

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**OREGON STATE MEDICAID FRAUD  
CONTROL UNIT:  
2016 ONSITE REVIEW**



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**OREGON STATE MEDICAID FRAUD CONTROL UNIT:  
2016 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 Oregon Unit in May 2016. 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) 2013 through 2015; (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 2013 through 2015; and (7) observation of Unit operations.

**WHAT WE FOUND**

For FYs 2013 through 2015, the Oregon Unit reported obtaining 92 criminal convictions, 34 civil judgments and settlements, and combined criminal and civil recoveries of nearly \$33 million. We found that the Oregon Unit was generally in compliance with applicable laws, regulations, and policy transmittals; however, we identified three areas where the Unit should improve its adherence to performance standards and its compliance with applicable Federal requirements. Specifically, the Unit did not fully secure its case files, part of the Unit's memorandum of understanding with two of its State partners was inconsistent with the Federal regulation governing Medicaid payment suspensions, and the Unit did not report some convictions and adverse actions to Federal partners within the appropriate timeframes.

**WHAT WE RECOMMEND**

We recommend that the Oregon Unit: 1) implement procedures for securing case files, 2) revise its memorandum of understanding with State partners to be consistent with Federal regulation, and 3) implement processes to ensure it reports convictions and adverse actions to Federal partners within the appropriate timeframes. The Unit concurred with all three recommendations.

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## OBJECTIVE

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

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## BACKGROUND

The mission of MFCUs is to investigate and prosecute Medicaid provider fraud and patient abuse or neglect under State law.<sup>1</sup> 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.<sup>2</sup> Currently, 49 States and the District of Columbia (States) have MFCUs.<sup>3</sup>

Each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.<sup>4</sup> 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.<sup>5, 6</sup>

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;<sup>7</sup>

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<sup>1</sup> 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.

<sup>2</sup> SSA § 1902(a)(61).

<sup>3</sup> 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.

<sup>4</sup> SSA § 1903(q)(6); 42 CFR § 1007.13.

<sup>5</sup> 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](http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm) on August 1, 2016.

<sup>6</sup> All FY references in this report are based on the Federal FY (October 1 through September 30).

<sup>7</sup> SSA § 1903(q)(2); 42 CFR § 1007.5 and 1007.9(a).

- develop a formal agreement, such as a memorandum of understanding (MOU), which describes the Unit’s relationship with the State Medicaid agency;<sup>8</sup> and
- have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority.<sup>9</sup>

### **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.<sup>10</sup> Each Unit receives Federal financial participation equivalent to 75 percent of its total expenditures, with State funds contributing the remaining 25 percent.<sup>11</sup> In FY 2015, combined Federal and State expenditures for the Units totaled \$251 million, \$188 million of which represented Federal funds.<sup>12</sup>

### **Administration and Oversight of the MFCU Program**

The Secretary of HHS delegated to OIG the authority to administer the MFCU grant program.<sup>13</sup> 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.<sup>14</sup> In addition, OIG has published 12 performance standards that it uses to assess whether a Unit is effectively performing its responsibilities.<sup>15</sup> 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 Oregon MFCU. During these onsite reviews, OIG evaluates Units’

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<sup>8</sup> 42 CFR § 1007.9(d).

<sup>9</sup> SSA § 1903(q)(1).

<sup>10</sup> SSA § 1903(a)(6)(B).

<sup>11</sup> Ibid.

<sup>12</sup> 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](http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm) on August 1, 2016.

<sup>13</sup> The SSA authorizes the Secretary of HHS to award grants to the Units (SSA § 1903(a)(6)(B)); the Secretary delegated this authority to the OIG.

<sup>14</sup> On occasion, OIG issues policy transmittals to provide guidance and instructions to MFCUs.

<sup>15</sup> 77 Fed. Reg. 32645 (June 1, 2012).

compliance with laws, regulations, and policies, as well as adherence to the 12 performance standards. OIG also makes observations about best 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.

### **Oregon MFCU**

The Oregon Unit's office is located in Portland. The Unit is an autonomous entity within the State's Office of the Attorney General. At the time of our review, the Unit's management was composed of a director, a chief investigator, and an assistant attorney in charge.

The Unit receives most of its referrals from the Oregon Health Authority (OHA) and Department of Human Services (DHS).<sup>16</sup> The Unit also receives referrals from other sources, such as private citizens and law enforcement agencies. Appendix B illustrates the Unit referrals by source for FYs 2013 through 2015. When the Unit receives a referral, an investigator conducts a preliminary assessment to determine whether the allegation has the potential for full investigation and is within the Unit's grant authority. If the preliminary assessment meets these criteria, the investigator drafts a referral memo to the Unit director, who decides whether to open a case.

If the Unit opens a case, Unit management typically assigns an attorney and an investigator to the case. The Oregon Unit has the authority to investigate cases of Medicaid fraud and cases of patient abuse or neglect, but does not have original authority to prosecute criminal matters.<sup>17</sup> The authority to prosecute criminals is vested with the county District Attorneys located across the State. However, District Attorneys routinely authorize Unit attorneys to prosecute criminal matters in State courts by deputizing them as special prosecutors. Appendix C provides details on opened and closed investigations.

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<sup>16</sup> OHA administers Oregon's Medicaid program, among other things, and DHS administers long-term care services for seniors and people with disabilities.

<sup>17</sup> For the purposes of this report, the misappropriation or theft of residential health care facility patients' private funds is included in the category of patient abuse and neglect.

## **Previous Review**

In 2011, OIG issued a report regarding its onsite review of the Oregon Unit. The review found that the Unit adhered to the 12 performance standards and complied with all applicable Federal rules and regulations that govern the grant.

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## **METHODOLOGY**

We conducted the onsite review in May 2016. 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 2013 through 2015; (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 2013 through 2015; and (7) observation of Unit operations. 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.

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## FINDINGS

### **For FYs 2013 through FY 2015, the Oregon Unit reported 92 criminal convictions, 34 civil judgments and settlements, and recoveries of nearly \$33 million**

For FYs 2013 through 2015, the Unit reported 92 criminal convictions and 34 civil judgments and settlements. See Table 1 for yearly convictions and civil judgments and settlements. Of the Unit’s 92 convictions over the 3-year period, 78 involved provider fraud and 14 involved patient abuse or neglect. Of the Unit’s 34 civil judgments and settlements, 33 were from “global” cases and 1 was from a State-only civil case.<sup>18</sup> According to Unit management, the Unit prioritizes the investigation of cases that will result in a criminal conviction and thus pursues few State-only civil cases.

**Table 1: Oregon MFCU Criminal Convictions and Civil Judgments and Settlements, FYs 2013 through 2015**

Case Outcomes	FY 2013	FY 2014	FY 2015	3-Year Total
Criminal Convictions	28	25	39	92
Civil Judgments and Settlements	13	13	8	34

Source: OIG review of MFCU self-reported quarterly statistical reports and other data, 2016.

For the same period, the Unit reported combined criminal and civil recoveries of nearly \$33 million. See Table 2 for the Unit’s yearly recoveries and expenditures.<sup>19</sup> Global cases accounted for \$24 million of the \$33 million in total recoveries. Of the approximately \$8 million in recoveries from nonglobal cases, \$2 million were from criminal cases and \$6 million were from a State-only civil case in FY 2013.

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<sup>18</sup> “Global” cases are civil False Claims Act cases that are litigated in Federal courts by the U.S. Department of Justice and involve a group of MFCUs. The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases on behalf of the States. Global cases accounted for 59 of the Unit’s 265 cases over the 3-year period.

<sup>19</sup> Figures in this paragraph and Table 2 are rounded.



**Table 2: Oregon MFCU Reported Recoveries and Total Expenditures, by Year, FYs 2013 through 2015**

Recovery Types	FY 2013	FY 2014	FY 2015	3-Year Total
Global Civil Recoveries	\$7,762,716	\$16,315,640	\$408,520	\$24,486,876
Nonglobal Civil Recoveries	\$6,493,889	\$0	\$0	\$6,493,889
Criminal Recoveries	\$697,088	\$737,499	\$188,867	\$1,623,454
<b>Total Civil and Criminal Recoveries</b>	<b>\$14,953,693</b>	<b>\$17,053,139</b>	<b>\$597,387</b>	<b>\$32,604,219</b>
Total Expenditures	\$1,806,515	\$2,067,044	\$2,219,588	\$6,093,146

Source: OIG review of MFCU self-reported quarterly statistical reports and other data, 2016.

### **The Unit did not fully secure its case files**

During the onsite review, OIG observed that the Unit’s paper case files were not secured from access by non-Unit staff. Federal regulation requires Units to “safeguard the privacy rights of all individuals and provide safeguards to prevent the misuse of information under the Unit’s control.”<sup>20</sup> This includes safeguarding potentially sensitive personally identifiable information about witnesses, victims, suspects, and informants. However, during our onsite review we observed that the Unit stored case files for closed cases in cabinets without locks, located in general office space. Although individuals must use a coded access card to enter the Unit’s general office space, non-Unit staff (including janitorial, information technology, and other Office of Attorney General staff) could access the space without supervision during non-business hours. Additionally, the Unit did not have policies or procedures for securing paper case files from unauthorized access.

### **Part of the Unit’s MOU with State partners was inconsistent with Federal regulation**

In its MOU with OHA and DHS, the Unit requested that in all cases in which a credible allegation of fraud is referred to the Unit, the Medicaid agency find good cause not to impose a payment suspension.<sup>21</sup> However, such a “blanket” request pertaining to all referrals is inconsistent with the

<sup>20</sup> 42 CFR § 1007.11(f).

<sup>21</sup> In the MOU, the Unit agreed to immediately notify DHS if a payment suspension would no longer compromise an investigation.

Federal regulation governing Medicaid payment suspensions.<sup>22, 23</sup> Federal law requires that a Medicaid agency suspend payments to a provider when there is a credible allegation of fraud against the provider, unless the Medicaid agency determines that good cause exists not to suspend payments.<sup>24</sup> Regulation stipulates that one type of good cause not to suspend payments is when law enforcement officials (e.g., MFCU officials) “specifically request” that a payment suspension not be imposed because the suspension may compromise or jeopardize “an” investigation.<sup>25</sup> The Centers for Medicare & Medicaid Services (CMS) clarified this part of the regulation in 2014, specifying that a blanket request to not suspend payments based on a credible allegation of fraud, applying to all referrals, is not acceptable and that “[e]ach case must be evaluated on its own merits to determine the appropriate course of action.”<sup>26</sup> Unit management reported that they were aware that the MOU needed to be revised to remove the blanket request and stated that they planned to make revisions in 2017. Management also noted that although the Unit had not updated the MOU to reflect the change, in January 2015 the Unit began making case-by-case determinations on whether to request that the Medicaid agency not impose payment suspensions for each referral.

### **Although the Unit reported nearly all convictions and adverse actions to Federal partners, it did not report some within the appropriate timeframes**

Although the Unit reported nearly all convictions to OIG and all adverse actions to the National Practitioner Data Bank (NPDB), it did not report some within the appropriate timeframes. Performance Standard 8(f) states that Units should transmit to OIG reports of all convictions for the purpose of exclusion from Federal health care programs within 30 days of sentencing. Additionally, Federal regulations require that Units report any

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<sup>22</sup> 42 CFR § 455.23(e)(1).

<sup>23</sup> Performance Standard 10(b) requires that the MOU meet current Federal legal requirements, “including...42 CFR § 455.23, ‘Suspension of payments in cases of fraud.’”

<sup>24</sup> P.L. No. 111-148, § 6402(h) codified at Social Security Act (SSA) § 1903(i)(2)(C). 42 CFR § 455.23.

<sup>25</sup> 42 CFR § 455.23(e)(1).

<sup>26</sup> CMS, *Medicaid Payment Suspension Toolkit*. Accessed at <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf> on June 17, 2016.

adverse actions resulting from prosecutions of healthcare providers to the NPDB within 30 calendar days from the date of the adverse action.<sup>27, 28</sup>

Although the Unit had procedures in place for reporting convictions to OIG, it did not report two convictions to OIG as required. Unit management reported that one conviction inadvertently was not submitted and that the other was not submitted because Unit management mistakenly believed that they were not required to report convictions involving non-healthcare offenses. Further, the Unit reported more than half of its convictions (54 of 92) more than 30 days after sentencing. Specifically, the Unit reported 14 convictions more than 90 days after sentencing, 12 within 61 to 90 days after sentencing, and 28 within 31 to 60 days after sentencing. Late reporting of convictions to OIG could delay the initiation of the program exclusion process, resulting in improper payments to providers by Medicare or other Federal health care programs, or possible harm to beneficiaries. Following the onsite review, the Unit sent information to OIG about the convictions that were not previously sent.

As required, the Unit reported 95 adverse actions to the NPDB. However, it reported 67 of these more than 30 days after the adverse action. Specifically, the Unit reported 21 adverse actions more than 90 days after the action, 8 within 61 to 90 days after the action, and 38 within 31 to 60 days after the action. The NPDB is designed 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. As with program exclusions, late reporting of adverse actions to the NPDB could result in improper payments or beneficiary harm.

According to the Unit, the main reason for late reporting to Federal partners was delays in receiving from courts the final sentencing documentation that Units must provide to OIG. The Unit provided documentation demonstrating that Oregon courts issue preliminary, hand-written sentencing orders on the date of sentencing and send the final sentencing documentation days or weeks later. The Unit also provided

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<sup>27</sup> SSA § 1128E(g)(1); 45 CFR § 60.3. Examples of adverse actions include criminal convictions; civil judgments (but not civil settlements); exclusions; and other negative actions or findings.

<sup>28</sup> 45 CFR § 60.5. In addition to Federal regulations, the Performance Standards also require the Unit to report to NPDB. Performance Standard 8(g) states that the Unit should report “qualifying cases to the Healthcare Integrity & Protection Databank [HIPDB], the National Practitioner Data Bank, or successor data bases.” We reviewed the reporting of adverse actions under NPDB requirements because the HIPDB and the NPDB were merged during our review period (FYs 2013 through 2015). 78 Fed. Reg. 20473 (April 5, 2013).

evidence that they sometimes contacted the court when final documentation was particularly late.

Unit management identified two other issues that contributed to reporting delays, particularly for convictions reported more than 90 days after sentencing. For some of these convictions, management stated that reporting was delayed because the Unit mistakenly thought that they needed to wait until all co-defendants were sentenced. The Unit also provided documentation indicating that an administrative assistant responsible for submitting conviction information to Federal partners resigned unexpectedly during the review period. Unit management indicated that this contributed to the reporting delays for several convictions.

### **Other observation: The Unit took steps to increase patient abuse and neglect referrals from local agencies**

In August 2013, the Unit created the Financial Abuse, Abuse and Neglect Group (FAANG) to conduct outreach with local agencies on potential patient abuse and neglect cases. FAANG's goals are to (1) increase patient abuse and neglect referrals to the Unit, and (2) ensure that patient abuse and neglect cases are investigated when local agencies lack the resources to pursue them. FAANG consists of the Unit's data analyst, Unit attorneys, and the assistant attorney in charge.

During 2014 and early 2015, the group reached out to each county in Oregon and designated a Unit attorney as the main contact for the local patient abuse and neglect agencies. Unit management reported that, at the time, some county district attorneys were not aware that the Unit could investigate and prosecute abuse and neglect cases. As part of FAANG, Unit attorneys periodically attend multi-disciplinary team meetings in their assigned counties with local prosecutors, adult protective service agencies, and other stakeholders. Unit attorneys sometimes give presentations about the Unit's mission and legal authorities and answer questions as needed.

Unit management reported that as a result of FAANG, the quality of patient abuse and neglect referrals from local agencies "improved dramatically." Unit management also reported that the relationships made with these agencies through FAANG had helped the Unit with some of its cases, particularly in remote counties.

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## **CONCLUSION AND RECOMMENDATIONS**

The Unit was generally in compliance with applicable laws, regulations, and policy transmittals; however, we identified three areas where the Unit should improve its adherence to performance standards and its compliance with applicable Federal requirements. Specifically, the Unit did not fully secure its case files, part of the Unit's MOU with two of its State partners was inconsistent with Federal regulation regarding Medicaid payment suspensions, and the Unit did not report all convictions to Federal partners as required or within the appropriate timeframes.

We recommend that the Oregon Unit:

### **Implement procedures for securing case files**

After our May 2016 onsite review, the Unit reported that it moved into a new building and sent documentation to OIG demonstrating that it began storing closed case paper files in a secure room. Although the paper case files are now secure, the Unit should develop and implement procedures to ensure that all case files and any associated personally identifiable information are secured from unauthorized access in the future.

### **Revise its MOU with State partners to be consistent with Federal regulation**

When the Unit revises its MOU with OHA and DHS in 2017, it should ensure that the MOU is consistent with Federal regulation. The Unit should remove the blanket request for good cause exceptions from the MOU and describe the process through which the Unit can request, on a case-by-case basis, that the Medicaid agency not impose a payment suspension based on a credible allegation of fraud.

### **Implement processes to ensure it reports convictions and adverse actions to Federal partners within the appropriate timeframes**

The Unit should implement processes to ensure it reports convictions to OIG within 30 days of sentencing and adverse actions to NPDB within 30 days of the action. Such processes could include contacting the various courts to explain the Unit's need to receive copies of sentencing documents promptly so that the Unit can make required reports within the appropriate timeframes. The Unit also could implement automated reminders that alert Unit staff to report convictions and adverse actions to Federal partners.

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## **UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

The Oregon Unit concurred with all three of our recommendations.

Regarding our recommendation to implement procedures to secure its case files, the Unit stated that it is in the process of implementing a new case file security policy.

Regarding our recommendation to revise its MOU, the Unit reiterated that it plans to revise the MOU with OHA and DHS in 2017. The Unit stated that the revised MOU will include the procedure that the Unit currently follows to review each case for possible suspension of payments based on a credible allegation of fraud.

Regarding our recommendation to implement procedures to ensure timely reporting to Federal partners, the Unit stated that it will continue to communicate with the courts regarding the Unit's need to receive final documentation within 30 days of sentencing. The Unit also noted that Oregon courts are adopting a new online system that the Unit hopes will grant more timely access to final documentation.

The full text of the Unit's comments is provided in Appendix E.

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## APPENDIX A

### 2012 Performance Standards<sup>29</sup>

<b>1. A UNIT CONFORMS WITH ALL APPLICABLE STATUTES, REGULATIONS, AND POLICY DIRECTIVES, INCLUDING:</b>
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.
<b>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.</b>
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.
<b>3. A UNIT ESTABLISHES WRITTEN POLICIES AND PROCEDURES FOR ITS OPERATIONS AND ENSURES THAT STAFF ARE FAMILIAR WITH, AND ADHERE TO, POLICIES AND PROCEDURES.</b>
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.
<b>4. A UNIT TAKES STEPS TO MAINTAIN AN ADEQUATE VOLUME AND QUALITY OF REFERRALS FROM THE STATE MEDICAID AGENCY AND OTHER SOURCES.</b>
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.

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<sup>29</sup> 77 Fed. Reg. 32645, June 1, 2012.

B. The Unit provides periodic feedback to the State Medicaid agency and other referral sources on the adequacy of both the volume and quality of its referrals.
C. The Unit provides timely information to the State Medicaid or other agency when the Medicaid or other agency requests information on the status of MFCU investigations, including when the Medicaid agency requests quarterly certification pursuant to 42 CFR 455.23(d)(3)(ii).
D. For those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases, the Unit takes steps, such as the development of operational protocols, to ensure that pertinent agencies refer such cases to the Unit, consistent with patient confidentiality and consent. Pertinent agencies vary by State but may include licensing and certification agencies, the State Long Term Care Ombudsman, and adult protective services offices.
E. The Unit provides timely information, when requested, to those agencies identified in (D) above regarding the status of referrals.
F. The Unit takes steps, through public outreach or other means, to encourage the public to refer cases to the Unit.
<b>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.</b>
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.
<b>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.</b>
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.
<b>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.</b>
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.

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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 pre-filing settlements.
<b>8. A UNIT COOPERATES WITH OIG AND OTHER FEDERAL AGENCIES IN THE INVESTIGATION AND PROSECUTION OF MEDICAID AND OTHER HEALTH CARE FRAUD.</b>
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.
<b>9. A UNIT MAKES STATUTORY OR PROGRAMMATIC RECOMMENDATIONS, WHEN WARRANTED, TO THE STATE GOVERNMENT.</b>
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.
<b>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.</b>
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).

Continued on page 15

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 <i>CMS Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit</i> .
<b>11. A UNIT EXERCISES PROPER FISCAL CONTROL OVER UNIT RESOURCES.</b>
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.
<b>12. A UNIT CONDUCTS TRAINING THAT AIDS IN THE MISSION OF THE UNIT.</b>
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

### Oregon MFCU Referrals by Referral Source for FYs 2013 Through 2015

Referral Source	FY 2013		FY 2014		FY 2015		Total
	Fraud	Abuse & Neglect <sup>1</sup>	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect	
Medicaid Agency – Other	62	11	89	24	93	25	304
Adult Protective Services	6	19	23	27	26	15	116
Other	14	2	22	7	27	7	79
Private Citizen	15	9	13	5	12	4	58
Medicaid Agency – SUR/S or OMIG	9	0	9	1	33	5	57
Law Enforcement	17	2	18	0	9	0	49
Managed Care Organizations	0	0	15	1	3	3	22
HHS OIG	6	0	8	1	3	3	19
Prosecutor	2	3	2	5	2	0	14
Provider Association	1	0	12	1	0	0	14
State Agencies – Other	4	1	2	0	3	0	10
Private Health Insurer	0	0	7	1	0	0	8
Provider	2	1	1	0	0	0	4
Ombudsman	2	0	0	1	0	0	4
Licensing Board	0	0	0	1	1	0	2
<b>Total</b>	140	48	221	75	212	62	760
<b>Annual Total</b>	<b>188</b>		<b>296</b>		<b>276</b>		

Source: OIG analysis of Unit Quarterly and Annual Statistical Reports, 2016.

<sup>1</sup> The category of abuse & neglect referrals includes patient funds referrals.

<sup>2</sup> The referral source “MFCU hotline” was not a category reported on the FY 2015 Annual Statistical Report.

<sup>3</sup> The referral source “Anonymous” was not a category reported on the FY 2013 and FY 2014 Quarterly Statistical Reports.

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## APPENDIX C

### Investigations Opened and Closed by the Oregon MFCU, by Case Type, FYs 2013 through 2015

Case Type	FY 2013	FY 2014	FY 2015	3-Year Total	Annual Average*
Opened	53	80	64	197	66
Patient Abuse and Neglect	3	15	7	25	8
Provider Fraud	50	65	57	172	57
Closed	70	44	82	196	65
Patient Abuse and Neglect	6	5	13	24	8
Provider Fraud	64	39	69	172	57

Source: OIG analysis of Unit Quarterly and Annual Statistical Reports, 2016.

\*Averages in this column are rounded.

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## APPENDIX D

### Detailed Methodology

Data collected from the seven sources below were used to describe the caseload and assess the performance of the Oregon 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 OHA and DHS. 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 issues involving internal controls or the use of resources. Prior to the onsite review, we reviewed the Unit's financial policies and procedures; its response to an internal control questionnaire; and documents (such as financial status reports) related to MFCU grants.

We reviewed three purposive samples to assess the Unit's internal control of fiscal resources. All three samples were limited to the review period of FYs 2013 through FY 2015. 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 849 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 829 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. Specifically, we selected and verified a purposive sample of 48 items from the current inventory list of 259 items maintained in the Unit's office.

*Interviews with Key Stakeholders.* In April and May 2016, we interviewed ten individual stakeholders from six agencies who were familiar with MFCU operations. Specifically, we interviewed two program integrity managers from OHA; two Assistant U.S. Attorneys; the Civil Enforcement Division Administrator for the Oregon Department of Justice;<sup>30</sup> two managers from the Office of Adult Abuse Prevention and Investigations; a policy analyst from the Oregon Department of Human Services; and two OIG Special Agents based in Oregon. 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 April 2016, we conducted an online survey of all 13 nonmanagerial staff within each professional discipline (i.e., investigators, investigative auditors, and attorneys) as well as support staff. We received responses from 12 staff members. 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 MFCU's director, chief investigator, and assistant attorney in charge in May 2016. We asked these individuals to provide information related to (1) the Unit's operations, (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance, (3) opportunities for the Unit to improve its operations and/or performance, and (4) clarification regarding information obtained from other data sources.

*Onsite Review of Case Files.* We requested that the Unit provide us with a list of cases that were open at any point during FYs 2013-2015. We requested data on the 265 open cases that 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

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<sup>30</sup> The division administrator supervises the MFCU director.

excluded 59 cases that were categorized as “global” from the list of cases. The remaining number of case files was 206.

We then selected a simple random sample of 100 cases from the population of 206 cases. We determined that 83 of these 100 sampled cases were open longer than 90 days, and 41 were open longer than 1 year. We reviewed the 83 sampled case files that were open for at least 90 days to determine whether documentation for required supervisory reviews was present. Additionally, we reviewed the 41 of those sampled case files that were open for at least a year to determine whether there were investigation or prosecution delays of 1 year or more that were not explained in the case files. Because our case file review generated no findings, we do not report estimates of the number of case files for these subpopulations, nor do we report point estimates and their 95-percent confidence intervals.

From the initial sample of 100 case files, we selected a further simple random sample of 50 files for a qualitative review of selected issues, such as case development. While onsite, we consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation. We did not estimate any population or subpopulation proportions from this additional sample of 50 case files.

*Onsite Review of Unit Operations.* During our May 2016 onsite visit, we reviewed the Unit’s workspace and operations. Specifically, we visited the Unit headquarters in Portland, Oregon. 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.<sup>31</sup>

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<sup>31</sup> All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu>.

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## APPENDIX E

### Unit Comments

ELLEN F. ROSENBLUM  
Attorney General



FREDERICK M. BOSS  
Deputy Attorney General

DEPARTMENT OF JUSTICE  
MEDICAID FRAUD UNIT

November 30, 2016

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

Dear Deputy Inspector General Murrin:

We are in receipt of the *Oregon State Medicaid Fraud Control Unit: 2016 Onsite Review* (Onsite Review). I would like to first take this opportunity to thank the OIG staff for their professionalism and willingness to ask many questions to better understand how our Medicaid Fraud Control Unit (MFCU) operates. Regarding the recommendations contained in the Onsite Review, we concur. Specifically:

- 1) As noted in the Onsite Review, with our move to our new office in July 2016, we have implemented all the steps necessary to secure files from non-staff personnel. Our new office has a security guard on the ground floor, access to our MFCU floor and our office itself is controlled by a key card, and files within MFCU are stored in a locked room and/or in locked file cabinets. Additionally, we are in the process of implementing a new "File Security Policy."
- 2) As noted in the Onsite Review, the MFCU reviews each case to determine the proper course of action regarding the possible suspension of payments based on a credible allegation of fraud. This has been the MFCU's policy since 2015 and as suggested in the Onsite Review, this procedure will be reflected when the Memorandum of Understanding with the single state agency is redrafted in 2017.
- 3) The Onsite Review correctly notes that our MFCU reported nearly all convictions and adverse actions to our Federal partners and that there were some delays beyond 30 days due to the MFCU being at the mercy of local courts, which often do not produce a final judgment within 30 days of convictions. Though these delays cannot be controlled by the MFCU, it is hoped these delays will be minimized by the adoption of a new internet e-Court system by Oregon courts, which hopefully will give us instant access to final judgments. As suggested in the Onsite Review, we will continue to stress to the courts the necessity of producing a final judgment within 30 days of conviction.

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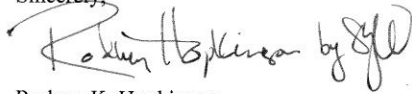


Suzanne Murrin  
November 30, 2016  
Page 2

The MFCU also appreciates the OIG's acknowledgement of our efforts to increase the quantity and quality of patient abuse and neglect referrals from local agencies. Specifically, our Financial Abuse, Abuse and Neglect Group (FAANG) has various members of the MFCU assigned to reach out to each of the 36 counties in the state as well as attend and give presentations to multi-disciplinary team meetings that deal with abuse and neglect in those counties. The Onsite Review correctly notes that the quality of patient abuse and neglect referrals have improved dramatically, and is just one of the reasons the MFCU had a record 39 convictions last year.

Thank you again and please do not hesitate to contact me if you have any questions or comments.

Sincerely,

A handwritten signature in black ink that reads "Rodney K. Hopkinson" followed by a stylized monogram or initials.

Rodney K. Hopkinson  
Director  
Oregon Medicaid Fraud Control Unit

RKH/lyr 7880580  
c: Rosemary Rawlins, OIG/OEI  
Frantzy Clement, OIG/OEI

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## **ACKNOWLEDGMENTS**

This report was prepared under the direction of Blaine Collins, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, and Michael Henry, Deputy Regional Inspector General; and in consultation with Richard Stern, Director of the Medicaid Fraud Policy and Oversight Division.

Rosemary Rawlins, of the San Francisco regional office, served as the project leader for the study. Other Office of Evaluation and Inspections staff who conducted the review include Matt DeFraga and Linda Min. Other Medicaid Fraud Policy and Oversight Division staff who participated in the review include Frantzy Clement. Office of Investigations staff also participated in the review. Other central office staff who contributed to this review include Kevin Farber, Lonie Kim, and Joanne Legomsky.

# Office of Inspector General

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