a simple random sample of 53 files for a more indepth review of selected issues, such as the timeliness of investigations and case development.

Through our case review, we determined that 2 sampled cases were global cases that had not been identified as globals in the case list. Two more cases should have been closed prior to the beginning of the review period, but were not because of an administrative oversight. These four cases were ineligible to be in the sample. After excluding the ineligible cases, we reviewed a total of 102 sampled case files total, including 92 closed cases, and 79 cases that were open longer than 90 days.

Because there were ineligible cases in the 106 sampled cases, there could be other ineligible cases in the population. Therefore, we estimated: (1) the population of eligible case files, (2) the subpopulation of eligible closed case files, and (3) the subpopulation of eligible cases active and open longer than 90 days, as shown in Table D-1.

Table D-1: Estimates of the Population of Eligible Case Files and Selected Subpopulations

Estimate Description	Sampled Case Files	Population of Case Files	95-percent Confidence Interval
Total eligible case files	102	1,197	1,130–1,231
Eligible closed case files	92	1,080	1,984–1,150
Eligible case files open longer than 90 days	79	927	815–1,023

Source: OIG analysis of Massachusetts MFCU case files, 2016.

Using the results of our review of the sampled case files, we reported one estimate for each of the above subpopulations. Appendix E contains the point estimates and their 95-percent confidence intervals.

Onsite Review of Unit Operations. During our October 2015 onsite visit, we reviewed the Unit's workspace and operations. Specifically, we visited the Unit headquarters in the State capital. While onsite, we

observed the Unit's offices and meeting spaces, security of data and case files, location of select equipment, and the general functioning of the Unit.

Data Analysis

We analyzed data to identify any opportunities for improvement and instances in which the Unit did not fully meet the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.[30]

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

APPENDIX E

Point Estimates and 95-Percent Confidence Intervals Based on Reviews of Case Files

Estimate	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of case files that were open longer than 90 days that lacked documentation of periodic supervisory review	79	17.7%	10.2%	27.6%
Percentage of case files that included documentation of supervisory approval for opening	102	88.2%	80.6%	93.7%
Percentage of closed case files that included documentation of supervisory approval for closing	92	100%	96.2%	100%

Source: OIG analysis of Massachusetts MFCU case files, 2016.

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APPENDIX F

Unit Comments

THE COMMONWEALTH OF MASSACHUSETTS
OFFICE OF THE ATTORNEY GENERAL
ONE ASHBURTON PLACE
BOSTON, MASSACHUSETTS 02108

MAURA HEALEY
ATTORNEY GENERAL

TEL: (617) 727-2200
www.mass.gov/ago

June 10, 2016

Suzanne Murrin
Deputy Inspector General for Evaluation and Inspections
Office of Inspector General
Department of Health and Human Services
Room 5660, Cohen Building
330 Independence Avenue, SW
Washington, DC 20201

Dear Deputy Inspector General Murrin:

With this letter, please accept the Massachusetts Medicaid Fraud Control Unit's comments on, and responses to, the recommendations found within your Agency's draft report, OEI-07-15-00390.

Recommendation 1: The Unit monitor implementation of its new policies and processes for documenting periodic supervisory review results.

Unit Response: The Unit concurs with this recommendation. As recognized by OIG's draft report, the Unit has streamlined a number of administrative processes using its intranet. The Unit will continue to utilize the intranet to facilitate documentation of supervisory reviews, a process which has been in place since FY 2014. The Unit will monitor the effectiveness of this system and ensure compliance with Performance Standard 7(a) through periodic self-reviews conducted by Unit support staff and management.

Recommendation 2: The Unit monitor implementation of its new policies and processes for ensuring that all convictions and adverse actions are being reported to Federal partners within required timeframes.

Unit Response: The Unit concurs with this recommendation. The Unit will monitor its policies and procedures which are intended to ensure compliance with adverse action reporting requirements. A standing discussion item on Federal reporting has been added to weekly meetings with support staff.

The Unit is pleased that its work to address the opioid crisis through enforcement efforts related to illegal prescribing was recognized in this report. The partnerships developed with other state and federal agencies have been critical to combatting this problem. The Unit also appreciates this

report's recognition of the efforts undertaken to streamline administrative processes through the use of our intranet.

Please accept the thanks of the Unit for the professionalism with which your on-site team conducted its audit, and the fairness of this report. The Unit is committed to making every effort to comply with the Performance Standards while continuing to diligently and aggressively carry out its mission.

/S/

Kevin Ready
Acting Director

/S/

ACKNOWLEDGMENTS

This report was prepared under the direction of Brian Whitley, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office, and Jennifer King, Deputy Regional Inspector General; and in consultation with Richard Stern, Director of the Medicaid Fraud Policy and Oversight Division.

Michala Walker, of the Kansas City regional office, served as the project leader for this study. Other Office of Evaluation and Inspections staff who conducted the study include Maria Balderas. Other Medicaid Fraud Policy and Oversight Division staff who participated in the review include Jordan Clementi. Office of Investigations staff also participated in the review. Office of Audit Services staff who conducted a financial review include Michael Jones, Marilyn Carrion, and Valerie Johnson. Other central office staff who contributed to this review include Kevin Farber, Lonie Kim, Joanne Legomsky, and Jacquelyn Towns.

Office of Inspector General

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