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New York Medicaid Fraud Control Unit: 2017 Onsite Inspection

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What OIG Found

The New York Medicaid Fraud Control Unit (MFCU or Unit) reported 370 indictments; 348 convictions; 211 civil settlements and judgments; and over $670 million in recoveries for fiscal years (FYs) 2014–2016. From the data we reviewed, we found that the Unit generally operated in accordance with applicable laws, regulations, policy transmittals, and the MFCU performance standards. However, we identified five findings involving the Unit's adherence to program requirements:

1. Unit practices left some case files vulnerable to unauthorized access.

2. The Unit did not have a written policy for conducting periodic supervisory reviews and noting the reviews in the Unit's case files.

3. The Unit did not report all convictions and adverse actions to Federal partners within the appropriate timeframes.

4. The Unit generally exercised proper fiscal controls, but it did not exercise proper fiscal controls over the sale and transfer of Unit vehicles.

5. Three Unit professional staff temporarily performed non-Unit duties, and the Unit did not deduct the associated costs from claimed Unit expenditures.

In addition to the five findings, we made observations regarding Unit operations and practices, including the following that we identified as beneficial practices that may be useful as a model to other Units:

- The Unit developed a strategic plan to increase efficiency in MFCU casework and to protect Medicaid program integrity.
- The Unit established data-analytics working groups to facilitate the Unit's data mining processes.
- Unit staff participated in moot court training to prepare for settlement negotiations and opening statements.

Unit Case Outcomes

FYs 2014–2016

- 370 indictments
- 348 convictions
- 211 civil settlements and judgments
- $670 million in recoveries

Unit Snapshot

The Unit has 299 staff spread among its New York City headquarters and its 7 regional offices.

The Unit is part of the Office of the New York State Attorney General.

The Unit includes a Civil Enforcement Division and an Electronic Investigative Support Group.

What OIG Recommends

We recommend that to address the five findings, the Unit (1) take steps to ensure that MFCU staff adhere to policies and procedures for securing case files; (2) create policies and procedures for conducting periodic supervisory reviews of Unit case files, and take steps to ensure that case files include documentation of periodic supervisory reviews; (3) ensure that the Unit consistently reports convictions and adverse actions to Federal partners within the appropriate timeframes; (4) ensure that—consistent with Unit policy—the Unit reimburses the Federal Government its share of proceeds received from the sale and transfer of vehicles and any other equipment; and (5) strengthen internal controls to ensure that the Unit excludes from its claimed grant expenditures all costs related to time spent by staff on non-Unit activities.

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BACKGROUND

Objective

To examine the performance and operations of the New York State Medicaid Fraud Control Unit

Medicaid Fraud Control Units

The function of Medicaid Fraud Control Units (MFCUs 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, must be "separate and distinct" from the State Medicaid agency, and must 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 Unit receives a Federal grant award equivalent to 75 percent of total expenditures.[5] In fiscal year (FY) 2016, combined Federal and State expenditures for the Units totaled approximately $259 million.[6]

OIG Grant Administration and Oversight of the MFCUs

The Office of Inspector General (OIG) administers a grant award to each Unit and provides oversight of Units.[7, 8] As part of its oversight, OIG reviews and recertifies each Unit annually. The recertification review consists of examining the following: the Unit's annual report; questionnaire responses from the Unit's director and stakeholders; and annual case statistics. Through the recertification review, OIG assesses a Unit's performance, as measured by the Unit's adherence to published performance standards;[9] the

[1] SSA § 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 of Unit funding. Thereafter, the Federal government contributes 75 percent and the State contributes 25 percent. The SSA authorizes the Secretary of Health and Human Services to award grants to the Units. The Secretary has delegated this authority to OIG.
[6] OIG analysis of FY 2016 MFCU annual statistical reporting data.
[7] See footnote 5.
[8] OIG's Office of Management and Policy (OMP) collects and examines a variety of financial information from Units. For example, MFCUs transmit Federal Status Reports to OMP on a quarterly and annual basis. These financial reports detail MFCU income and expenditures.
[9] 77 Fed. Reg. 32645 (June 1, 2012).

Unit's compliance with applicable laws, regulations, and OIG policy transmittals;[10] and the Unit's case outcomes. See Appendix A for MFCU performance standards, including performance indicators for each standard. OIG further assesses a Unit's performance by periodically conducting onsite Unit reviews that may identify findings and make recommendations for improvement. During an onsite review, OIG may also make observations regarding Unit operations and practices, including identifying beneficial practices that may be useful to other Units. In addition, OIG provides training and technical assistance, as appropriate, to Units while onsite and on an ongoing basis.

New York MFCU

The New York MFCU is headquartered in New York City and has seven regional offices: Albany, Buffalo, Hauppauge, New York City, Pearl River, Rochester, and Syracuse. The Unit is a division of the New York State Attorney General's Office. The national MFCU program is modeled after the New York Special Prosecutor's Office, which was established in the 1970s. As with today's MFCUs, the Special Prosecutor's Office was staffed by coordinated teams of specialists, attorneys, investigators, and auditors, all dedicated to the investigation and prosecution of cases of health care fraud and patient abuse.[11]

[10] OIG occasionally issues policy transmittals to provide guidance and instruction to MFCUs.

[11] Following widespread and shocking revelations of fraud in the New York nursing home industry, an independent Special Prosecutor, Charles J. Hynes, was appointed in January 1975 to investigate and prosecute health care providers statewide. In the first 2 years, the Special Prosecutor's office obtained 50 convictions of nursing home owners and recovered millions of dollars in restitution and fines. Hynes testified before several congressional committees, outlining the framework for federally funded State anti-fraud units patterned after the New York Special Prosecutor's Office. Each Unit would be separate and distinct from the corresponding State Medicaid agency in order to maintain the Unit's investigative independence, and each Unit would have statewide prosecutorial authority.

Exhibit 1: New York MFCU Office Locations

Source: OIG analysis of New York State Medicaid Fraud Control Unit, 2016 Annual Report.

The New York MFCU includes a Civil Enforcement Division. The Civil Enforcement Division handles civil fraud investigations, including qui tam cases (whistleblower actions). The Civil Enforcement Division is composed of 36 Unit staff, including a Civil Enforcement Division Chief, 15 attorneys (in addtion to the Chief), 18 auditors, 1 computer program analyst, and 1 support staffer. The Unit also plays a significant role in the National Association of Medicaid Fraud Control Units' (NAMFCU) global cases. Global cases are civil cases that involve both the Federal Government and a group of States. A New York MFCU attorney has served on the Association's Global Case Committee and has co-chaired the Qui Tam Subcommittee since 2008. A New York MFCU auditor has co-chaired NAMFCU's Data Analytic Subcommittee since 2008, and three additional Unit auditors have served on the subcommittee since 2013.

The New York MFCU also includes an Electronic Investigative Support Group. This group organizes and analyzes State Medicaid claims data for MFCU investigations and manages the Unit's computer network. Further, the Unit's Electronic Investigative Support Group manages NAMFCU's Global Case Repository. The repository is a centralized system that provides

NAMFCU's global case teams with the ability to coordinate their investigations and avoid duplication of efforts.

The New York MFCU is the largest of the 50 MFCUs and employed 299 staff at the end of FY 2017. These stafff included a director and deputy director; 82 investigators; 86 auditors; 55 attorneys (in addition to the director and deputy director, who are both attorneys); analysts; and support staff. The Unit director has been employed by the MFCU since 2007 and was promoted to acting director in 2013 and director in 2016. During the review period of FYs 2014–2016, the Unit expended $140 million, with a State share of $35 million.

Referrals. The Unit receives referrals of fraud and patient abuse or neglect primarily from the State Medicaid agency, but also receives many referrals from private citizens and other State agencies. Appendix B lists Unit referrals by source for FYs 2014 through 2016. When the Unit receives a referral, the appropriate regional MFCU office determines whether to open a preliminary investigation, open a full investigation, or refer it to another agency.

Investigations. Once the Unit opens a preliminary or full investigation, regional managers assign a team to the case. Teams assigned to fraud cases generally include an investigator, attorney, auditor, and, as appropriate for the case, a nurse analyst. Cases of patient abuse or neglect are assigned a team consisting of an investigator, attorney, and a nurse analyst.

The Unit does not maintain a written policy requiring a specific frequency for supervisory reviews of case files. Unit management reported that regional MFCU directors, who are the first-line supervisors for Unit staff in regional offices, are given flexibility regarding the format and frequency of supervisory reviews of each case and how those reviews are documented. The regional directors are encouraged, but not required, to document the reviews through emails and through calendar records.

Prosecutions. The New York MFCU has Statewide criminal prosecutorial authority. If a case is not within the Unit's prosecutorial authority, the MFCU typically refers it to either a district attorney or the appropriate United States Attorney's Office (Northern, Southern, Eastern, or Western Districts of New York). The Unit's Civil Enforcement Division works jointly with Federal prosecutors on cases brought under the State False Claims Act.

New York Medicaid Program

New York State Department of Health. The New York Department of Health includes the State Medicaid Agency as well as the Office of Medicaid Inspector General (OMIG). Among other functions, OMIG serves as the

program integrity unit for the State's Medicaid program.[12] New York's Medicaid program contracts with 19 mainstream MCOs[13] to provide health care coverage for over 4 million beneficiaries.[14,] In FY 2017, total New York Medicaid expenditures were $78.6 billion.[15]

MCO Contract. The New York Medicaid Managed Care model contract (adopted for all 19 MCOs in New York State) requires MCOs, upon identifying "reasonably suspected" cases of fraud and abuse, to make referrals to the State Medicaid agency and OMIG. OMIG in turn refers such matters to the MFCU when it deems them to be credible allegations of fraud.[16]

Prior OIG Report

OIG conducted a previous onsite review of the New York Unit in 2011. In that review, OIG found that (1) although the number of referrals to the Unit increased during the review period, the number of cases the Unit opened and closed decreased; (2) the Unit did not establish annual training plans and provided limited training opportunities to staff; (3) the Unit lacked policies and procedures to reflect many of its current practices; (4) case files lacked consistent documentation of the opening and closing of cases and of supervisory reviews; and (5) the Unit lacked internal controls over purchase cards, reconciliation of accounting records, and vehicle sale and transfer.[17]

OIG recommended that the Unit (1) seek to expand staff sizes to reflect the number of staff approved in the Unit's budget; (2) establish annual training plans and increase the number of training opportunities available to staff; (3) ensure that its memorandum of understanding (MOU), its policies, and its procedures reflect current practices; (4) ensure that its case files are

[12] OMIG has the authority to pursue civil and administrative actions against Medicaid providers and recipients engaged in fraud, abuse, or illegal practices.
[13] Mainstream managed care provides comprehensive medical services including hospital care, physician services, dental services, pharmacy benefits, and many others. New York State Office of the State Comptroller, *Mainstream Managed Care Organizations—Administrative Costs Used in Premium Rate Setting*. October 2016. Accessed at https://osc.state.ny.us/audits/allaudits/093017/14s55.pdf on September 17, 2018.
[14] New York State Department of Health, *Recipients Enrolled in Mainstream Medicaid Managed Care by County, Plan, Aid Category, and NYSoH*. Accessed at https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/2018/docs/en06_18.pdf on July 2, 2018. NYSoH is New York State of Health—the State's health insurance marketplace, created in accordance with the Patient Protection and Affordable Care Act.
[15] OIG, *MFCU Statistical Data for FY 2017*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2017-statistical-chart.pdf on March 30, 2018.
[16] According to the MFCU's Memorandum of Understanding with the Department of Health and OMIG, a "credible allegation of fraud means an allegation that has indicia of reliability and has been verified" by the State Medicaid agency, OMIG, the MFCU, another State agency, or law enforcement organization.
[17] OIG, *New York State Medicaid Fraud Control Unit: 2011 Onsite Review*. Accessed at https://oig.hhs.gov/oei/reports/oei-02-11-00440.pdf on February 1, 2018.

maintained with greater consistency and reviewed more frequently; and (5) establish written policies and procedures for certain controls. In response to the recommendations, the Unit (1) hired 75 new employees; (2) established a training plan covering all disciplines and support staff and increased training opportunities for Unit staff; (3) updated its MOU and its policies and procedures to reflect its current practices; (4) adopted an electronic case-management system to maintain case files and instructed supervisors to document case file reviews; and (5) implemented internal controls over purchase cards, assigned two supervisors to oversee the Unit's financial systems, and reimbursed the Federal Government for the Federal portion of funds received from the transfer of vehicles. On the basis of information that OIG received from the Unit, OIG considered these recommendations implemented.

Methodology

We conducted the onsite inspection of the New York MFCU in August 2017. Our review covered the 3-year period of FYs 2014–2016. We analyzed data from eight sources: (1) Unit documentation; (2) financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with the Unit's managers and selected staff; (5) a survey of Unit staff; (6) a review of a purposive sample of 20 case files that were open at some point during the review period; (7) a review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period; and (8) observations of Unit operations. (See Appendix C for a detailed methodology.) In examining the Unit's operations and performance, we applied the published performance standards, but we did not consider every performance indicator for every standard.

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.

PERFORMANCE ASSESSMENT

We reviewed the New York Unit's compliance with applicable laws, regulations, and policy transmittals, and adherence to each of the MFCU performance standards. For this review, we observed the Unit's substantial case outcomes, identified some opportunities for improvement, and made observations regarding the Unit's adherence to each of the performance standards. The observations include three beneficial practices that may be of particular interest to other MFCUs.

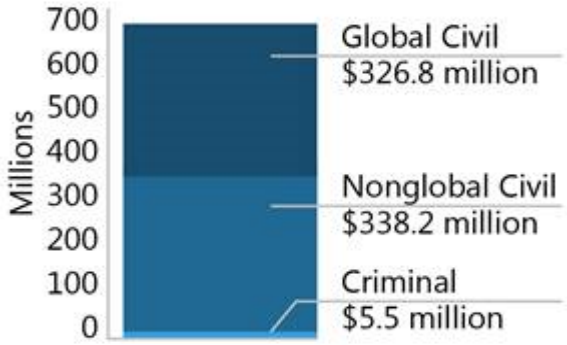
CASE OUTCOMES

Observation

The Unit reported substantial criminal and civil case outcomes. From FYs 2014 through 2016, the Unit reported 370 indictments; 348 convictions; and 211 civil settlements and judgments.

Additionally, the Unit reported total recoveries of over $670 million for FYs 2014–2016. See Exhibit 2 for a breakdown of the Unit's recoveries.

Exhibit 2: The Unit reported combined civil and criminal recoveries of over $670 million (FYs 2014–2016)



Source: OIG analysis of Unit statistical data, FYs 2014–2016.
Note: "Global" cases are those that involve both the Federal Government and a group of States and are coordinated by the National Association of Medicaid Fraud Control Units.

Beneficial Practice

The Unit developed a written Strategic Plan. In early 2015, the Unit developed a written Strategic Plan for 2015 through 2019. The Plan outlines the Unit's mission and goals and includes highly detailed strategies for meeting particular goals. Among other strategies, the Plan prioritizes certain types of investigations such as (1) criminal investigations into violent patient abuse and patient death, and obtaining stronger sentences in such cases; (2) fraud allegations directly against managed care companies, including those that provide long-term care; (3) fraud investigations involving nursing home owners and management responsible for systemic causes of resident abuse and neglect; and (4) fraud investigations of other large providers. For civil fraud, the Plan establishes a priority for false claims investigations with higher potential for monetary recoveries or risk of patient harm and establishes an approach to triage the high volume of qui tam complaints that the Unit receives.

Unit management stated its belief that the Strategic Plan helps Unit staff make informed decisions regarding the optimal use of resources as they conduct their work. One Unit investigator expressed the view that the Strategic Plan provides a general plan for how Unit staff can efficiently conduct casework.

STANDARD 1	A Unit conforms with all applicable statutes, regulations, and policy directives.

Observation

From the information we reviewed, the New York Unit generally complied with applicable laws, regulations, and policy transmittals. In the data we reviewed, we identified only one compliance concern related to the security of Unit case files, as explained below.

Finding

Unit practices left some case files vulnerable to unauthorized access. During our onsite review at the MFCU's headquarters location, we observed that the Unit did not fully secure some paper case files, which could leave case files vulnerable to unauthorized access. OIG observed that the Unit stored the unsecured files in unlocked office spaces and in boxes on top of file cabinets where non-MFCU staff might have access. Unit management explained that the location of the boxes was temporary while the Unit was preparing for an upcoming move that occurred shortly after our onsite inspection. According to Performance Standard 1, a Unit must conform with all applicable statutes, regulations, and policy transmittals, including regulations regarding the security of case files.[18]

Unit management explained that individuals must use a coded access card to enter the Unit's general office area. However, janitorial staff routinely accessed the Unit's office during nonbusiness hours when Unit staff were not present. The Unit had a policy related to case file security, which directed Unit staff to "never leave PHI [protected health information] on your desk or elsewhere in your office where it can be viewed by persons not authorized to see it."[19]

STANDARD 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.

Observation

The Unit did not maintain staff levels in accordance with its approved budget. As a part of its oversight role, OIG approves the number of staff requested by the Unit in its annual budget. During OIG's 2011 onsite review, OIG found that the Unit employed 306 staff members although the Unit requested and OIG approved funding for 380 positions.[20] Further, Unit managers acknowledged that the decline in staff levels led to a decline in the Unit's overall caseload. According to one manager, "There are cases we probably should do but can't because we don't have the manpower; we have to refer them back." As a result, the OIG recommended that the Unit

[18] 42 CFR § 1007.11(f).

[19] The policy defines PHI as "any (1) individually identifiable health information, including demographic data, that is (2) created or received by a health care provider, health plan, employer, or health care clearinghouse, and (3) relates to (a) the individual's past, present or future physical or mental health condition; (b) the provision of health care to the individual; (c) the past, present, or future payment for the provision of health care to the individual." Additionally, citing 45 CFR § 160.103, the policy states: "Health information is individually identifiable if it includes common identifiers such as name, address, birth date, and social security number, or if there is a reasonable basis to believe that the information available could be used to identify the individual." In addition to containing PHI, MFCU case files may contain sensitive law enforcement information.

[20] OIG, *New York State Medicaid Fraud Control Unit: 2011 Onsite Review*. Accessed at https://oig.hhs.gov/oei/reports/oei-02-11-00440.pdf on February 1, 2018.

seek to expand staff sizes to reflect the number of staff approved in the Unit's budget. Since OIG's 2011 onsite review, the Unit reported that it had hired 169 employees, but had also lost employees to retirement and natural attrition.

At the end of FY 2017, the Unit was approved for 340 staff but employed only 299, meaning that 12 percent of the Unit's approved positions were vacant. On average, 12 percent of all other MFCUs' approved positions were also vacant at the end of FY 2017. Unit management reported that it continues to fill vacant positions as current employees retire or resign. Additionally, Unit management reported that its current number of professional staff is reasonable in comparison to the State's total Medicaid program expenditures and the volume of referrals that the Unit receives.

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

Observation

The Unit maintained written policies and procedures. The Unit reported that, since 2013, it has maintained policy and procedure manuals as part of its Intranet system—known as "MFCUnet"—and that it continues to update its policy and procedure manuals as necessary.

Additionally, the Unit maintains an audit manual that is intended to ensure that MFCU staff of all disciplines comply with the OIG Performance Standards and Unit policies and procedures. Unit management reported that the manual includes guidance to help MFCU teams identify and investigate Medicaid fraud. The manual also includes MFCU reference and resource materials; legal terminology, principles, processes, and resources; auditor guidelines; an audit plan; investigation tip sheets; and reference materials on managed care. A committee of Unit staff meets quarterly to update the manual.

STANDARD 4	A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.

Observations

The Unit conducted outreach to encourage referrals. The Unit took steps to maintain volume and quality of referrals through a number of outreach efforts. The Unit reported that to encourage referrals, it has regular meetings and contact with agencies, prosecutors, and law enforcement across the State and country. For example, the Unit reported having regular meetings and contact with the New York City Health and Hospitals Corporation, the New York State Department of Health, and the U.S. Food and Drug Administration, among others, to encourage referrals. The Unit

also reported meeting with prosecutors from the Northern, Eastern, Southern, and Western Districts of New York and with local and Federal law enforcement to discuss referrals and collaboration.[21]

The MFCU reported that despite its having taken steps to increase the quantity and quality of referrals from MCOs, the quantity of referrals from MCOs was inadequate. MFCU staff reported taking steps to increase the quantity and quality of referrals from MCOs. Specifically, the Unit reported hosting meetings with New York MCOs to discuss specific investigations of fraud, common fraud schemes, and how to facilitate communication between MCOs and the Unit. The Unit also worked with the State Medicaid agency to revise the New York Medicaid Managed Care Model Contract to require MCOs to broaden the scope of referrals made by MCOs to the State Medicaid agency. Unit management reported that despite the MFCU's having taken these steps. MCOs in New York are not providing sufficient referrals. The Unit reported that it received 13 MCO fraud referrals during the review period.

Beneficial Practice

The Unit used data-analytics working groups to facilitate data mining processes. Data mining is the process of identifying fraud through the screening and analysis of data. In 2013, OIG issued a regulation that permits Federal financial participation for costs of data mining if the Unit is granted a waiver after meeting certain criteria.[22] OIG granted data-mining approval to the Unit in 2016. Since receiving approval, the Unit has created "data-analytics working groups" to provide guidance, training, and assessment of the Unit's data mining efforts. The groups include (1) the Data Analytics Tools group; (2) the Data Sources group; (3) the Fraud and Abuse group; and (4) the Governance group. One Unit staff member described the Unit's use of working groups as a practice that is particularly beneficial to Unit operations and which may be useful for other Units as well.

[21] We were unable to determine from the data collected by OIG whether the steps taken by the Unit resulted in a greater number of referrals from these sources.

[22] 42 CFR § 1007.20. To conduct data mining, MFCUs must receive preapproval from OIG.

Source: New York MFCU application for data mining, July 2016.

STANDARD 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.

Observation

Unit case files generally contained supervisory approval of case openings and closings. According to Performance Standard 5(b), supervisors should approve the opening and closing of all investigations, 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. Our review found that the sampled case files generally contained supervisory approval of case opening and closings. However, the Unit did not have a written policy regarding supervisory reviews, including the frequency of such reviews and how the reviews should be documented in the Unit's case files. See page 12 for OIG's finding regarding supervisory reviews.

STANDARD 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.

Observation

The Unit's caseload included both cases of fraud and cases of patient abuse or neglect, covering a broad mix of provider types. At the end of FY 2016, the Unit's cases were distributed among 55 provider types. During the review period, 83 percent of the Unit's cases involved fraud, and 17 percent involved patient abuse or neglect.

STANDARD 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.

Finding

The Unit did not have a written policy for conducting periodic supervisory reviews or noting the reviews in the Unit's case files. During OIG's 2011 onsite review of the Unit, we recommended that the Unit ensure that case files be maintained with greater consistency and reviewed more frequently. In response to OIG's recommendation, the Unit instructed supervisors to record supervisory reviews in Unit case files. Unit management reported that they instructed supervisors and staff to "memorialize, in a simplified manner, discussions with significant case implications, and to file such notes electronically."

According to Performance Standard 7(a), reviews by supervisors should be conducted periodically, consistent with the Unit's policies and procedures, and should be noted in the case file. However, at the time of OIG's review, the Unit did not have a written policy for periodic supervisory review of criminal cases that specified how frequently such reviews should be conducted or instructed staff to document such reviews in the Unit's case files.[23] Unit management explained that supervisors in each regional office are permitted to schedule supervisory case reviews at their discretion. Regional Unit supervisors explained that, to the extent that case files are periodically reviewed by regional supervisors, the nature and frequency of supervisory case file reviews are different in each of their offices. Regional Unit supervisors stated that they may review cases monthly, every 6 weeks, once every two months, or twice a year, depending on the regional office's practice.

STANDARD 8	A Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health care fraud.

Observation

The Unit maintains a positive working relationship with law enforcement partners, but does not frequently work joint cases with OIG. OIG maintains a positive working relationship with Unit staff and meets with the Unit monthly to discuss new cases, initiatives, and future areas of work. However, according to Unit management, the Unit pursues

[23] The Unit's *Procedures for MFCU Qui Tam False Claims Act Cases* requires Unit attorneys to report to the Chief of the Unit's Civil Enforcement Division on the progress of qui tam investigations at "regular intervals" or at 6-month intervals if the seal is to be extended or the action is administratively suspended. OIG was unable to determine whether the policy was being implemented during the review period.

most cases independently from OIG. Thus, there were few joint cases during the review period.

The U.S. Attorney's Offices have also reported positive interactions with MFCU staff. Federal prosecutors at the New York U.S. Attorneys' Offices reported pursuing Federal civil cases jointly with the Unit. For example, one Federal prosecutor stated that the U.S. Attorneys' Offices collaborate successfully with the Unit on Federal False Claims Act qui tam cases. The Unit generally investigates and prosecutes criminal cases without assistance from the U.S. Attorneys' Offices.

Finding

The Unit did not report all convictions and adverse actions to Federal partners within the appropriate timeframes. Although the Unit had procedures in place for reporting convictions to OIG, the Unit did not report six of its convictions to OIG. Additionally, the Unit did not report 13 percent of its convictions (34 of 305) to OIG within 30 days of sentencing. The Unit reported 10 of these convictions to OIG more than 60 days after sentencing. Although the Unit had procedures in place for reporting adverse actions to the National Provider Data Bank (NPDB), the Unit did not report 15 of its adverse actions to the NPDB. Additionally, the Unit did not report 26 percent of its adverse actions (80 of 307) to the NPDB within 30 days of sentencing. The Unit reported 47 of these adverse actions to the NPDB more than 60 days after sentencing.

Performance Standard 8(f) states that the Unit should transmit reports to OIG of all convictions for the purpose of exclusion from Federal health care programs within 30 days of sentencing. Federal regulations require that Units report any adverse actions resulting from investigations or prosecutions of healthcare providers to the NPDB within 30 calendar days of the date of the final adverse action.[24] Performance Standard 8(g) also states that the Unit should report qualifying cases to the NPDB.[25]

Unit management offered that one possible explanation for the delayed reporting is the Unit's internal practice regarding the sharing of case information. Unit documents that include conviction and sentencing information may be designated as "NOT FOR USE OUTSIDE OF MFCU" to alert staff that information should not be shared outside of the Unit. However, Unit management stated that there is no process in place for "unchecking" the alert box when it is time to send the information to OIG or

[24] 45 CFR § 60.5.

[25] Performance Standard 8(g) states that the Unit should report "qualifying cases to the Healthcare Integrity & Protection Databank [HIPDB], the National Practitioner Data Bank, or successor data bases." The HIPDB and the NPDB merged in 2013; therefore, we reviewed the reporting of adverse actions under NPDB requirements. See 78 Fed. Reg. 20473 (April 5, 2013). Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions. See 45 CFR § 60.3.

the NPDB. As a result, the Unit did not report some convictions and adverse actions to Federal partners within the appropriate timeframes.

STANDARD 9	A Unit makes statutory or programmatic recommendations, when warranted, to the State government.

Observation

The Unit made recommendations regarding program deficiencies to the State Medicaid agency. The Unit informed the State Medicaid agency of potential program deficiencies identified through MFCU investigations. For example, during the review period, the Unit proposed amendments to the MCO contracts, intended to improve the timeliness of referrals from MCOs to the State Medicaid agency. According to Unit management, the Unit makes such recommendations through a series of privileged emails with attachments. The Unit then follows up with phone conversations with counsel for the State Medicaid agency and OMIG, the program integrity unit for New York's Medicaid program.

STANDARD 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.

Observation

The Unit's MOU with the State Medicaid agency reflected current practice, policy, and legal requirements. The Unit's MOU with the State Medicaid agency is a three-party agreement among the MFCU, the State Medicaid agency, and OMIG. The MOU was executed in January 2014 and was amended in July 2016 as part of the MFCU's application to OIG for a waiver to conduct data mining.

STANDARD 11	A Unit exercises proper fiscal control over its resources.

Findings

The Unit generally exercised proper fiscal control, but it did not exercise proper controls over the sale and transfer of Unit vehicles. In the course of our review, the Unit identified and alerted OIG to an accounting issue relating to the sale and transfer of Unit vehicles. During the review period, the Unit sold 19 vehicles that it no longer needed through auction and transferred 5 additional vehicles that it no longer needed to other State agencies. The Unit had written policies and procedures in place for determining and documenting the value of vehicles and for accounting for their sale or transfer to ensure that the Federal Government was reimbursed accordingly. However, the Unit did not reimburse the Federal Government its share of proceeds received from the sale and transfer of the vehicles. After discovering this error, the Unit reimbursed the Federal Government accordingly. The Unit also reported that it had taken steps to strengthen its

procedures related to its disposition of vehicles and to retrain its staff in the vehicle acquisition and surplus process.

The Unit disclosed similar issues regarding the sale and transfer of vehicles on a previous occasion. In 2009, the Unit transferred vehicles that were no longer needed to the New York State Department of General Services for auction or transfer to another State agency. However, the Unit did not receive the proceeds of the sale or transfer or reimburse the Federal government for the vehicles. At that time, the Unit lacked written policies and procedures for determining and documenting the value of vehicles for purposes of reimbursing the Federal Government. The Unit worked with OIG to develop a method for determining the value of vehicles and reimbursed the Federal Government in 2011.

Three Unit professional staff temporarily performed non-Unit duties, and the Unit did not subtract the associated costs from claimed Unit expenditures. During the review period, three Unit staff members were temporarily reassigned to other Office of Attorney General law enforcement duties, and the associated costs were not subtracted from claimed Unit expenditures. Federal regulations state that Federal reimbursement is limited to costs attributable to the establishment and operation of the Unit.[26] Although OIG guidance permits Unit staff to engage in temporary non-Unit activities, the Unit must document and maintain records of the time spent on these activities, and exclude related costs from the Unit's claimed expenditures.[27]

The Unit's policy and procedures for ensuring that costs associated with non-MFCU activities are not charged to the grant are set forth in the New York Office of State Comptroller's Guide to Financial Operations. The Guide includes terminology, policies, and procedures used in connection with Federal grants and links to the Federal regulations regarding reimbursement of costs for the MFCU grant program. However, we determined that the Unit improperly claimed approximately $26,503 (with a Federal share of $19,877) in salaries, fringe costs,[28] and related indirect costs for these employees while they were assigned to non-Unit duties. After our review, the Unit worked with OIG to return these funds.

[26] 42 CFR § 1007.19(d).
[27] OIG, *OIG State Fraud Policy Transmittal Number 2014-1*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/policy_transmittals/State%20Fraud%20Policy%20Transmittal%20No%20%202014-1.pdf on February 2, 2018.
[28] Fringe costs are the costs for fringe benefits (i.e., the nonwage compensation that an employer provides to an employee).

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

Observation

Unit staff and management reported excellent training opportunities. During OIG's 2011 onsite review, we recommended that the Unit establish annual training plans and increase the number of training opportunities available to staff. In response, the Unit reported that it made training a key priority and established a training plan for all professional and administrative staff. Since 2013, the Unit has offered a multiday Medicaid fraud training program designed for investigators, auditors, attorneys, and paralegals who were hired in the preceding year.

The Unit reported that in FY 2016, staff attended over 200 different training courses. The Unit holds annual regional training in both the "downstate" and "upstate" areas, as well as biannual training for all Unit staff. Unit staff also reported attending courses provided by the National Association of Medicaid Fraud Control Units, the National Association of Attorneys General, and other organizations. One regional manager stated: "The level of training given here is amazing. It is beneficial, useful, and very relevant."

Beneficial Practice

Unit staff participated in moot-court training to prepare for settlement negotiations and opening statements. Approximately 3 years ago, the Unit began moot-court training. Prior to beginning a trial, Unit attorneys practice opening arguments and settlement negotiations in front of other Unit staff. Staff propose questions about the case to prepare Unit attorneys for the actual trial. Unit staff reported that this training has been very successful at preparing Unit attorneys for litigation.

CONCLUSION AND RECOMMENDATIONS

The New York Unit reported substantial case outcomes for FYs 2014-2016. A number of practices may have contributed to the New York Unit's success, including a commitment to training and the Unit's Strategic Plan. OIG also identified three beneficial practices that the Unit employed that may serve as a model for other States: the use of moot-court training, the use of data analytics working groups, and the development of a Strategic Plan.

From the information we reviewed, we determined that the New York Unit also generally adhered to applicable legal requirements and performance standards, but we identified five findings.

In evaluating adherence to program requirements, we found that Unit practices left some case files vulnerable to unauthorized access. We also found that the Unit did not have a written policy for conducting periodic supervisory reviews and noting the reviews in the Unit's case files.

We also found that the Unit had not always reported its convictions and adverse actions to Federal partners within established timeframes. Finally, from the information we reviewed, we found that the Unit generally exercised proper fiscal controls. However, we found two areas in which the Unit should strengthen its financial controls.

We recommend that to address these findings, the New York Unit:

Take steps to ensure that Unit staff adhere to policies and procedures for securing case files

The Unit should take steps to ensure that Unit staff adhere to Unit policies and procedures specifying how and where to securely store paper files. The Unit should take steps to ensure that all case files and any associated personally identifiable information are secured from access by non-Unit staff. For example, the Unit could take steps to include file security as part of staff training, or it could remind Unit staff to store paper case files and other documentation containing personally identifiable information in locked offices or file cabinets to prevent access by janitorial staff during nonbusiness hours. Specifically, the Unit should make staff aware that leaving case files in unsecured locations, even on a temporary basis, is not an acceptable practice.

Create policies and procedures for conducting periodic supervisory reviews of Unit case files, and take steps to ensure that case files include documentation of periodic supervisory reviews

The Unit should create policies and procedures for conducting and documenting periodic supervisory reviews of Unit case files. The Unit could

use automated reminders to ensure that documentation is maintained. The Unit could consider standardizing supervisory review policies and procedures across regional offices to ensure that all case files include documentation of periodic supervisory reviews.

Ensure that the Unit consistently reports convictions and adverse actions to Federal partners within the appropriate timeframes

The Unit should ensure that it consistently reports convictions to OIG within 30 days of sentencing and adverse actions to the NPDB within 30 days of the action, or as soon as practicable if the Unit encounters delays in receiving the necessary information from the sentencing court. The Unit could implement automated reminders that alert Unit staff when to report convictions and adverse actions to Federal partners.

Ensure that—consistent with Unit policy—the Unit reimburses the Federal Government its share of proceeds received from the sale and transfer of vehicles and any other equipment

In accordance with Unit policy, the Unit should ensure that it reimburses the MFCU grant the Federal share of proceeds from the sale and transfer of vehicles and any other equipment. To promote future compliance, the Unit could also provide administrative staff with training regarding the vehicle disposition and surplus process.

Strengthen internal controls to ensure that the Unit excludes from its claimed grant expenditures all costs related to time spent by staff on non-Unit activities

The Unit should strengthen internal controls to ensure that if Unit employees engage in temporary non-MFCU duty assignments, the Unit does not charge the wages and other expenses associated with those activities to the grant.

UNIT COMMENTS AND OIG RESPONSE

The New York Unit concurred with all five of our recommendations.

First, the Unit concurred with our recommendation to take steps to ensure that Unit staff adhere to policies and procedures for securing case files. The Unit stated that it has implemented revised policy and procedures to ensure security of Unit case files.

Second, the Unit concurred with our recommendation to create policies and procedures for conducting periodic supervisory reviews of Unit case files and to take steps to ensure that case files include documentation of periodic supervisory reviews. The Unit stated that it has developed a written policy for consistent documentation of periodic supervisory reviews and has a plan to assess its implementation in each of its regional offices.

Third, the Unit concurred with our recommendation to ensure that the Unit consistently reports convictions and adverse actions to Federal partners within the appropriate timeframes. The Unit stated that it has updated its internal guidance to emphasize the Federal timeframes and to encourage other State or local agencies to provide information that the Unit needs before it reports convictions and adverse actions to its Federal partners. The Unit also stated that it has corrected certain forms that may have caused reporting delays.

Fourth, the Unit concurred with our recommendation to ensure that—consistent with Unit policy—the Unit reimburses the Federal Government its share of proceeds received from the sale and transfer of vehicles and any other equipment. The Unit stated that it has updated procedures regarding how vehicles and other items are "surplussed" to properly account for any impact on Federal grant funding to the Unit.

Finally, the Unit concurred with our recommendation to strengthen internal controls to ensure that the Unit excludes from its claimed grant expenditures all costs related to time spent by staff on non-Unit activities. The Unit stated that it modified its electronic time and attendance system to facilitate the tracking and charging of employee time on temporary assignments. The Unit stated that it will also train Unit staff to use the system.

For the full text of the Unit's comments, see Appendix D.

APPENDIX A: MFCU Performance Standards[29]

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; [30]

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 Unite employs an appropriate mix and number of attorneys, auditors, investigators, and other professional staff that is both commensurate with the State's total Medicaid program expenditures and that allows the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.

D) The Unit employs a number of support staff in relation to its overall size that allows the Unit to operate effectively.

E) To the extent that a Unit maintains multiple office locations, such locations are distributed throughout the State, and are adequately staffed, commensurate with the volume of case referrals and workload for each location.

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

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

[29] 77 Fed. Reg. 32645, June 1, 2012.

[30] For FYs 2016 and later, grant administration requirements and cost principles are found at 45 CFR part 75.

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.

F) The Unit has an information management system that allows for the monitoring and reporting of case information, including the following:

1) The number of cases opened and closed and the reason that cases are closed.
2) The length of time taken to determine whether to open a case referred by the State Medicaid agency or other referring source.
3) The number, age, and types of cases in the Unit's inventory/docket.
4) The number of referrals received by the Unit and the number of referrals by the Unit to other agencies.
5) The dollar amount of overpayments identified.
6) The number of cases criminally prosecuted by the Unit or referred to others for prosecution, the number of individuals or entities charged, and the number of pending prosecutions.
7) The number of criminal convictions and the number of civil judgments.
8) The dollar amount of fines, penalties, and restitution ordered in a criminal case and the dollar amount of recoveries and the

types of relief obtained through civil judgments or prefiling settlements.

8) A Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health care fraud.

A) The Unit communicates on a regular basis with OIG and other Federal agencies investigating or prosecuting health care fraud in the State.

B) The Unit cooperates and, as appropriate, coordinates with OIG's Office of Investigations and other Federal agencies on cases being pursued jointly, 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.

E) For cases that have civil fraud potential, the Unit investigates and prosecutes such cases under State authority or refers such cases to OIG or the U.S. Department of Justice.

F) The Unit transmits to OIG, for purposes of program exclusions under section 1128 of the Social Security Act, all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders.

G) The Unit reports qualifying cases to the Healthcare Integrity & Protection Databank, the National Practitioner Data Bank, or successor data bases.

9) A Unit makes statutory or programmatic recommendations, when warranted, to the State government.

A) The Unit, when warranted and appropriate, makes statutory recommendations to the State legislature to improve the operation of the Unit, including amendments to the enforcement provisions of the State code.

B) The Unit, when warranted and appropriate, makes other regulatory or administrative recommendations regarding program integrity issues to the State Medicaid agency and to other agencies responsible for Medicaid operations or funding. The Unit monitors actions taken by the State legislature and the State Medicaid or other agencies in response to recommendations.

10) A Unit periodically reviews its Memorandum of Understanding (MOU) with the State Medicaid agency to ensure that it reflects current practice, policy, and legal requirements.

A) The MFCU documents that it has reviewed the MOU at least every 5 years, and has renegotiated the MOU as necessary, to ensure that it reflects current practice, policy, and legal requirements.

B) The MOU meets current Federal legal requirements as contained in law or regulation, including 42 CFR 455.21, "Cooperation with State Medicaid

fraud control units," and 42 CFR 455.23, "Suspension of payments in cases of fraud."

C) The MOU is consistent with current Federal and State policy, including any policies issued by OIG or the Centers for Medicare & Medicaid Services (CMS).

D) Consistent with Performance Standard 4, the MOU establishes a process to ensure the receipt of an adequate volume and quality of referrals to the Unit from the State Medicaid agency.

E) The MOU incorporates by reference the *CMS Performance Standard for Referrals of Suspected Fraud From a State Agency to a Medicaid Fraud Control Unit*.

11) A Unit exercises proper fiscal control over Unit resources.

A) The Unit promptly submits to OIG its preliminary budget estimates, proposed budget, and Federal financial expenditure reports.

B) The Unit maintains an equipment inventory that is updated regularly to reflect all property under the Unit's control.

C) The Unit maintains an effective time and attendance system and personnel activity records.

D) The Unit applies generally accepted accounting principles in its control of Unit funding.

E) The Unit employs a financial system in compliance with the standards for financial management systems contained in 45 CFR 92.20.

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

A) The Unit maintains a training plan for each professional discipline that includes an annual minimum number of training hours and that is at least as stringent as required for professional certification.

B) The Unit ensures that professional staff comply with their training plans and maintain records of their staff's compliance.

C) Professional certifications are maintained for all staff, including those that fulfill continuing education requirements.

D) The Unit participates in MFCU-related training, including training offered by OIG and other MFCUs, as such training is available and as funding permits.

E) The Unit participates in cross-training with the fraud detection staff of the State Medicaid agency. As part of such training, Unit staff provide training on the elements of successful fraud referrals and receive training on the role and responsibilities of the State Medicaid agency.

APPENDIX B: Unit Referrals by Source for Fiscal Years 2014 Through 2016

	FY 2014		FY 2015		FY 2016	
Referral Source	Fraud	Abuse & Neglect[1]	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect
Medicaid agency – PI/SURS[2]	82	12	85	1	64	2
Medicaid agency – other	103	1,503	77	1,415	87	1,456
Managed care organizations	0	0	74	0	35	0
State survey and certification agency	0	0	0	0	0	0
Other State agencies	40	18	35	8	27	15
Licensing board	1	0	4	0	0	0
Law enforcement	28	9	36	5	22	7
Office of Inspector General	6	0	4	2	4	1
Prosecutors	0	0	0	0	0	1
Providers	15	3	31	5	19	6
Provider associations	0	0	2	0	0	0
Private health insurer	4	0	6	0	7	0
Long-term-care ombudsman	0	1	1	3	4	3
Adult protective services	0	0	0	0	0	0
Private citizens	249	102	262	111	253	93
Other	122	27	56	12	57	12
Total	650	1,675	673	1,562	579	1,596
Annual Total	2,325		2,235		2,175	

Source: OIG analysis of Unit Quarterly and Annual Statistical Reports, FYs 2014-2016.

[1] The category of abuse & neglect referrals includes referrals involving misappropriation of patient funds.

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

APPENDIX C: Detailed Methodology

Data Collection and Analysis

We collected and analyzed data from the eight sources below to identify any opportunities for improvement and instances in which the Unit did not adhere to the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.[31] We also used the data sources to make observations about the Unit's case outcomes as well as the Unit's operations and practices concerning the performance standards.

Review of Unit Documentation. Prior to the onsite inspection, we reviewed the recertification analysis for FYs 2014–2016 which included examining the Unit's recertification materials, including (1) the annual reports, (2) Unit Director's recertification questionnaires, (3) the Unit's memorandum of understanding with the State Medicaid agency, (4) the Program Integrity Director's questionnaires, and (5) the OIG Special Agent-in-Charge questionnaires. We also reviewed the Unit's self-reported FY 2014 quarterly statistical reports and the FY 2015 and FY 2016 annual statistical reports about case outcomes. We reviewed the 2011 OIG onsite review recommendations and the Unit's implementation of those recommendations. Finally, while onsite, we reviewed the Unit's policies and procedures.

Review of Unit Financial Documentation. To evaluate internal control of fiscal resources, we reviewed policies and procedures related to the Unit's budgeting, accounting systems, cash management, procurement, property, and staffing. We reviewed records in the Payment Management System (PMS)[32] and revenue accounts to determine the accuracy of the Federal Financial Reports (FFRs) for FYs 2014 through 2016. We also obtained the Unit's claimed grant expenditures from its FFRs and the supporting schedules.

We selected three purposive samples to assess the Unit's internal control of fiscal resources. The three samples included the following:

1. To assess the Unit's expenditures, we selected a purposive sample of 30 transactions totaling $1,894,909[33] within the direct cost categories

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

[32] The PMS is a grant payment system operated and maintained by the Department of Health and Human Services, Program Support Center, Division of Payment Management. The PMS provides disbursement, grant monitoring, reporting, and case management services to awarding agencies and grant recipients, such as MFCUs.

[33] The transaction detail included multiple lines relating to accounting entries which comprised the reported expenditures. We selected 5 transactions from each of the 6 Federal

across the 3 years of the review period. We reviewed supporting documentation to determine whether the costs claimed were allowable, allocable, and reasonable, in accordance with Federal regulations.

2. To assess inventory, we selected and verified a purposive sample of 30 items from the current inventory list of 2,078 fixed assets.
3. To assess employee time and effort, we reconciled Unit payroll registers to payroll expenditures. We then reviewed timecard records from five pay periods across the 3 years of the review period for nine Unit employees on staff.[34]

Interviews with Key Stakeholders. In July 2017, we interviewed key stakeholders, including officials in the New York State Medicaid Office of Inspector General (OMIG); the New York Department of Health; the New York City Human Resources Administration; the U.S. Attorneys' Office; and the Federal Bureau of Investigation. We also interviewed the supervisor from OIG's Region II Office of Investigations, which works regularly with the Unit. We focused these interviews on the Unit's relationship and interaction with OIG and other Federal and State authorities, and we identified findings. We used the information collected from these interviews to develop subsequent interview questions for Unit management.

Onsite Interviews with Unit Management and Selected Staff. We conducted structured onsite interviews with the Unit's management in August 2017. We interviewed the Unit Director, Deputy Director, and Regional Office Directors; the Chief of the Unit's Civil Enforcement Division; the two Chiefs of Criminal Investigations; the Unit's Chief Auditor; and the Director of the Unit's Electronic Investigation Support Group. We asked these individuals to provide information related to (1) Unit operations; (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance; (3) opportunities for the Unit to improve its operations and/or performance; and (4) clarification regarding information obtained from other data sources.

Survey of Unit Staff. In June 2017, we conducted an online survey of 75 Unit staff members within the professional disciplines (i.e., investigators, auditors, and attorneys) and support staff. We received responses from 61 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

cost categories, which contained 6,303 transactions, to review 30 transactions in total. Selections varied in amount from $961 to $616,863.

[34] We randomly selected six Unit employees for review from the payroll registers. The remaining three Unit employees were selected because the Unit notified us that they were temporarily reassigned to work for another State agency.

performance. The survey also sought information about the Unit's compliance with applicable laws and regulations.

Onsite Review of Case Files. To craft a sampling frame, we requested that the Unit provide us with a list of cases that were open at any time during FYs 2014 through 2016, as well as the current status of the case; case opening and closing dates, if applicable; whether the case was criminal, civil, or global; the provider type involved in the case; and whether the case was worked jointly with OIG. The total number of cases was 1,827.

We excluded all "global" cases from our review of the Unit's case files 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 excluded 332 global cases, leaving 1,495 case files.

We then selected a purposive sample of 20 cases from the population of 1,495 cases to obtain a mix of status (open/closed), by the type of provider being investigated, and by whether the case was an independent Unit case or worked jointly with OIG. We reviewed the 20 case files for adherence to the relevant performance standards and compliance with statute, regulation, and policy transmittals. During the review of the sampled cases, we consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation.

Review of Unit Submissions to OIG and the NPDB. We also reviewed all convictions submitted to OIG for program exclusion during the review period (299), and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period (291). We reviewed whether the Unit submitted information on all sentenced individuals to OIG for program exclusion and all adverse actions to the NPDB for FYs 2014–2016. We also assessed the timeliness of the submissions to OIG and the NPDB.

Onsite Review of Unit Operations. During our 2017 onsite inspection, we reviewed the Unit's workspace and operations. To conduct this review, we visited the Unit headquarters in New York City, New York. 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. We did not visit the Unit's regional offices.

APPENDIX D: Unit Comments

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

BARBARA D. UNDERWOOD
ATTORNEY GENERAL

DIVISION OF CRIMINAL JUSTICE
MEDICAID FRAUD CONTROL UNIT

September 14, 2018

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

Re: New York State Medicaid Fraud Control Unit (OEI-12-17-003540)

Dear Deputy Inspector General Murrin:

We appreciate the opportunity to receive and respond to the HHS-OIG Onsite Inspection of the New York State Medicaid Fraud Control Unit ("New York MFCU") for the Inspection Period FFY 2014-16. We also appreciate the diligence shown by the HHS-OIG Onsite Inspection team and the positive communication which facilitated our analysis and response to the Onsite Report.

HHS-OIG has requested that the New York MFCU respond with comments to the Onsite Inspection, including whether we concur with the recommendations and draft timelines for actions.

In the response below, we have set forth the text of the summary recommendations from the Onsite Inspection (pp. 17-18) and our response and plans for action.

Overview:

We concur in whole with the Recommendations.

The Report's Performance Assessment recognizes New York MFCU's "substantial results" and accurately reports its 370 indictments, 348 convictions, and 211 civil settlements and judgments amounting to over $670 million in ordered recoveries during Federal Fiscal Years 2014 to 2016, including $338.2 million in NonGlobal civil recoveries, $326.8 million in Global civil recoveries, and $5.5 million in criminal restitution.

We appreciate HHS-OIG's efforts in noting beneficial practices of the Unit. New York MFCU has long been a leader in developing national practices and we intend to continue to do so. The practices developed during the Review Period and identified by HHS-OIG -- including developing a strategic plan, establishing data analytics working groups, and moot court training to prepare for settlement

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negotiations and opening statements -- have fostered our Unit's performance. "Moot courts" have aided our achievement of a conviction rate of 93%. Our strategic plan fosters more impactful cases, as demonstrated by our ordered recoveries and internally tracked metrics reflecting that 98 of our 348 convictions in Federal Fiscal Years 2014 to 2016 were of corporate providers, managers, CEOs, presidents, vice presidents, managers, as well as owners, administrators, directors of nursing and assistant directors of nursing at facilities statewide. Our strategic plan, data analytics and emphasis on remedies combine to help our team direct resources to matters that result in just dispositions that have greater impact in serving our federally-defined mission to fight Medicaid provider fraud, to prosecute nursing home resident abuse and neglect, and to protect Medicaid program integrity. Our approach also results in the efficient and effective disposition of matters that would otherwise result in large but uncollectible restitution orders, without benefit to Program integrity. For Federal Fiscal Years 2014 to 2016, our total amount actually collected was $546.3 million. Finally, we appreciate the Report's noting that New York MFCU plays a significant role in the National Association for Medicaid Fraud Control Units' (NAMFCU) civil Global cases through investment by experienced Unit employees in leadership roles on significant NAMFCU Committees. This Unit investment supports the process resulting in Global False Claims Act qui tam recoveries inuring to and reported by many MFCUs. We also continue to lend the experience of our staff to nationwide training and initiatives on fraud, patient abuse and neglect, and newer areas such as the state and federal response to the opioid crisis.

Responses to Specific Recommendations:

Take steps to ensure that Unit staff adhere to policies and procedures for securing case files

Response:

We concur with the Recommendation.

Analysis:

The Unit is mindful of the importance of securing case files and has multiple policies involving the protection of personal healthcare information and confidential law enforcement information, in both traditional and digital forms. Our policy and training endeavor to reinforce such practices. We have also emphasized and invested in moving to greater use of electronic records storage since at least January 2012. As noted in the inspection report, the New York City offices were challenged in mid-2017 by the sheer volume of paper files accumulated in our largest Regional Office for well over 20 years, the need to prepare for the upcoming office move, and the lack of efficient available space in our former building, and so some materials were in secure areas but not within locked cabinets. Those overflow materials were potentially accessible by janitorial staff of the building after-hours. We have no reason to believe these materials were ever accessed improperly.

Paper remains a challenge in healthcare fraud investigations, as there is no Medicaid program requirement to move away from traditional paper records; we find that both bad-faith providers and

poorly-managed providers continue to use and misuse paper records and that we will continue to need to obtain such records during our investigations. In addition, paper storage in New York City remains challenging, and the alternatives, such as warehousing and scanning, are also time-consuming and costly. Fortunately, during preparation for our move in April, 2018, we assessed and securely disposed of over 10,000 boxes of outdated material, with the result that such files no longer pose a disclosure risk and secure space has been freed up for future needs.

Plan:

As the Onsite Report noted, the Unit was in the process of moving from those New York City offices to new offices with improved features that we anticipated being considerably more secure. We assessed the new office features and have implemented revised policy and procedures to take advantage of those features in New York City, and reiterated that policy with suitable local adjustments for all MFCU offices. (We have included a copy of the policy with the Confidential Supplement to this Response.)

Create policies and procedures for conducting periodic supervisory reviews of Unit case files, and take steps to ensure that case files include documentation of periodic supervisory reviews

Response:

We concur with the Recommendation.

Analysis:

New York MFCU supervisors have conducted case reviews as a matter of policy and practice since the inception of the Unit, with variations accounting for technology and practice changes in the past 40 years. Policy statements and technology development since the last Onsite review in 2011emphasized use of our then-new electronic file system as a method of retaining records of such reviews. MFCU Executive staff see first-hand that regional supervisors are consistently well-informed and closely involved as to the development of investigations, and we are confident that such supervision is effective. Our electronic file system permits quick review and retrieval of file contents.

We agree that specific practices as to documentation of periodic supervisory reviews have been inconsistent, and we acknowledge that such materials are difficult to assess by persons not familiar with the Unit's files. We agree that increased uniformity is likely to lead to benefits that exceed the effort of implementation.

Plan:

The Unit has developed a written policy calling for consistent documentation of periodic supervisory reviews, which defines the elements of such practices. In essence, the policy calls for file reviews on a general 90-day timeframe, with documentation of such reviews in a consistent manner, with guidance as to the timing and methodology for cases that are in various stages of development. The policy provides the flexibility that is warranted to meet the needs of our seven Regional Offices and

separate Civil Enforcement Division, which vary in size from 18 to 96 employees and, to a degree, in types of investigations handled. At the time of this writing, we have offered New York MFCU Regional Directors two alternative formats, to be applied consistently within the Region, one based on our existing case management database and the other based on generating stand-alone documentation. We intend to assess the alternatives approximately eight quarters from now. (We have included a copy of the policy with the Confidential Supplement to this Response.)

Ensure that the Unit consistently reports convictions and adverse actions to Federal partners within the appropriate timeframes

Response:

We concur with the Recommendation.

Analysis:

Among the hundreds of successful New York MFCU prosecutions during the Review Period, the Onsite review accurately identified several instances where successful prosecutions leading to criminal sanctions on providers and other persons were not reported to our Federal partners within the appropriate timeframes. We have reviewed the specific incidents with staff assigned to the matters and have examined factors leading to such outcomes.

As the Onsite Report notes, we determined that some instances were within our direct control due to confusing report formats, and we have taken steps to improve practices and update training materials so that such information is conveyed more effectively. Some instances were the result of discrepancies between Federal timeliness requirements on the Unit which are not matched by a corresponding obligation on the agencies upon which we must turn for the material. (For example, although the federal standard calls for the Unit to provide information to two federal units within 30 days, there is no time requirement under state law for a court or other agency to provide us with the transcripts or certificates necessary to meet our obligation in a timely manner.) Although much of the latter form of delay is outside of our control, we can increase staff awareness of the impact of such delay and encourage the outside agencies towards more expeditious action. This increased attention is likely to improve compliance to the degree it is within our control, under the operating structure maintained by the outside agencies.

With respect to the latter scenario, we suggest that HHS-OIG consider a mechanism for an alternative form of reporting that would enable HHS-OIG to initiate federal action without further delay while awaiting receipt of the specific definitive paperwork. We also suggest that HHS-OIG consider consolidating all such reporting to federal agencies via a single portal.

Plan:

We have updated our internal guidance materials to emphasize the federal requirements and provide guidance on facilitating responses from agencies outside of our control, as well as correcting

language on internal forms that inadvertently caused some of the delays. (We have included a copy of the updated guidance material with the Confidential Supplement to this Response.)

Ensure that the Federal government, consistent with Unit policy, is reimbursed its share of proceeds received from the sale and transfer of vehicles and any other equipment

Response:

We concur with the Recommendation.

Analysis:

As part of our fleet-management program for our investigator vehicles, high-mileage/high-maintenance vehicles are routinely surplussed, when appropriate, using the State's Office of General Services process applicable to all State agencies, and the federal share is reimbursed in the ordinary course. For a few of the surplussed vehicles during the Review Period, a Unit employee made an error while filling out a section of the transfer paperwork designating a federal reimbursement obligation, and, as that paper does not route back through the Unit, our Finance Department did not have the opportunity to note and correct the error at the time of the vehicle transfer. Even though we were subsequently able to detect the error and adjust the financial impact, we agree that such initial mistakes should be avoided whenever possible.

Plan:

We have updated our procedures for vehicle surplus (as well as other surplus activity) to re-emphasize accounting for Federal Financial Participation (FFP) and for double-checking the accuracy of transfer paperwork at the level of our Finance Unit before the vehicle is sold. (We have included a copy of the policy with the Confidential Supplement to this Response.)

Strengthen internal controls to ensure that costs related to time spent by staff on non-Unit activities are excluded from the Unit's claimed grant expenditures

Response:

We concur with the Recommendation.

Analysis:

The Unit is mindful of HHS-OIG policy transmittals concerning non-Unit assignments of Unit staff and endeavors to ensure that such activities do not draw against FFP. The three identified incidents were related to Unit employees who were temporarily assigned to law enforcement duties for other bureaus of the Attorney General's Office Criminal Justice Division (one staffer conducted a murder

trial, one conducted a grand jury investigation, and one temporarily supervised a team of organized crime investigators). The Unit, along with the Attorney General's Office, accounted for and properly re-allocated the time and costs associated with the employees' assignments in a timely manner using manual payroll adjustments. However, as found, there was a timing gap between the Attorney General's Office and another state agency responsible for approving aspects of payroll changes of this type that was not noted, resulting in a net balance of reimbursements to MFCU for some fringe benefit aspects. Those adjustments have now been made. Coordinating with the Attorney General's Office, we also developed a modification to our electronic time and attendance system that facilitates tracking and charging temporary assignments.

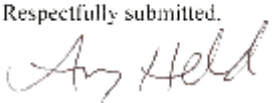
Plan:

The improved procedure using our time and attendance system has been activated since August, 2015. We will continue to use the improved time and attendance system modification and to train temporarily-assigned staff to use that system, while maintaining awareness of the need for prompt and precise reconciliation of FFP among MFCU and OAG payroll and budget staff.

Conclusion:

New York MFCU Assistant Deputy Attorney General Paul J. Mahoney and I appreciate the efforts of HHS-OIG and the insight provided by the Onsite Inspection. We are proud of our team's recognized accomplishments through its implementation of the Unit's strategic plan. We look forward to further enhancing our procedures to optimize performance. We will follow through with our enhanced procedures in order to improve efficiency and continue our successful tradition of leadership. New York MFCU remains committed to meeting and exceeding the standards for Medicaid Fraud Control Units. We value HHS-OIG's support, our relationships with NAMFCU, other MFCUs and state and federal law enforcement partners nationwide, and are grateful for the opportunity to serve the Unit's mission.

Respectfully submitted.



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Jordan Clementi of the Medicaid Fraud Policy and Oversight Division served as the team leader for this inspection. Additional Medicaid Fraud Policy and Oversight Division staff who participated include Susan Burbach and Frantzy Clement. Office of Audit Services staff who conducted a financial review include Julio Agosto and Rafael Echevarria. Office of Investigations staff also participated in the inspection. Office of Evaluation and Inspections staff who provided support include Kevin Farber and Christine Moritz.

This report was prepared under the direction of 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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