Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MONTANA STATE MEDICAID FRAUD CONTROL UNIT: 2012 ONSITE REVIEW

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WHY WE DID THIS STUDY

The Office of Inspector General (OIG) oversees all State Medicaid Fraud Control Units (MFCUs or Units) with respect to Federal grant compliance. As part of this oversight, OIG annually reviews and certifies all Units. In addition, OIG conducts onsite reviews of selected States. These reviews assess Unit performance in accordance with the 12 MFCU performance standards and monitor Unit compliance with Federal grant requirements, laws, and regulations.

HOW WE DID THIS STUDY

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

WHAT WE FOUND

From fiscal years 2010 through 2012, the Unit reported recoveries of $9.8 million, 6 convictions, and 31 civil judgments and settlements. Ninety-five percent of Unit case files contained documentation of supervisory approval to open cases; however, 40 percent of closed case files lacked documentation of supervisory approval to close cases. In addition, 65 percent of Unit case files lacked documentation of periodic supervisory reviews. The Unit also did not refer sentenced providers to OIG for program exclusion within the appropriate timeframe. Finally, the Unit's memorandum of understanding (MOU) with Montana's State Medicaid agency—the Department of Public Health and Human Services (DPHHS)—did not reflect current law and practice as required, and the Unit did not always adhere to the MOU stipulations.

WHAT WE RECOMMEND

We recommend that the Montana Unit (1) ensure that supervisory approval to close cases and periodic supervisory reviews are documented in Unit case files, (2) ensure that it refers providers for exclusion to OIG within the appropriate timeframe, (3) revise its MOU with DPHHS, and (4) adhere to the MOU provisions. The Unit concurred with all four of our recommendations.

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OBJECTIVE

To conduct an onsite review of the Montana State 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 (HHS) determines that operation of a Unit would not be cost-effective because (1) minimal Medicaid fraud exists in that State; and (2) 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) 2012, combined Federal and State grant expenditures for the Units totaled $217.3 million, of which Federal funds represented $162.9 million.[4, 5] That year, the 50 Units employed 1,901 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] The staff reviews complaints provided by the State Medicaid agency and other sources and determines their potential for criminal prosecution and/or civil action. Collectively, in FY 2012, the 50 Units reported 1,337 convictions and

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

[2] SSA § 1902(a)(61). 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.

[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. "Medicaid Fraud Control Units," Office of Inspector General (OIG) web site. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp on May 21, 2013.

[4] OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/ on March 19, 2013.

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

[6] OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*.

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

823 civil judgments and settlements. That year, the Units reported recoveries of approximately $2.9 billion.[8]

Units are required to have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an office with such authority.[9] In Montana and 43 other States, the Units are located within offices of State Attorneys General that have this authority. In the remaining six States, the Units are located within other State agencies; generally, such Units must refer cases to offices with prosecutorial authority.[10] Additionally, each Unit must be a single, identifiable entity of State government, distinct from the State Medicaid agency, and each Unit must develop a formal agreement—e.g., a memorandum of understanding (MOU)—that describes the Unit's relationship with that agency.[11]

Oversight of the MFCU Program

The Secretary of HHS delegated to OIG the authority both to annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs of operating them.[12] All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.[13] To receive Federal reimbursement, each Unit must submit an initial application to OIG.[14] OIG reviews the application and notifies the Unit whether it is approved and the Unit is certified. Approval and certification are valid for a 1-year period; the Unit must be recertified each year thereafter.[15]

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.[16] OIG developed and issued 12 performance standards to define the criteria that OIG applies in assessing whether a Unit is effectively carrying out statutory

[8] OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*. Pursuant to 42 CFR § 1007.17, Units report the total amount of recovered funds in their annual reports to OIG. "Recoveries" are defined as the amount of money that defendants are required to pay as a result of a judgment or settlement in criminal and civil cases, and may not reflect actual collections. Recoveries may involve cases that include participation by other Federal and State agencies.

[9] SSA § 1903(q)(1).

[10] In 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 a Medicaid Inspector General who conducts and coordinates anti-fraud, waste, and abuse activities for the State agency.

[11] SSA § 1903(q)(2) and 42 CFR § 1007.9(d).

[12] 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 referred to as Federal Financial Participation.

[13] SSA § 1903(a)(6)(B).

[14] 42 CFR § 1007.15(a).

[15] 42 CFR § 1007.15(b) and (c).

[16] SSA § 1902(a)(61).

functions and meeting program requirements.[17] Examples include maintaining an adequate caseload through referrals from several sources, maintaining an annual training plan for all three of the professional disciplines (i.e., for auditors, investigators, and attorneys), and establishing policy and procedures manuals to reflect the Unit's operations. See Appendix A for a complete list of the performance standards.[18]

Montana Unit

The Unit is an autonomous entity within the Montana Department of Justice's Division of Criminal Investigation and has the authority to prosecute cases of Medicaid fraud and of patient abuse and neglect. At the time of our review, the Unit had eight employees—six in the State capital of Helena, and one investigator located in each of the two satellite offices.[19] The Unit Director serves as the Chief Investigator and directly supervises all Unit employees.

The Unit receives referrals of provider fraud from the State Medicaid agency—the Montana Department of Public Health and Human Services (DPHHS)—and from Federal agencies, such as OIG. The Unit receives patient abuse and neglect referrals from DPHHS's Certification Bureau and from Adult Protective Services. In addition, the Unit receives both types of referrals from other State and local agencies, from healthcare providers, and from the public through a Medicaid Fraud Control Unit hotline and a fraud-reporting form located on the Montana Department of Justice's Web site.[20] For additional information on Unit referrals, see Appendix C.

Upon receiving a referral, Unit employees gather background information on it and forward it to the Unit Director for review. The Director screens the referral and decides whether to open it as a case or refer it to another agency. For additional information on the Unit's opened and closed investigations, including a breakdown by case type and provider category, see Appendix D.

After the Director opens a referral for investigation, a Unit auditor gathers preliminary data on the case and the Director assigns the case to an

[17] 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at http://oig.hhs.gov on November 22, 2011.

[18] Prior to the time of our onsite data collection (December 2012), OIG published a revision of the performance standards, 77 Fed. Reg. 32645 (June 1, 2012). See Appendix B for a complete list of the revised performance standards. Unless otherwise noted, the performance standards referred to in this report were published in 1994 and were in effect during most of our review period (FYs 2010 through 2012).

[19] The Unit Director, Chief Attorney, two auditors, one investigator, and an administrative assistant are located in Helena.

[20] The Unit occasionally will open cases that were not formally referred by an outside source. For example, a case may be brought to the Unit's attention by the media.

investigator. The Unit may open a case and pursue it through a variety of actions, including criminal prosecution, civil action, or a combination of the two. The Unit may close a case for a variety of reasons, including but not limited to resolving it through criminal and/or civil action or referring it to another agency.

Previous Review

In 2007, OIG conducted an onsite review of the Montana Unit and found that a Unit attorney and a Unit administrative support staff member "regularly engaged" in non-Unit activities. This 2012 onsite review of the Unit found no indication that this issue persisted.

METHODOLOGY

We analyzed data from seven sources: (1) a review of documentation, policies, and procedures related to the Unit's operations, staffing, and caseload for FYs 2010 through 2012; (2) a review of financial documentation for FYs 2010 through 2012; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management and selected staff; (6) an onsite review of case files that were open in FYs 2010 through 2012; and (7) an onsite review of Unit operations.

We analyzed data from all seven sources to describe the caseload and assess the performance of the Unit. We also analyzed the data to identify any opportunities for improvement and any instances in which the Unit did not meet the performance standards or was not operating in accordance with laws, regulations, and policy transmittals.[21] In addition, we noted practices that appeared to benefit the Unit. We based these observations on statements from Unit staff, data analysis, and our own judgment. We did not independently verify the effectiveness of these practices, but included the information because it may be useful to other Units in their operations.

We conducted the onsite review in December 2012.

Data Collection and Analysis

Review of Unit Documentation. We collected and reviewed documentation, policies, and procedures related to the Unit's operations, staffing, and cases, including its annual reports, quarterly statistical reports, and responses to recertification questionnaires. We reviewed this documentation to determine how the Unit investigates and prosecutes Medicaid cases. The documentation also included data such as the

[21] All relevant regulations, statutes, and policy transmittals are available online at http://oig.hhs.gov.

number of referrals received by the Unit and the number of investigations opened and closed. Additionally, we confirmed with the Unit Director that the information we had was current at the time of our review and, as necessary, requested any additional data or clarification that was needed.

Review of Financial Documentation. We reviewed Unit financial practices to determine compliance with applicable laws and regulations and to determine the need for additional internal controls. Prior to the onsite review, we reviewed the Unit's financial policies and procedures, its response to an internal control questionnaire, and MFCU grant-related documents such as financial status reports. During the onsite review, we reviewed a sample of the Unit's purchase and travel transactions. In addition, we reviewed reviewed vehicle records, the equipment inventory, and a sample of time and effort records.

Interviews With Key Stakeholders. We conducted structured interviews with seven individual stakeholders among four agencies who were familiar with Unit operations. Specifically, we interviewed DPHHS's Surveillance Utilization Review System (SURS) Supervisor; DPHHS's Certification Bureau Chief; an Assistant U.S. Attorney based in Montana; an investigator for the U.S. Attorney's Office based in Montana; the Investigations Bureau Chief[22] for the Division of Criminal Investigation of the Montana Department of Justice; an OIG Assistant Special Agent in Charge for the State of Montana; and an OIG Special Agent who has worked with the Unit. These interviews focused on the Unit's interaction with external agencies, Unit operations, opportunities for improvement, and any practices that appeared to benefit the Unit and that may be useful to other Units in their operations.

Survey of Unit Staff. We conducted an electronic survey of Unit staff.[23] We requested and received responses from five nonmanagerial staff members, for a 100-percent response rate.[24] Our questions focused on operations of the Unit, opportunities for improvement, and practices that appeared to benefit the Unit and that may be useful to other Units in their operations. The survey also sought information about the Unit's compliance with applicable laws, regulations, and policy transmittals.

Interviews With Unit Management and Selected Staff. We conducted structured interviews with the Unit's Director (Chief Investigator), Chief Attorney, and an auditor. We asked them to provide us with additional

[22] The Investigations Bureau Chief supervises the Unit Director.

[23] We did not survey one of the Unit's nonmanagerial auditors because we interviewed that auditor onsite.

[24] This report uses the terms "management" and "supervisors" interchangeably. "Nonmanagement" employees are Unit staff members who have no supervisory authority.

information necessary to better understand the Unit's operations, identify opportunities for improvement, identify practices that appeared to benefit the Unit and that may be useful to other Units in their operations, and clarify information obtained from other data sources.

Onsite Review of Case Files. We selected a simple random sample of 55 case files from the 105 cases that were open at any point from FY 2010 through FY 2012.[25] The design of this sample allowed us to estimate the percentage of all 105 cases with various characteristics at the 95-percent confidence level. We reviewed these 55 sampled case files and the Unit's processes for monitoring the status and outcomes of cases. From these 55 case files, we selected another simple random sample of 35 files and conducted a more comprehensive review to identify any other potential issues. For population and sample size counts, as well as confidence interval estimates, see Appendix E.

Onsite Review of Unit Operations. While onsite, we reviewed the Unit's operations. Specifically, we observed intake of referrals, data analysis operations, security of data and case files, and the general functioning of the Unit.

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.[26]

[25] This figure includes cases opened before FY 2010 that remained open at some point during FYs 2010–2012.

[26] Full text of these standards is available online at http://www.ignet.gov/pande/standards/oeistds11.pdf.

FINDINGS

From FY 2010 through FY 2012, the Unit reported recoveries of $9.8 million, 6 convictions, and 31 civil judgments and settlements

From FY 2010 through FY 2012, the Unit reported total criminal and civil recoveries of $9.8 million—an annual average of $3.3 million (see Table 1). Of the $9.8 million in recoveries, the Unit attributed $9.7 million to civil recoveries and $77,000 to criminal recoveries. "Global" case judgments and settlements accounted for $9.5 million of the total civil recoveries and global cases accounted for 4 of the Unit's 105 cases over the 3-year period.[27] The Unit's annual average expenditures for FYs 2010 through 2012 were $697,000.[28]

Table 1: Montana Unit Reported Recovered Funds, FYs 2010 Through 2012

	FY 2010	FY 2011	FY 2012	3-Year Total	Annual Average*
Reported Criminal Recoveries	$58,294	$5,916	$13,437	$77,647	$25,882
Global Recoveries	$1,326,958	$2,950,573	$5,222,030	$9,499,561	$3,166,520
Non-Global Civil Recoveries	$59,978	$0	$140,423	$200,401	$66,800
Total Reported Recoveries	**$1,445,230**	**$2,956,489**	**$5,375,890**	**$9,777,609**	**$3,259,203**
Total Expenditures	$657,113	$724,219	$710,704	$2,092,036	$697,345

Source: OIG review of Unit self-reported QSR and other data, FYs 2010–2012.

*Averages in this table are rounded.

From FY 2010 through FY 2012, the Unit Reported 6 Convictions and 31 Civil Judgments and Settlements. From FY 2010 through FY 2012, the Unit reported 6 convictions and 31 civil judgments and settlements—an annual average of 2 convictions and 10.3 civil judgments and settlements (see Table 2).

[27] Unit-reported recoveries include funds recovered from multi-State, or "global," civil false claims cases, both those worked directly by the Unit and those worked by staff from other Units.

[28] The figures presented in this finding are rounded.

Table 2: Unit Convictions and Civil Judgments and/or Settlements, FYs 2010 Through 2012[29]

	FY 2010	FY 2011	FY 2012	3-Year Total	Annual Average
Convictions	2	0	4	6	2
Civil Judgments and/or Settlements	11	10	10	31	10.3

Source: OIG review of Unit self-reported QSR and other data, FYs 2010–2012.

From FYs 2010 through 2012, the Unit opened an average of 34 cases annually—an average of 26 provider fraud and 9 patient abuse and neglect cases. From FYs 2010 through 2012, the Unit closed an average of 27 cases annually, with an average of 19 provider fraud and 8 patient abuse and neglect cases.[30] From FYs 2010 through 2012, the Unit received an average of 126 referrals annually—an average of 109 provider fraud and 17 patient abuse and neglect referrals.

Ninety-five percent of case files contained documentation of supervisory approval to open cases; however, 40 percent of closed case files lacked documentation of supervisory approval to close cases

According to Performance Standard 6(b), Unit supervisors should approve the opening and closing of cases to ensure a continuous case flow and the timely completion of cases. Supervisory approval to open and close cases demonstrates that Unit supervisors are monitoring the intake of cases and the timeliness of case resolutions, thereby promoting the efficiency and effectiveness of Unit staff. The Unit documented supervisory approval to open cases in 95 percent of the case files. However, 40 percent of closed case files lacked documented supervisory approval to close cases.

Sixty-five percent of case files lacked documentation of periodic supervisory reviews

According to Performance Standard 6(c), supervisory reviews should be "conducted periodically and noted in the case file" to ensure timely case completion.[31] Sixty-two percent of Unit case files lacked documentation of at least one supervisory review and 65 percent of the case files lacked documentation of additional, periodic supervisory reviews.

[29] Civil Judgments and/or Settlements include those received from global cases.

[30] Closures include multiple cases opened before FY 2010.

[31] For the purposes of this report, supervisory approval to open and close a case does not constitute a supervisory "review." "Periodic supervisory reviews" indicates that a supervisor reviewed a case more than once between the case's opening and closing and documented those reviews in the case file.

Unit management and staff reported that all open cases are reviewed during monthly staff meetings and that the Unit Director is informally involved in all cases. Unit management reported that for some of the Unit's complex cases, it documents significant case activity on a "case activity tracking" sheet to ensure that these cases move forward in a timely manner.

The Unit did not refer sentenced providers to OIG for program exclusion within the appropriate timeframe

According to Performance Standard 8(d), when a convicted provider is sentenced, the Unit should send a referral letter to OIG "within 30 days or other reasonable time period" for the purpose of program exclusion.[32] The Unit reported six total convictions within the review period but referred none of these sentenced providers to OIG for program exclusion within the appropriate timeframe. However, after we determined that the Unit did not refer these providers to OIG for exclusion within the appropriate timeframe, the Unit provided documentation indicating it later referred the providers to OIG for exclusion.[33]

The Unit's MOU with DPHHS did not reflect current law and practice

According to Performance Standard 10, Units should periodically review their MOUs with the State Medicaid agency to ensure that the MOUs reflect current law and practice. As required by Federal regulations, the Unit had an MOU (dated July 2010) with DPHHS/SURS.[34] However, the MOU did not include payment suspension provisions for providers who are subject to an ongoing investigation related to credible allegations of fraud.[35] Federal regulations also require that the MOU include a provision requiring the State Medicaid agency to provide the Unit with "access to, and free copies of, any records or information kept by the agency or its contractors."[36] However, contrary to this regulation, an MOU provision stipulates that "any cost associated with MFCU special requests which require system changes

[32] Pursuant to 42 U.S.C. § 1320a-7(a), OIG excludes from participation in Federal health care programs any person or entity convicted of a criminal offense related to the delivery of an item or service under the Medicaid program or to the neglect or abuse of patients in residential health care facilities. No payment may be made by Medicaid, Medicare, or other Federal health care programs for an item or service provided, ordered, or prescribed by an excluded individual or entity. 42 CFR § 1001.1901.

[33] We made this determination in September 2012. The documentation provided by the Unit indicated that the providers were referred for exclusion in October 2012.

[34] 42 CFR § 1007.9(d).

[35] 42 CFR §§ 455.23 and 1007.9(e).

[36] 42 CFR § 455.21(a)(2)(i) and 42 CFR § 1007.9(d).

will be paid by the MFCU."[37] Both the Unit Director and SURS staff reported, however, that SURS has never charged the Unit for data. Unit management reported that it is working with DPHHS to issue a revised MOU that incorporates the payment suspension provision and removes the stipulation that the Unit may be charged for special data requests.

The Unit did not provide training to SURS or hold bimonthly meetings with SURS, as stipulated in the MOU

Pursuant to the Unit's MOU with DPHHS, the Unit "agrees to provide training specific to Medicaid provider fraud detection to SURS at least once a year."[38] However, DPHHS/SURS staff reported that Unit trainings to SURS are "few and far between," and the Unit Director reported that the Unit has not provided training to SURS in "a couple of years." Another provision in the MOU stipulates that the Unit and SURS will meet "at least every two months" for various purposes, including discussing potential referrals and open cases. Both the Unit Director and SURS staff reported, however, that the two agencies had not met in over 6 months. SURS staff reported that the two agencies had not met because SURS was busy working on its Medicaid Management Information System.

Other observation: The Unit received a limited number of fraud referrals from DPHHS

Pursuant to Federal regulations, a State Medicaid agency must refer all cases of suspected fraud to the Unit in its State.[39] According to the Unit's MOU with DPHHS, DPHHS "will, at the earliest practical opportunity in its preliminary investigation, advise the MFCU of any suspected fraud."[40] However, the Unit reported that DPHHS/SURS sent only seven total fraud referrals to the Unit during the review period, including only one referral in FY 2012.[41] According to SURS staff, any referral to the Unit was

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[37] *Memorandum of Understanding between the Montana Department of Justice and the Montana Department of Public Health and Human Services*, Part III, § A and B.

[38] Ibid., Part III, § E.

[39] 42 CFR § 455.21(a)(1).

[40] *Memorandum of Understanding between the Montana Department of Justice and the Montana Department of Public Health and Human Services*, Part III, § E.

[41] The Medicaid Integrity Group (MIG) of the Centers for Medicare & Medicaid Services conducts periodic onsite program integrity reviews of State Medicaid programs. In 2010, the MIG conducted a review of DPHHS. The resulting July 2011 MIG report noted that DPHHS referred very few cases to the Unit. This report recommended that DPHHS "develop more suspected fraud cases for the MFCU," and that DPHHS and the Unit should meet to discuss any barriers to the successful prosecution of fraud. MIG, *Montana Comprehensive Program Integrity Review Final Report* (July 2011), pp. 8–9. Accessed at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/MTfy10.pdf on May 21, 2013.

considered to be a "credible allegation of fraud" and therefore subject to provider payment suspension.[42] SURS staff further reported that all such referrals must be approved by a DPHHS administrator and, therefore, unless the referral clearly constituted a credible allegation of fraud, SURS was reluctant to make any referrals to the Unit.

[42] A State Medicaid agency must suspend all Medicaid payments to a provider if the agency determines that the provider is under investigation for a credible fraud allegation, unless the agency or a law enforcement entity has good cause not to suspend payments or to suspend them only in part. 42 CFR § 455.23(a)(1).

[42] A State Medicaid agency must suspend all Medicaid payments to a provider if the agency determines that the provider is under investigation for a credible fraud allegation, unless the agency or a law enforcement entity has good cause not to suspend payments or to suspend them only in part. 42 CFR § 455.23(a)(1).

CONCLUSION AND RECOMMENDATIONS

From FY 2010 through FY 2012, the Unit reported recoveries of $9.8 million, 6 convictions, and 31 civil judgments and settlements. Unit case files consistently contained documentation of supervisory approval to open cases.

Other opportunities for Unit improvement exist. Specifically, Unit case files did not consistently contain documentation of supervisory approval to close cases or documentation of periodic supervisory reviews. In addition, the Unit did not refer sentenced providers to OIG for program exclusion within the appropriate timeframe. The Unit's MOU with DPHHS did not reflect current law and practice, and the Unit did not always adhere to the MOU stipulations. Finally, the Unit received a limited number of fraud referrals from DPHHS. With the exception of the MOU stipulation that the Unit may be charged for special data requests, we found no evidence of noncompliance with applicable laws, regulations, and policy transmittals.

We recommend that the Montana Unit:

Ensure that supervisory approval to close cases and periodic supervisory reviews are documented in Unit case files

The Unit could use its case activity tracking sheets to document both periodic supervisory case reviews and supervisory approval to close cases in all case files.

Ensure that letters referring providers for exclusion are submitted to OIG within the appropriate timeframe

The Unit should ensure that letters referring providers for exclusion are sent within 30 days of defendant sentencing, consistent with the 2012 Performance Standard 8 (f).

Revise its MOU with DPHHS to reflect current law and practice

The Unit should revise its MOU with DPHHS to include payment suspension provisions for providers who are subject to an ongoing investigation related to credible allegations of fraud. In addition, the Unit should revise its MOU with DPHHS to remove the stipulation that the Unit may be charged for data requests.

Ensure that it consistently adheres to its MOU

Consistent with the stipulations of the MOU between the Unit and DPHHS, the Unit should provide Medicaid provider fraud detection training to DPHHS/SURS on an annual basis and meet with DPHHS/SURS at least bimonthly.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Unit concurred with the four report recommendations.

Regarding our first recommendation, the Unit adopted a case review form that will be attached to each open case file. The Unit also amended its policies and procedures manual to reflect supervisory responsibility to approve the opening and closing of cases, as well as to document periodic case file reviews in the case files.

Regarding our second recommendation, the Unit referred all omitted convictions to OIG for program exclusion. The Unit also amended its policies and procedures manual to reflect the Unit Director's responsibility to ensure that all convictions are reported to OIG for program exclusion.

Regarding our third recommendation, the Unit created a revised draft of its MOU with DPHHS that incorporates the suggested revisions mentioned in this report.

Regarding our fourth recommendation, the Unit has established a training plan with DPHHS/SURS that requires quarterly cross-training between the two agencies, beginning in January 2014.

The full text of the Unit's comments is provided in Appendix F. We did not make any changes to the report as a result of the Unit's comments.

APPENDIX A

Performance Standards for MFCUs (Units)[43]

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

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

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

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

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

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

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

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

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

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

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

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

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

[43] 59 Fed. Reg. 49080 (Sept. 26, 1994). These performance standards were in effect during most of our review period and precede the performance standards published in June 2012.

a. Does the Unit have policy and procedure manuals?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    c. The number of arrests and indictments.

    d. The number of convictions.

    e. The amount of overpayments identified.

    f. The amount of fines and restitution ordered.

    g. The amount of civil recoveries.

    h. The numbers of administrative sanctions imposed.

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

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

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

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

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

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

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

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

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

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

    a. Is the MOU more than 5 years old?

    b. Does the MOU meet Federal legal requirements?

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

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

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

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

    b. Does the Unit maintain an equipment inventory?

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

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

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

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

    c. Are continuing education standards met for professional staff?

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

APPENDIX B

Revised 2012 Performance Standards for MFCUs (Units)[44]

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.

[44] 77 Fed. Reg. 32645 (June 1, 2012).

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.

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.

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.

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.

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 dollar amount of overpayments identified.
6. 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.
7. The number of criminal convictions and the number of civil judgments.
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 C

Referrals of Provider Fraud and Patient Abuse and Neglect to the Montana MFCU by Source, FYs 2010 Through 2012

Table C-1: Total MFCU Referrals of Fraud and Abuse Referrals and Annual Average

Case Type	FY 2010	FY 2011	FY 2012	3-Year Total	Annual Average*
Patient Abuse and Neglect	25	14	11	**50**	**17**
Provider Fraud	86	133	108	**327**	**109**
Total	**111**	**147**	**119**	**377**	**126**

Source: Montana Medicaid Fraud Control Unit (Unit) response to Office of Inspector General (OIG) data request.

*Averages in this table are rounded.

Table C-2: Unit Referrals, by Referral Source

	FY 2010		FY 2011		FY 2012			
Referral Source	**Fraud**	**Abuse and Neglect**	**Fraud**	**Abuse and Neglect**	**Fraud**	**Abuse and Neglect**	**Total**	**Percentage of All Referrals**
Private Citizens	45	0	73	2	43	4	**167**	44.3
Providers	14	3	24	3	20	0	**64**	17.0
State Medicaid Agency–Other	8	4	8	0	11	1	**32**	8.5
Unit Hotline	0	0	1	0	20	0	**21**	5.6
State Survey and Certification Agency	3	5	3	5	0	1	**17**	4.5
Adult Protective Services	1	11	4	0	0	0	**16**	4.2
Law Enforcement	6	0	6	0	2	2	**16**	4.2
Other	2	0	4	1	8	0	**15**	4.0
Other State Agencies	0	1	2	2	2	2	**9**	2.4
State Medicaid Agency–SURS	3	0	3	0	1	0	**7**	1.9
Private Health Insurers	3	0	2	0	0	0	**5**	1.3
OIG	0	0	2	0	1	1	**4**	1.1
Long-Term Care Ombudsman	0	0	1	1	0	0	**2**	0.5
Prosecutors	0	1	0	0	0	0	**1**	0.3
Provider Associations	1	0	0	0	0	0	**1**	0.3
Total	86	25	133	14	108	11	**377**	100
Annual Total		**111**		**147**		**119**		
Annual Average*							**126**	

Source: Unit response to OIG data request.

*Average is rounded.

APPENDIX D

Investigations Opened and Closed by Provider Category and Case Type, FYs 2010 Through 2012

Table D-1: Total Annual Opened and Closed Investigations

Case Type	FY 2010	FY 2011	FY 2012	3-Year Total	Annual Average*
Opened	28	39	36	103	34
Patient Abuse and Neglect	14	7	5	26	9
Provider Fraud	14	32	31	77	26
Closed	12	38	31	81	27
Patient Abuse and Neglect	7	13	3	23	8
Provider Fraud	5	25	28	58	19

Source: Montana MFCU response to OIG data request.

*Averages in this table are rounded.

Table D-2: Total Investigations, by Case Type

Case Type	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Patient Abuse and Neglect	14	7	7	13	5	3
Provider Fraud	14	5	32	25	31	28
Total	**28**	**12**	**39**	**38**	**36**	**31**

Source: Unit response to OIG data request.

Table D-3: Patient Abuse and Neglect Investigations

Provider Category	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Non-Direct Care	2	1	2	4	3	2
Nurses/Doctors' Assistants	4	3	3	2	1	1
Nursing Facilities	4	0	1	5	0	0
Other Long-Term Care Facilities	0	0	0	0	1	0
Other	4	3	1	2	0	0
Total	**14**	**7**	**7**	**13**	**5**	**3**

Source: Unit response to OIG data request.

Table D-4: Provider Fraud Investigations

Provider Category	FY 2010		FY 2011		FY 2012	
Facilities	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Hospitals	0	0	2	3	2	2
Nursing Facilities	1	0	3	2	0	1
Other Long-Term Care Facilities	0	0	1	1	0	0
Other	0	0	0	0	5	4
Practitioners	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Counselors/Psychologists	1	1	4	4	1	0
Dentists	1	0	1	1	0	0
Doctors of Medicine or Osteopathy	2	0	1	2	0	1
Other	0	0	2	2	2	1
Medical Support	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Durable Medical Equipment Suppliers	0	0	2	1	2	2
Home Health Care Agencies	0	0	1	1	1	0
Home Health Care Aides	6	3	11	4	15	11
Laboratories	0	0	0	0	1	1
Nurses/Doctors' Assistants	1	0	1	1	0	1
Pharmaceutical Manufacturers	0	0	1	1	2	2
Pharmacies	1	0	1	1	0	1
Transportation Services	0	0	1	1	0	0
Other	1	1	0	0	0	1
Program Related	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
All Programs*	0	0	0	0	0	0
Total	**14**	**5**	**32**	**25**	**31**	**28**

Source: Unit response to OIG data request.

*For example, managed care, Medicaid program administration, and billing companies.

APPENDIX E

Case File Review Population, Sample Size Counts, and Confidence Interval Estimates

Table E-1 shows population and sample counts and percentages by case type. Note that both samples have percentages of case types similar to the general population, though sample counts for some case types are very small. Because of these small sample sizes, we cannot reliably generalize what we found in our sample review to each case type in the population, and only our overall estimates project to the population of all case files. We estimated the 4 population values for all 105 case files from the results of our review of the case files selected in our simple random samples. Table E-2 includes the estimate descriptions, sample sizes, point estimates, and 95-percent confidence intervals for these four estimates.

Table E-1: Population and Sample Size Counts for Case Types

Case Type	Population Count and (%) n=105	Sample Count* and (%) n=55	Sample Count* and (%) n=35
Closed	79 (75%)	47 (85%)	28 (80%)
Open	26 (25%)	8 (15%)	7 (20%)
Civil	4 (4%)	2 (4%)	2 (6%)
Criminal	101 (96%)	53 (96%)	33 (94%)
Global	4 (4%)	2 (4%)	2 (6%)
Patient Abuse/Neglect	26 (25%)	13 (23%)	9 (26%)
Provider Fraud	75 (71%)	40 (73%)	24 (68%)

Source: The Montana MFCU provided a list of all case files open during FYs 2010 through 2012.

*OIG generated this random sample.

Table E-2: Confidence Intervals for Key Case File Review Data

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Case Files With Documented Supervisory Approval for Opening	55	94.5%	87.6–97.1%
Case Files With Documented Supervisory Approval for Closing	47	59.6%	49.4–69.6%
Case Files With No Documentation Of at Least One Supervisory Review	55	61.8%	51.5–70.9%
Case Files With No Documentation Of Periodic Supervisory Reviews	55	65.4%	55.3–74.8%

APPENDIX E

Unit Comments

DIVISION OF CRIMINAL INVESTIGATION

DEPARTMENT OF JUSTICE
STATE OF MONTANA

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August 27, 2013

Mr. Stuart Wright, Deputy Inspector General for Evaluation and Inspections
Department of Health and Human Services
Office of Inspector General
Cohen Building
330 Independence Avenue, S.W.
Washington, D.C. 20201-0003

In Re: OEI-09-12-00700

Dear Mr. Wright:

The Montana Medicaid Fraud Control Unit (MFCU) received the 2012 Onsite Review Report including recommendations by the review team. We concur with the four recommendations stated in the report.

The specific actions taken by the MT MFCU are as follows:

-The first recommendation was that supervisory approval to close cases and the periodic supervisory reviews of open cases should be documented in the case files. We adapted a case review form that is in use by another MFCU and that document is now attached to each open case. A hard copy of the case review form is included with all electronic and hard copy case files. Additionally, we amended the MFCU Policy and Procedures Manual to reflect the responsibility of the unit director to open and close cases and to document the periodic case file reviews with assigned personnel.

-The second recommendation was that letters referring providers for exclusion must be submitted to OIG within the appropriate timeframe, which is 30 days from the conviction date. We have corrected previous notification omissions and the convictions reported on the onsite audit team's Data Collection Instrument have been sent to OIG Exclusions. Two more convictions are pending the court's final judgment and they will be sent to OIG Exclusions as soon as we receive that judgment. The renewal for the MT

MFCU with the Data Bank was completed on May 1, 2013. Convictions are now being reported to the Data Bank in the manner required, i.e., within 30 days following conviction. (Prior convictions were also "caught up" and reported to that agency.) The policy manual was amended to reflect the unit director's responsibility to make those notifications.

-The third recommendation was that the SURS/MFCU Memorandum of Understanding (MOU) needed to be revised to reflect current law and practice. The final draft of the updated MOU was completed and signatures were obtained from the administrator and attorney of the state's Medicaid program and from the administrator of the MT Division of Criminal Investigation (of which the MFCU is a part) and by the MFCU prosecutor.

-The fourth and final recommendation was that the MFCU consistently adhere to the MOU with SURS. That recommendation included cross-training between the two units. We have set up a training plan between the MFCU and SURS to bring us into conformity with the MOU.

The timeline for the recommendations is as follows:

The first, second, and third recommendations have already been implemented. The fourth recommendation regarding cross-training with the MT DPHHS SURS will commence in November 2013 and will be occurring quarterly beginning in January 2014.

Thank you for the work of the onsite team. Please let me know if you have any questions; my direct telephone number is (406) 444-4606 and my email contact is dfosket@mt.gov.

Sincerely,

/S/

Debrah Fosket, Director
Medicaid Fraud Control Unit
Montana Division of Criminal Investigations

Cc: MT Attorney General Tim Fox
MT Division of Criminal Investigations Administrator Bryan Lockerby

ACKNOWLEDGMENTS

This report was prepared under the direction of Timothy S. Brady, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, and Michael Henry, Deputy Regional Inspector General.

Matthew DeFraga served as the lead analyst for this study. Other Office of Evaluation and Inspections staff who provided support include Rosemary Rawlins. Central office staff who provided support include Susan Burbach, Kevin Farber, Christine Moritz, and Sherri Weinstein. Office of Investigations staff who provided support include Bill Kennedy.

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