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New Hampshire
Medicaid Fraud
Control Unit:
2017 Onsite Review

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New Hampshire Medicaid Fraud Control Unit: 2017 Onsite Review

What OIG Found

The case outcomes of the New Hampshire Medicaid Fraud Control Unit (MFCU)—i.e., the MFCU’s convictions of fraud, patient abuse, or neglect; its criminal recoveries; its civil judgments and settlements; and its civil recoveries—were low during Federal fiscal years (FYs) 2014–2016. We found a variety of factors that contributed to the low case outcomes. These factors included:

- a lack of incoming referrals from the Medicaid Program Integrity Unit and other key sources;
- turnover in staffing and leadership; and
- investigative delays and a lack of documented supervisory reviews of case files

What OIG Recommends

We recommend that the MFCU work with its State partners and managed care organizations and that it take steps to address the operational factors that contributed to its low case outcomes. Specifically, we recommend that the MFCU:

- develop and implement a plan to increase referrals from the Medicaid Program Integrity Unit and managed care organizations;
- develop and implement a plan to reduce turnover in staff and leadership;
- implement policies and procedures to ensure that significant investigative delays are explained in the case files and that periodic supervisory reviews are documented; and
- revise its fiscal control policies governing vehicle costs.

The MFCU concurred with all four recommendations.

MFCU Case Outcomes

The MFCU had low criminal and civil case outcomes during FYs 2014–2016, in comparison both to its past performance history and as compared to similarly sized MFCUs from other States. The MFCU’s case outcomes for FYs 2014–2016 consisted of:

- no fraud convictions;
- four convictions of patient abuse or neglect;
- \$13,923 in criminal recoveries;
- 25 civil judgments and settlements; and
- \$2.6 million in civil recoveries.

Why OIG Did This Review

The primary purpose of this onsite review was to identify and address factors that contributed to the MFCU’s low case outcomes during FYs 2014–2016.

The Office of Inspector General (OIG) administers MFCU grant awards, annually recertifies each MFCU, and oversees MFCU performance in accordance with the requirements of the grant. As part of this oversight, OIG conducts periodic onsite reviews of MFCUs and prepares public reports. This onsite review supplements OIG’s annual recertification of this MFCU.

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BACKGROUND

Objective

To examine performance and operational issues that the Office of Inspector General identified during its recertification and onsite review of the New Hampshire Medicaid Fraud Control Unit.

Medicaid Fraud Control Units

The function of Medicaid Fraud Control Units (MFCU or Units) is to investigate Medicaid provider fraud and patient abuse or neglect, and to prosecute those cases under State law or refer them to other prosecuting offices.¹ Under the Social Security Act (SSA), a MFCU is a “single, identifiable entity” of State government, and the MFCU must be “separate and distinct” from the State Medicaid agency and employ one or more investigators, attorneys, and auditors.² Each State must operate a MFCU or receive a waiver.³ Currently, 49 States and the District of Columbia operate MFCUs.⁴ Each MFCU receives a Federal grant award, equivalent to 75 percent of total allowable expenditures.⁵ In Federal fiscal year (FY) 2017, the 50 Units collectively reported 1,528 convictions; 961 civil judgments or settlements; and about \$1.8 billion in recoveries.⁶

OIG Grant Administration and Oversight of the MFCUs

The Office of Inspector General (OIG) administers the grant award to each MFCU and provides oversight of MFCUs.^{7, 8} As part of its oversight, OIG

¹ Social Security Act § 1903(q)(3). Regulations at 42 CFR § 1007.11(b)(1) add that the Unit’s responsibilities may include reviewing complaints of misappropriation of patients’ private funds in residential health care facilities.

² SSA § 1903(q).

³ SSA § 1902(a)(61).

⁴ “State” refers to the States, the District of Columbia, and the U.S. territories. The State of 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.

⁵ SSA § 1903(a)(6). For a Unit’s first 3 years of operation, the Federal government contributes 90 percent of funding and the State contributes 10 percent.

⁶ OIG, *MFCU Statistical Data for Fiscal Year 2017*, accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2017-statistical-chart.pdf on May 2, 2018.

⁷ As part of grant administration, OIG receives and examines financial information from Units, such as budgets and quarterly and final Federal Financial Reports that detail MFCU income and expenditures.

⁸ The SSA authorizes the Secretary of Health and Human Services to award grants (SSA § 1903(a)(6)) and to certify and annually recertify the Units (SSA § 1903(q)). The Secretary delegated these authorities to OIG in 1979.

reviews and recertifies each MFCU annually. The recertification review consists of examining the following: the MFCU's annual report; questionnaire responses from the MFCU's director and stakeholders; and annual case statistics (collectively referred to as "recertification data"). Through the recertification review, OIG assesses a MFCU's performance, as measured by the MFCU's adherence to published performance standards;⁹ the MFCU's compliance with applicable laws, regulations, and OIG policy transmittals;¹⁰ and the MFCU's case outcomes—i.e., its convictions of fraud, patient abuse, or patient neglect; its criminal recoveries; its civil judgments and settlements; and its civil recoveries. (See Appendix A for MFCU performance standards, including performance indicators for each standard.) OIG further assesses MFCU performance by periodically conducting onsite reviews, that may identify findings and make recommendations for improvement. During an onsite review, OIG may also make observations regarding MFCU operations and practices, including identifying beneficial practices that may be useful to share with other MFCUs. In addition, OIG provides training and technical assistance to MFCUs while OIG is onsite and also on an ongoing basis.

New Hampshire MFCU

The New Hampshire MFCU's office is located in Concord, the State capital. The MFCU is an entity within the State's Attorney General's Office. At the time of our May 2017 review, the MFCU had eight staff positions: a director (who was also an attorney), another attorney, an investigator, a financial analyst (who served as the MFCU's auditor), a paralegal, and a legal secretary.¹¹ The director served as the immediate supervisor for the other staff members.¹² For FYs 2014–2016, the MFCU spent nearly \$2.3 million, with a State share of about \$569,000.¹³

Referrals. The MFCU may receive fraud referrals from the State Medicaid agency¹⁴ and Medicaid managed care organizations (MCOs), as well as from other sources such as private citizens, local prosecutors, OIG, and other law

⁹ MFCU performance standards are published at 77 Fed. Reg. 32645 (June 1, 2012). The performance standards were developed by OIG in collaboration with the MFCUs and were originally published at 59 Fed. Reg. 49080 (Sept. 26, 1994).

¹⁰ OIG occasionally issues policy transmittals to provide guidance and instruction to MFCUs. Policy transmittals may be found at <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp>.

¹¹ At the time of our onsite review, two of the eight staff positions were vacant. The MFCU had vacancies for both the attorney and investigator positions.

¹² Unless otherwise specified, the term "MFCU director" refers to the director at the time of the onsite review in May 2017. This director started in the position in May 2016.

¹³ OIG, "Expenditures and Statistics," *Medicaid Fraud Control Units—MFCU Statistical Data*. Accessed at <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp> on June 21, 2018.

¹⁴ The New Hampshire Department of Health and Human Services serves as the State Medicaid agency.

enforcement agencies. The MFCU may receive referrals of patient abuse or neglect from Adult Protective Services, health care providers, the Long-Term Care Ombudsman, and law enforcement agencies. Appendix B identifies the MFCU's referrals, by source, during FYs 2014–2016. When the MFCU receives a referral, the MFCU director reviews it to determine whether to open a full investigation. If the director decides not to open a case, the MFCU can send the referral to another agency for investigation or administrative action.

Investigations and Prosecutions. After the MFCU opens a case, an investigator and/or financial analyst conducts an investigation in consultation with one of the attorneys. If the director determines that the case warrants prosecution, it is submitted to higher level officials in the State Attorney General's Office for review, and the officials decide whether the MFCU should prosecute the case.¹⁵

New Hampshire Medicaid Program

In FY 2017, New Hampshire's Medicaid expenditures were approximately \$2.2 billion.¹⁶ Since 2013, New Hampshire has been transitioning its Medicaid program from fee-for-service to one based on managed care. As of August 2016, approximately 96 percent of New Hampshire's roughly 186,000 Medicaid beneficiaries received their services through two MCOs.¹⁷ Each MCO operates its own Special Investigation Unit that engages in a variety of program integrity activities, such as conducting audits of claims data to identify and address fraud, waste, and abuse. State contracts with the MCOs require that the Special Investigation Units refer any suspected provider fraud to the State Medicaid agency's Program Integrity Unit.¹⁸

The Program Integrity Unit is responsible for monitoring the State's Medicaid program for instances of fraud, waste, and abuse, and for recommending policy and procedure changes.¹⁹ It has staff to review

¹⁵ New Hampshire has civil and criminal authorities to address false claims. The State enacted a civil False Claims Act in 2005. In general, the New Hampshire False Claims Act contains provisions that establish civil liabilities and authorize associated penalties for individuals who knowingly present, or cause to be presented, a false or fraudulent claim. In addition to this authority, there is a *Prohibited Acts* criminal statute to address false claims. See NH Rev Stat §§ 167:61-b–167:61-e and NH Rev Stat § 167:61-a.

¹⁶ OIG, *Medicaid Fraud Control Unit 2017 Statistical Chart*, accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2017-statistical-chart.pdf on May 29, 2018.

¹⁷ CMS, Center for Program Integrity, *New Hampshire Focused Program Integrity Review* (May 2017), pp. 1-2. Accessed at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/NHfy16.pdf> on November 20, 2017.

¹⁸ The Program Integrity Unit is part of the New Hampshire Department of Health and Human Services, Office of Improvement & Integrity.

¹⁹ New Hampshire Department of Health and Human Services, Program Integrity Unit. Accessed at <https://www.dhhs.nh.gov/oii/pi.htm> on March 14, 2018.

algorithm outputs from an electronic fraud detection system and to generate fraud referrals based on that analysis of the Medicaid data. The Program Integrity Unit also conducts preliminary investigations of referrals that it receives from other sources. These referral sources include, but are not limited to, the public, MCOs, and other State agencies. If there is a reason to believe—on the basis of the Program Integrity Unit’s preliminary investigation of the referrals—that an incident of fraud has occurred, the Program Integrity Unit is required to refer the case to the MFCU.^{20, 21}

Previous OIG Onsite Review

In 2012, OIG issued a report regarding its onsite review of the MFCU. The report contained four recommendations stemming from the MFCU’s nonadherence to certain performance standards. OIG recommended that the MFCU (1) ensure that it maintains an adequate workload through referrals from the State Medicaid agency; (2) ensure that case files contain documented supervisory reviews; (3) seek to expand staffing to reflect the number of staff approved in its budget; and (4) establish annual training plans for each professional discipline. From the MFCU’s reporting of subsequent actions it had taken, OIG considered each of these recommendations as having been implemented.

Methodology

We conducted the onsite review in May 2017. The review team consisted of OIG evaluators, auditors, law enforcement agents, and a director from another State MFCU. The primary purpose of the review was to follow up on issues that OIG had identified through its ongoing administration and oversight activities. We focused the review on five general areas: (1) case outcomes; (2) referrals; (3) staff and leadership turnover; (4) MFCU operations; and (5) fiscal controls.

Our review covered the 3-year period of FYs 2014–2016. We based our inspection on an analysis of data from six sources: (1) MFCU documentation; (2) financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with the MFCU’s managers and staff; (5) a review of case files that were open at some point during the review period; and (6) observation of MFCU operations. (See Appendix C for a detailed methodology.)

²⁰ The memorandum of understanding between the Medicaid agency and the MFCU states that all cases of suspected provider fraud or abuse should be referred to the MFCU. *Memorandum of Understanding between New Hampshire Office of the Attorney General and New Hampshire Department of Health and Human Services*, March 16, 2017, p. 2, Term 4.

²¹ If the Program Integrity Unit receives a complaint of Medicaid fraud or identifies questionable practices it is required to conduct a preliminary investigation to determine whether sufficient evidence exists to warrant a full investigation. See 42 CFR § 455.14. In addition, the agency must refer all cases of suspected provider fraud to the MFCU. See 42 CFR § 455.21.

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. These inspections differ from other OIG evaluations in that they support OIG's direct administration of the MFCU grant program, but they are subject to the same internal quality controls as other OIG evaluations, including internal peer review.

FINDINGS

The MFCU's case outcomes were low during FYs 2014–2016

During FYs 2014–2016, the New Hampshire MFCU's case outcomes were low compared to previous years, and its number of fraud convictions was lower than for any other similarly sized MFCU.²² The low case outcomes held true for both criminal and civil cases. Exhibit 1 displays the MFCU's case outcomes during FYs 2014–2016 and FYs 2011–2013, and the range of outcomes among similarly sized MFCUs during FYs 2014–2016. For example, the New Hampshire MFCU had no fraud convictions during FYs 2014–2016, whereas it had four fraud convictions during the previous 3-year period. In the 3-year period of FYs 2014–2016, the number of fraud convictions among similarly sized MFCUs ranged from 9 to 98.

Exhibit 1: The New Hampshire MFCU's case outcomes were low compared to previous years and similarly sized MFCUs.*

Type of Case	Outcome	New Hampshire MFCU		Similarly Sized MFCUs
		FYs 2014–2016	Previous 3-year period (FYs 2011–2013)	FYs 2014–2016 (range)
Criminal	Fraud convictions	0	4	9 to 98
	Patient abuse or neglect convictions	4	9	0 to 62
	Criminal recoveries	\$13,923	\$1.1 million	\$224,000 to \$15.2 million
Civil	Civil settlements and judgments	25	43	19 to 49
	Civil recoveries	\$2.6 million	\$14.9 million	\$1.5 million to \$44.4 million

* Source: OIG MFCU Statistical Data Charts, FYs 2014-2016.

²² Although comparison across similarly sized MFCUs provides context for the case outcomes of a particular MFCU, many factors other than a MFCU's staff size can affect case outcomes. See Appendix C for a detailed description of our analysis, including the selection of similarly sized MFCUs and limitations associated with the comparative analysis.

The MFCU received few fraud referrals from the Medicaid Program Integrity Unit and other key sources; the MFCU initiated greater referral outreach in FY 2016

The New Hampshire MFCU received a total of six fraud referrals from the Program Integrity Unit during FYs 2014–2016, which was the second lowest number among similarly sized MFCUs.^{23,24} The MFCU had received the same total number of fraud referrals from the Program Integrity Unit during the previous 3-year period. This pattern of a low number of fraud referrals from the Program Integrity Unit to the New Hampshire MFCU was also noted in OIG’s 2012 onsite review report.

The continued pattern of few fraud referrals from the State’s Program Integrity Unit to the MFCU is concerning because the Program Integrity Unit monitors the State’s Medicaid program for fraud. The Program Integrity Unit also has staff to analyze Medicaid data for fraud and to conduct preliminary investigations of referrals that it receives from a variety of sources. Therefore, it should be a significant source of quality referrals for the MFCU. Appendix B illustrates the MFCU’s referrals, by source, during FYs 2014–2016. Performance Standard 4 states that a MFCU should take steps to ensure that it receives an adequate volume and quality of referrals from its State Medicaid agency and other sources.

We found that one factor limiting the number of fraud referrals that the MFCU received during FYs 2014–2016 was that the Program Integrity Unit did not review and send MCO-generated referrals to the MFCU in a timely manner.²⁵ Officials from the Program Integrity Unit identified six fraud referrals that they received from the MCOs during FYs 2014–2016, but did not send to the MFCU during that period.²⁶ The officials acknowledged that the Program Integrity Unit should have reviewed those referrals from MCOs and—after appropriate preliminary investigation—sent them to the MFCU during FYs 2014–2016. Those officials said that the six referrals had not been reviewed or forwarded in a timely manner because the Program Integrity Unit had key staff vacancies at the time. The Program Integrity Unit eventually forwarded the six referrals to the MFCU in FY 2017, which

²³ By comparison, the number of fraud referrals that similarly sized MFCUs received from their respective Program Integrity Units during FYs 2014–2016 ranged from 4 to 165 per MFCU.

²⁴ The MFCU received one additional fraud referral from another part of the Medicaid agency during FYs 2014–2016.

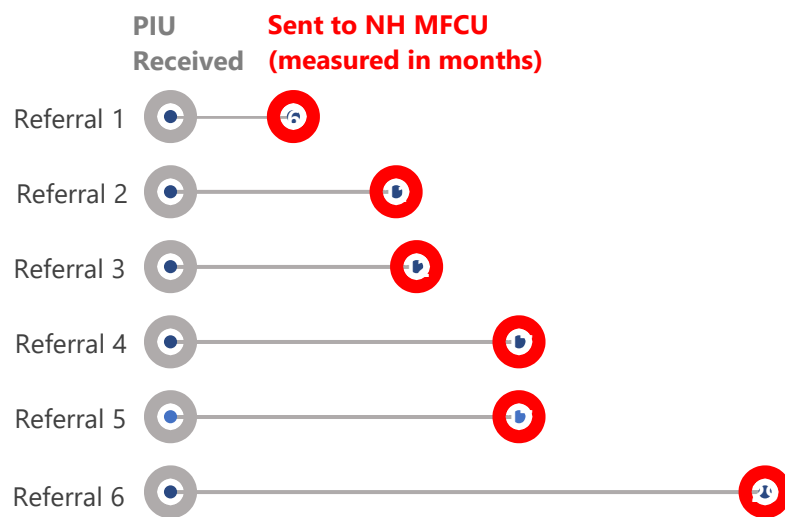
²⁵ Each of the MCOs’ contracts with the State and each of the MCOs’ policies and procedures require that the Special Investigations Units refer any suspected provider fraud to the Program Integrity Unit.

²⁶ In addition to the six MCO-generated referrals that Program Integrity Unit officials reported having received during FYs 2014–2016 and having relayed to the MFCU in FY 2017, there was one additional MCO referral that the Program Integrity Unit reported having received in FY 2014 and having reviewed and sent to the MFCU that same year. However, the MFCU reported that it had not received any MCO fraud referrals during that period, either from the Program Integrity Unit or directly from the MCOs. It is possible that for this one referral, the MFCU might have received the information but did not deem it to constitute an actual referral.

was the year of the OIG onsite review. The time that had elapsed between when the Program Integrity Unit received each of the six referrals and when it sent them to the MFCU ranged from 6 months to 29 months. See Exhibit 2. According to the MFCU director, the delays for each of these referrals compromised the viability of any potential investigations or prosecutions.

The low volume of MCO-generated referrals over a 3-year period is concerning for a State where about 96 percent of the Medicaid population is served by MCOs. Performance Standard 6(B) states that for a State that relies substantially on managed care entities for the provision of Medicaid services, the MFCU’s case mix should consist of a commensurate number of MCO cases. In a 2017 report, CMS highlighted this issue in observing that the number of fraud referrals that each of New Hampshire’s MCOs had sent to the Program Integrity Unit was “low” compared to the size of the plans.²⁷ A low number of MCO fraud referrals in a State that is predominantly served by MCOs makes it difficult for the MFCU to carry out its mission effectively.

Exhibit 2: The MFCU experienced significant delays in receiving MCO referrals from the Program Integrity Unit.*



* Source: Program Integrity Unit’s response to OIG data request, September 2017.

In FY 2016, the MFCU initiated outreach efforts in an attempt to increase incoming referrals

In May 2016, the MFCU director initiated efforts to increase the number of fraud referrals from the MCOs. The MFCU held meetings with Special Investigations Unit staff from the two MCOs. During these meetings, MFCU

²⁷ CMS (Center for Program Integrity), *New Hampshire Focused Program Integrity Review* (May 2017), p. 4, accessed at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/NHfy16.pdf> on November 29, 2017. The CMS analysis of referrals used data from FYs 2013–2015.

leadership provided education on fraud trends, the importance of referring any suspected fraud, and the kinds of information needed in a quality referral of fraud.²⁸

The MFCU also expanded its outreach to increase the number of referrals of patient abuse or neglect. The MFCU provided outreach and education addressing how and when to make referrals to the MFCU. The information was provided to nursing homes, local law enforcement agencies, a police academy, and other long-term care facilities and State agencies.

As part of the effort to increase referrals of patient abuse or neglect, the MFCU director established a process that would notify the MFCU whenever the State's Adult Protective Services agency referred an allegation of patient abuse or neglect to local law enforcement. This process may have contributed to a significant increase in referrals of patient abuse or neglect to the MFCU.²⁹ The MFCU received no referrals from Adult Protective Services in FYs 2014–2015, but received 27 from that agency in FY 2016 and 46 in FY 2017.³⁰

The MFCU also created two documents to facilitate its outreach. One was a pamphlet that described the MFCU and its role in combating Medicaid fraud, drug diversion, and patient abuse and neglect. The pamphlet included contact information for the MFCU and other State oversight and law enforcement agencies. The other document was a "jurisdiction" chart that illustrated the types of allegations that the MFCU has authority to investigate under the MFCU grant. These efforts may have contributed to an increase in the number of fraud referrals sent to the MFCU in FY 2017. For example, during FYs 2014–2016, the MFCU received no fraud referrals from the State's certification and survey agency. However, the MFCU received 22 fraud referrals from that agency in FY 2017.

The MFCU experienced significant turnover among staff and leadership

Although the staffing level remained generally constant (at eight employees), the MFCU experienced significant staff turnover during FYs 2014–2016. At the time of our onsite review, the staff member with the longest tenure had served with the MFCU for approximately 3 years. Of the eight individuals who left the MFCU, five transitioned elsewhere within the State Attorney General's Office. Staff turnover may have also contributed to low case outcomes. One MFCU staff member commented that staff turnover "killed production."

²⁸ In the last few months of the FY 2014–2016 period, the MFCU director initiated outreach efforts to increase referrals of fraud. However, in FY 2017, the MFCU reported receiving no referrals from MCOs, either directly or through the Program Integrity Unit.

²⁹ By examining patient-abuse referrals sent to law local enforcement, the MFCU may have been able to assume responsibility for some cases falling under its jurisdiction.

³⁰ The total of number of patient abuse or neglect referrals received from all sources increased from a total of 37 during FYs 2014–2015 to 58 in FY 2016.

A few cases had investigative delays; almost half of the case files lacked documented supervisory review

The MFCU leadership also had significant turnover. The MFCU had two different directors during the 3-year period of FYs 2014–2016. The first of these departed in February 2016. The subsequent director, who was serving as director at the time of our onsite review, left the MFCU after serving about 15 months (from May 2016 to August 2017). Another individual began as director of the MFCU in September 2017.

We identified significant investigative delays associated with a few of the case files that we reviewed and a lack of documented periodic supervisory reviews for almost half of the case files. Among the 95 case files we reviewed, 13 cases appeared to have experienced significant investigative delays.³¹ Performance Standard 5(B) states that MFCU supervisors should take action as necessary to ensure that investigations and prosecutions are completed in an appropriate timeframe. However, case files associated with 13 investigations lacked documentation of any investigative activities for at least 1 year, and 5 of those 13 case files lacked documentation of any investigative activities for longer than 2 years.

The MFCU staff did not have explanations for the delays in 9 of the 13 cases that we identified as having delays. Of these nine cases with unexplained delays, seven were assigned to one investigator who left the MFCU before our onsite review. MFCU staff explained that for many of these cases, the allegations associated with the cases were too old to effectively investigate or prosecute when new MFCU personnel took over the cases.

We also found that many case files lacked documented supervisory reviews. Among the 95 case files that we reviewed, almost half—44—lacked documentation that supervisors conducted periodic reviews of the cases. OIG’s 2012 report on its prior New Hampshire MFCU onsite review contained a similar finding. Performance Standard 7(A) indicates that MFCU supervisors should review case files periodically and that these reviews should be noted in the related case files. MFCU staff did not have explanations for the lack of documentation in the case files. However, prior to our onsite review, the then-director of the MFCU strengthened the case file review policy for supervisors by requiring reviews every 90 days, rather than every 120 days. At the time of our onsite review, it was too early to assess whether this policy change had had any impact on the MFCU’s review practices.

³¹ Although our initial sample of cases consisted of 102 cases, 6 of those cases had been closed after preliminary review and MFCU staff could not locate 1 other file.

The MFCU generally maintained proper fiscal controls, but lacked some policy guidance

During FYs 2014–2016, the MFCU generally maintained adequate internal controls related to accounting, budgeting, personnel, procurement, property, and equipment. However, although the MFCU claimed expenditures that represented allowable costs, it did not have policies and procedures in place to ensure that vehicle costs were allocated in accordance with Federal regulations.³²

³² The MFCU claimed vehicular costs on one occasion that were not directly related to MFCU activities. 45 CFR § 75.405(a). A cost is allocable to a particular Federal award or other cost objective if the goods or services involved are chargeable or assignable to that Federal award or cost objective in accordance with relative benefits received.

CONCLUSION AND RECOMMENDATIONS

A variety of factors contributed to the low case outcomes that the MFCU experienced during FYs 2014–2016. These factors were (1) a lack of incoming referrals from the Medicaid Program Integrity Unit and other key sources; (2) turnover in staffing and leadership; and (3) investigative delays and a lack of documented supervisory reviews of case files. Therefore, we recommend that the MFCU:

Develop and implement a plan to increase referrals from the Medicaid agency and MCOs

Both this 2017 onsite review and OIG’s prior 2012 review found a lack of incoming referrals from the Medicaid agency. The MFCU should further engage with the Medicaid agency’s Program Integrity Unit, and with the two MCOs’ Special Investigative Units, to develop and implement a plan to increase the number of referrals to the MFCU. The plan should include provisions that would ensure the appropriate quantity, quality, and timeliness of referrals. The MFCU should build upon the increased outreach that it initiated in 2016 to ensure that its partners have all the information that the MFCU can supply to help increase referrals from them. The MFCU should also monitor the flow of referrals from these sources, and should take action to alert the Medicaid agency and MCOs if referrals remain low or begin to decline over time.

Develop and implement a plan to reduce staff and leadership turnover

The MFCU should identify the causes of its significant staff and leadership turnover and address those causes. In consultation with OIG and other appropriate officials at the State Attorney General’s office, the MFCU should develop a written plan to address MFCU employee retention, both at the staff and director levels. Continual staff turnover can disrupt casework continuity and result in investigative delays. Frequent changes in MFCU leadership can also make it more difficult to maintain consistent internal practices, such as supervisor oversight of casework. The plan should identify methods for recruiting and retaining employees.

Implement policies and procedures to ensure that significant investigative delays are explained in the case files and that periodic supervisory reviews are documented

Both this 2017 onsite review and OIG’s prior 2012 review found that MFCU cases lacked documented supervisory reviews. Documented supervisory review of cases is important in helping to ensure that cases do not have unnecessary investigative delays and in helping to advance cases. Although the MFCU took actions that appeared to have addressed OIG’s

recommendation from 2012, those actions did not have a lasting effect—again, many cases had no documentation that periodic supervisory reviews had occurred. The MFCU should establish a documented process to record when and whether periodic supervisory reviews occur.

Revise its fiscal control policies governing vehicle costs

The MFCU should revise its fiscal control policies to ensure that the allocation of equipment costs, such as vehicle costs, is in accordance with Federal regulation.

MFCU COMMENTS AND OIG RESPONSE

The MFCU concurred with all four of our recommendations.

Regarding our recommendation that the MFCU develop and implement a plan to increase referrals from the Medicaid agency and MCOs, the MFCU stated that it now participates in monthly case review meetings that are attended by the Program Integrity Unit and MCOs. During these meetings, the agencies examine pending investigations and referrals. The MFCU said that it will foster close collaboration with the Program Integrity Unit to increase the number of referrals.

Regarding our recommendation that the MFCU develop and implement a plan to reduce staff and leadership turnover, the MFCU stated that its future recruitment efforts would target individuals with a demonstrated commitment to the MFCU's mission. The MFCU further expressed its intent to keep attorneys within the MFCU to the extent possible, so as to allow them to develop subject-matter expertise, and to refrain from transferring staff to positions external to the MFCU.

Regarding our recommendation that the MFCU implement policies and procedures to ensure that significant investigative delays are explained in the case files and that periodic supervisory reviews are documented, the MFCU reported revising its case file review process. The MFCU stated that as part of this effort, it would review and redesign the forms used to document case file reviews, and that it anticipates completing this effort within 4 months.

Regarding our recommendation that the MFCU revise its fiscal control policies governing vehicle costs, the MFCU reported implementing a new policy requiring staff to record vehicular miles associated with off-grant activities, so that the costs can be deducted from allowable grant reimbursement requests. The MFCU expects the new policy to be added to its *Policy and Procedure Manual* within 45 days.

The full text of the MFCU's comments is provided in Appendix D.

APPENDIX A: MFCU Performance Standards³³

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 website; and
- E) Terms and conditions of the notice of the grant award.

2) A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.

- A) The Unit employs the number of staff that is included in the Unit's budget estimate as approved by OIG.
- B) The Unit employs a total number of professional staff that is commensurate with the State's total Medicaid program expenditures and that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
- C) The Unit employs an appropriate mix and number of attorneys, auditors, investigators, and other professional staff that is both commensurate with the State's total Medicaid program expenditures and that allows the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
- D) The Unit employs a number of support staff in relation to its overall size that allows the Unit to operate effectively.
- E) To the extent that a Unit maintains multiple office locations, such locations are distributed throughout the State, and are adequately staffed, commensurate with the volume of case referrals and workload for each location.

3) A Unit establishes written policies and procedures for its operations and ensures that staff are familiar with, and adhere to, policies and procedures.

- A) The Unit has written guidelines or manuals that contain current policies and procedures, consistent with these performance

³³ 77 Fed. Reg. 32645 (June 1, 2012).

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 providers 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.

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- 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 pre-filing 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, case 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.

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- 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 exercise proper fiscal control over Unit resources.

- A) The Unit promptly submits to OIG its preliminary budget estimates, proposed budget, and Federal financial expenditure reports.
- B) The Unit maintains an equipment inventory that is updated regularly to reflect all property under the Unit's control.
- C) The Unit maintains an effective time and attendance system and personnel activity records.
- D) The Unit applies generally accepted accounting principles in its control of Unit funding.
- E) The Unit employs a financial system in compliance with the standards for financial management systems contained in 45 CFR 92.20.

12) A Unit conducts training that aids in the mission of the Unit.

- A) The Unit maintains a training plan for each professional discipline that includes an annual minimum number of training hours and that is at least as stringent as required for professional certification.
- B) The Unit ensures that professional staff comply with their training plans and maintain records of their staff's compliance.
- C) Professional certifications are maintained for all staff, including those that fulfill continuing education requirements.
- D) The Unit participates in MFCU-related training, including training offered by OIG and other MFCUs, as such training is available and as funding permits.
- E) The Unit participates in cross-training with the fraud detection staff of the State Medicaid agency. As part of such training, Unit staff provide training on the elements of successful fraud referrals and receive training on the role and responsibilities of the State Medicaid agency.

APPENDIX B: New Hampshire MFCU Referrals Received, by Source, FYs 2014–2016

Source	FY 2014		FY 2015		FY 2016		Period Total		Total
	Fraud	Patient Abuse/Neglect	Fraud	Patient Abuse/Neglect	Fraud	Patient Abuse/Neglect	Fraud	Patient Abuse/Neglect	
Public/Private Citizens	39	3	36	3	19	3	94	9	103
Adult Protective Services	0	0	0	0	2	27	2	27	29
Other Law Enforcement	4	1	0	6	3	10	7	17	24
Providers	5	6	0	7	1	2	6	15	21
Other/MFCU Hotline	3	1	2	0	11	4	16	5	21
Other State Agencies	2	0	0	0	4	6	6	6	12
Long-Term Care Ombudsman	0	4	0	2	0	5	0	11	11
Licensing Board	3	1	1	2	0	1	4	4	8
HHS OIG	0	0	4	0	4	0	8	0	8
SURS/PIU*	1	0	2	0	3	0	6	0	6
Prosecutors	0	1	1	0	0	0	1	1	2
Medicaid Agency-Other	0	0	1	0	0	0	1	0	1
MCOs	0	0	0	0	0	0	0	0	0
Total	57	17	47	20	47	58	151	95	246
	74		67		105				

* SURS is an acronym for the State's Surveillance and Utilization Review Subsystem and PIU is an acronym for the State's Program Integrity Unit. New Hampshire's PIU was formerly referred to as its SURS.

APPENDIX C: Detailed Methodology

The onsite review team consisted of OIG evaluators, auditors, and agents, as well as a director from another State MFCU. The primary purpose of the review was to follow up on issues identified by OIG through its ongoing oversight activities. We focused the review on five general areas: (1) case outcomes, (2) referrals, (3) staff turnover, (4) MFCU operations, and, (5) fiscal controls.

We analyzed qualitative and quantitative data from a variety of sources. These included:

- case outcome data;
- referral data associated with the MFCU;
- other documentation submitted by the MFCU;
- structured interviews with MFCU staff and key stakeholders;
- onsite review of case files;
- onsite observations; and
- documentation related to the MFCU's fiscal controls.

Data Collection and Analysis

Case outcomes

Prior to the onsite visit, we examined statistical reports and other documentation submitted by the MFCU to OIG. This included MFCU case outcome data pertaining to FYs 2014–2016 and the previous 3-year period (FYs 2011–2013).³⁴ We examined five case outcome measures: (1) the number of fraud convictions; (2) the number of convictions for patient abuse or neglect; (3) the amount of monetary recoveries associated with criminal convictions; (4) the number of civil settlements and judgments; and (5) the amount of monetary recoveries associated with civil cases.

For each measure, we performed two types of comparative analysis. We compared outcomes for the New Hampshire MFCU during each 3-fiscal-year period to determine whether outcomes changed during FYs 2014–2016. We also compared New Hampshire's outcomes for FYs 2014–2016 to those of other similarly sized MFCUs.³⁵ The 8 similarly sized MFCUs have staff sizes ranging from 6 to 10 employees; the New Hampshire MFCU has an approved staffing level of 8 employees.³⁶

³⁴ To provide context about the effect of some New Hampshire MFCU initiatives, we included some FY 2017 data.

³⁵ Although comparison across similarly sized MFCUs provides context for the case outcomes of a particular MFCU, many factors other than a MFCU's staff size can affect case outcomes.

³⁶ The figures of 6-10 employees comes from the numbers of employees that MFCUs reported having at the end of FY 2016.

Referrals of fraud and patient abuse or neglect

We examined data associated with referrals sent to and received by the MFCU from a variety of sources. This included the number of referrals that the MFCU reported receiving during FYs 2014–2016; the number of referrals from the previous 3-FY period; and the number of referrals received by similarly sized MFCUs during FYs 2014–2016. These data included both fraud referrals and those allegations related to patient abuse or neglect. For six referrals of provider fraud that the Program Integrity Unit referenced as having received from the State’s MCOs, we learned when the Program Integrity Unit had relayed the referrals to the MFCU (2017) and then calculated for each referral the timespan (in months) between when the Program Integrity Unit had received the referral and when it passed the referral along to the MFCU. We also examined the processes that the MFCU used for monitoring the opening of cases, and we examined the outcomes of cases. We also reviewed the MFCU’s memorandum of understanding with the State Medicaid agency.

Other documentation

We examined the MFCU’s policies and procedures and held discussions with Unit management to gain an understanding of those policies and procedures. We confirmed with the MFCU director that the information we had was current and requested any additional data or clarification that we needed. We also examined data associated with the MFCU’s staff, both to identify the number of MFCU staff and to determine how long each staff member had been at the MFCU during the period of FYs 2014–2016.

Interviews with MFCU staff and director

We conducted interviews with all the MFCU staff, including the then-director of the MFCU, at the time of the onsite review. These interviews focused on case outcomes—why they were low during FYs 2014–2016 and how to improve them. The interviews were informed by our analysis of the MFCU’s case-outcomes data, other documentation, and stakeholder interviews. We asked MFCU staff to provide us with any additional context that could help us understand the MFCU’s operations, including issues with retaining staff. Subsequent to the onsite review, we followed up with the MFCU director and the director’s successor, to clarify certain data that we collected onsite and to gain further information.

Key stakeholder interviews

In April and May 2017, we interviewed individual stakeholders from eight entities who were familiar with the MFCU’s operations. Staff conducting the

structured interviews included OIG evaluators and agents, and a director from another State MFCU. Stakeholders whom we interviewed included a manager and an attorney from the Medicaid agency's Program Integrity Unit; the Criminal Bureau Chief from the New Hampshire Department of Justice;³⁷ the State's Long-Term Care Ombudsman; a manager from the Bureau of Elderly and Adult Services (Adult Protective Services); Special Investigations Unit staff from the State's two MCOs; two Assistant U.S. Attorneys; and another OIG agent who worked closely with the MFCU.

We focused these interviews on (1) the MFCU's relationship and interactions with these entities; (2) any areas in which stakeholders believed the MFCU had opportunities for improvement; and (3) practices that may be beneficial to the MFCU's operations or to other MFCUs. As needed, we followed up with some of the interviewees after the onsite review.

Case file reviews

We asked the MFCU to provide us with a list of cases that were open at any point during FYs 2014–2016. The MFCU provided us with a list of 224 cases that met these parameters. Forty-three of these cases were "global" cases, which we excluded from consideration for our onsite review of case files. (Global cases are False Claims Act cases that are litigated in Federal court by the U.S. Department of Justice and typically involve a group of MFCUs.) Of the remaining 181 cases on the list, 78 were related to fraud allegations. We examined case files related to all 78 of these cases because we were most concerned with the MFCU's low fraud outcomes for FYs 2014–2016. We added one additional case to our list of fraud cases because it was not clear whether it was a case of fraud or a case of patient abuse or neglect.

Of the 102 cases of patient abuse or neglect on the MFCU's list, we purposively selected the 23 cases that the MFCU had opened since January 2015 to give us a picture of the MFCU's most recent investigations of patient abuse or neglect. With the assistance of OIG agents and the director from another State MFCU, we reviewed referrals received by the MFCU and the MFCU's processes for monitoring the opening, status, and outcomes of cases.³⁸ We also reviewed the MFCU's approach to investigating and prosecuting cases there were open at some point during FYs 2014–2016.

Onsite observations

While onsite, we examined the MFCU's workspace and operations to identify any instances of nonadherence to performance standards and/or instances of noncompliance with applicable Federal laws, regulations, and

³⁷ The Criminal Bureau Chief directly supervises the MFCU director.

³⁸ To verify—in the absence of documentation—whether the periodic reviews for these files had ever been conducted, we followed up with the MFCU staff.

OIG policy transmittals. Among other things, we evaluated the security of the MFCU's case files and the functionality of the MFCU's electronic system for tracking case files.

Fiscal review

OIG auditors reviewed the MFCU's internal fiscal controls and use of fiscal resources to identify any internal control issues or other issues involving the use of resources. The review examined the MFCU's response to a questionnaire about internal controls over accounting, budgeting, personnel, procurement, property, and equipment and the MFCU's financial policies and procedures. OIG staff also held discussions with MFCU staff about policies and procedures and questionnaire responses.

We also examined the MFCU's claimed grant expenditures for FYs 2014–2016. For these expenditures, we (1) reviewed quarterly and annual Federal financial status reports (SF-425 forms) that the MFCU submitted to OIG; (2) examined, on a limited test basis, evidence supporting selected expenditures within the direct cost categories; and (3) verified, on a limited test basis, whether selected indirect costs were adequately allocated to the MFCU in accordance with the approved indirect cost rate proposal.

While onsite, we reviewed three purposive samples to assess the MFCU's internal control of fiscal resources:

1. To assess the MFCU's expenditures, we selected 38 transactions for additional review. We selected these transactions from the monthly expenditures for 3 months, one for each fiscal year. We purposively included transactions from different Federal cost categories and included automated as well as manual journal entries. We then requested and reviewed documentation supporting the selected transactions.
2. 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 to support the time and effort of MFCU staff during the selected pay periods.
3. We also reviewed the MFCU's fixed-asset inventory. The fixed-asset inventory accounted for 109 items that were present and 5 items that had been either disposed of or replaced.

APPENDIX D: MFCU Comments

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September 7, 2018

Suzanne Murrin
Deputy Inspector General
for Evaluation and Inspections
Office of Inspector General
Washington, D.C. 20201

Re: *New Hampshire Medicaid Fraud Control Unit: 2017 Onsite Review*,
OEI-09-17-00200

Dear Deputy Inspector General Murrin:

Thank you for providing your draft report and the opportunity to comment on its recommendations. The Medicaid Fraud Control Unit (MFCU) and I commend the audit team for its courtesy and professionalism during the onsite last year. I concur with each of their recommendations, which are discussed in turn.

1. Develop and implement a plan to increase referrals from the Medicaid agency and MCOs.

Although a report of Medicaid fraud report may come from any source, the state's Program Integrity Unit (PIU) is the principal source of referrals. In addition to suspected fraud detected in the screening process of fee-for-service claims, PIU is also the conduit for credible allegations of fraud reported by either of the two managed care organizations (MCOs). MFCU and PIU are separate and independent entities, but unity of effort is essential to accomplish our shared mission. A harmonious and collaborative working relationship between MFCU and PIU directors and staff are the key ingredient to more quality fraud referrals.

The previous MFCU director held that position for little more than eighteen months—most of which was after the audit review period. During her tenure, she established regular, frequent communication with her PIU counterpart. The current director has continued that practice. The MFCU now participates in the monthly case review meetings PIU has with MCOs to examine pending investigation and referrals. In addition to frequent phone conversations, the directors meet on an *ah hoc* basis to assess and develop pending cases. As a testament to the collaborative relationship now existing between the units, the PIU director invited the MFCU director to attend the "Interactions between Medicaid Fraud Control Units and Program Integrity

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Units Symposium” at the National Advocacy Center last April. The MFCU will continue to foster close collaboration with PIU to increase the number of referrals.

Another of the previous director’s initiatives should yield increased numbers of patient abuse cases in the future. The Bureau of Elder and Adult Services generates a “law enforcement referral form” for each of the abuse and neglect reports it receives. MFCU is now copied on each of those referrals. As a result, we are actively investigating two cases of resident abuse and neglect.

For the first time in over a year, MFCU is staffed at full compliment. As a result, it has the resources to resume targeted outreach to educate health care professionals and other audiences regarding its mission and the reporting of credible fraud allegations. The director has spoken twice already to NH Police Standards and Training classes. Investigators have provided relevant training to nursing home staffs following the investigation of pill diversion allegations. MFCU personnel have been directed to accept, whenever possible, invitations to speak to industry and other relevant groups. I will ask MFCU to provide an account of the number of outreach events conducted over the next six months.

2. Develop and implement a plan to reduce staff and leadership turnover.

The audit period was marked by significant MFCU staff and leadership turnover. Only three of the eight current staff members have been with the unit for two years or more; only one of three attorneys has. The high incidence of turnover among department talent has not been confined to MFCU. The reasons cited by departing personnel generally fall into two categories:

(1) Compensation. Most attorneys who leave the department report being motivated by the opportunity to earn higher salaries. The department’s ability to set salaries is a function of state law and appropriations. Our statutes designate four lawyer classifications and assign a market anchor pay structure for each. Last month, the Governor and Executive Council approved my request to award salary increases for all department attorneys, which were apportioned utilizing merit-based criteria. Nonetheless, the department will remain at a significant competitive disadvantage as long as other state agencies, public sector employers, and private sector employers pay similarly situated attorneys higher salaries than we are currently authorized to pay. I am committed to addressing this imbalance on an on-going basis.

(2) Professional Opportunity. Some of the attorneys who left MFCU in recent years cited the opportunity to pursue other professional aspirations in and outside the department. The two most recent directors left to accept senior compliance positions—at a managed care organization and a local hospital, respectively. One MFCU attorney billet was vacant during the on-site audit. That vacancy was created when the incumbent departed to accept a senior administrative position in another state agency; she has since been appointed as the Chief Legal Officer for one of the largest state departments. The last attorney to depart MFCU was reassigned to fill a critical, newly created civil rights position within the department.

I cannot prevent an attorney from departing to pursue a coveted opportunity outside the department, nor would I. But, to the extent that I can, I am committed to keeping MFCU attorneys within the unit to develop their subject-matter expertise. As vacancies arise, we will

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recruit staff with demonstrated commitment to MFCU's mission. And we will refrain from transferring talent to other positions within the department during their three-year commitment period.

3. Implement policies and procedures to ensure that significant investigative delays are explained in case files and that periodic supervisory reviews are documented.


The audit report notes that, after the close of the review period but before the onsite review, the then-current MFCU director implemented a case review policy mandating supervisory review every 90 days. Continued adherence to that policy should address the internal investigative delays noted by the audit. Supervisory reviews have been memorialized utilizing "confidential memos" in the ProLaw data base or in the paper file. The unit is currently in the process of reviewing and redesigning its standardized forms and will promulgate one for this specific purpose, which should aid in record retrieval during future audits. The catalogue of new forms will be complete within 120 days. Finally, the report noted significant delays in the transmittal of preliminary investigations and fraud referrals from PIU to MFCU. The likelihood of future delays of that sort should be reduced significantly now that the PIU and MFCU directors conduct monthly case assessments and reviews. Those meetings will continue indefinitely.

4. Review fiscal control policies governing vehicle costs.

It is my understanding that the only irregularity noted in the review of vehicle costs was an instance when a MFCU investigator refueled his department vehicle while he was off-grant for poll inspection during an election. Investigators have since been instructed to record any miles driven for off-grant purposes on their monthly vehicle use report. The auditor will calculate an amount, based upon the existing IRS mileage reimbursement rate, representing off-grant vehicle use, which will be deducted from allowable vehicle reimbursement request. This policy will take effect immediately and will be memorialized in the MFCU Policy and Procedure Manual (Sec. 3.17.F) within 45 days.

In closing, I sincerely appreciate the talent, time, and effort invested in this audit. Before becoming Attorney General, health care law was my primary practice area. The MFCU is well aware of my particular interest holding Medicaid cheats accountable, deterring like-minded fraudsters, and ensuring that precious Medicaid resources are dedicated solely to their intended purpose. Your objective, unvarnished assessment of our past performance and constructive recommendations for future success were most welcomed. In the meantime, please feel free to contact me if you have any questions or concerns.

Sincerely,



Gordon J. MacDonald
Attorney General

ACKNOWLEDGMENTS

Michael Henry served as the team leader for this study, and Matthew DeFraga served as the lead analyst. Others in the Office of Evaluation and Inspections who conducted the study include Anthony Soto McGrath. Medicaid Fraud Policy and Oversight Division staff who participated in the review include Susan Burbach. Office of Evaluation and Inspections staff who provided support include Kevin Farber, Christine Moritz, and China Tantameng.

We would also like to acknowledge the contributions of Office of Audit Services staff, including Ravinder Chana and Charles McKenney. Office of Investigations staff and a peer reviewer from another State MFCU also participated in this review.

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

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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