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Office of Inspector General

New Jersey Medicaid Fraud Control Unit: 2017 Onsite Review

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Report in Brief
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What OIG Found

During fiscal years (FYs) 2015–2017, we found that the New Jersey Medicaid Fraud Control Unit (the Unit) did not comply with all applicable legal requirements or adhere to all performance standards. Specifically, we identified six areas in which the Unit should improve its adherence to program requirements:

1. The Unit Director lacked supervisory authority over Unit detectives and independent decision-making authority over day-to-day Unit operations.
2. The Unit pursued few "nonglobal" civil fraud cases, and the memorandum of understanding (MOU) with the Office of the State Comptroller's Medicaid Fraud Division (MFD) lacked guidance for handling such cases.
3. Although the Unit and the MFD communicated regularly, fraud referrals from the MFD were low and had decreased in recent years.
4. Low staffing levels affected the Unit's ability to investigate cases and accept referrals.
5. The Unit did not always follow its internal control procedures for time and attendance.
6. Thirty-four percent of case files lacked documentation of supervisory oversight.

What OIG Recommends and How the Unit Responded

We recommend that the Unit (1) change the supervisory structure to provide the Unit Director with supervision of all Unit staff, oversight of all its caseload, and independence to make management decisions; (2) develop and implement a plan to pursue more nonglobal fraud cases as civil matters, and revise the MOU with MFD to include guidance for handling such cases; (3) take additional steps to ensure that the Unit receives an adequate number and quality of fraud referrals from the MFD; (4) assess the adequacy of existing staffing levels and, if appropriate, consider a plan to expand the size of the Unit; (5) follow its internal controls for time and attendance; and (6) ensure that all case files include documentation of supervisory oversight. The Unit concurred with all six recommendations.

Unit Case Outcomes

FYs 2015–2017

- 56 indictments
- 56 convictions
- 42 global civil settlements and judgments
- $58.6 million in recoveries

Unit Snapshot

The Unit is part of the Office of the Insurance Fraud Prosecutor in the New Jersey Office of Attorney General.

The Unit has a total of 29 employees, with 17 people in its Trenton headquarters and 12 people in its Whippany satellite office.

Why OIG Did This Review

The Office of Inspector General (OIG) administers the MFCU grant awards, annually recertifies each Unit, and oversees the Unit's performance in accordance with the requirements of the grant. As part of this oversight, OIG conducts periodic onsite reviews of Units and prepares public reports.

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BACKGROUND

Objectives

1. To examine a previously identified area of concern related to the supervisory structure of the New Jersey Medicaid Fraud Control Unit's (MFCU or Unit).
2. To examine the performance and operations of the Unit.

Medicaid Fraud Control Units

The function of MFCUs 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 that 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 Unit receives a Federal grant award equivalent to 75 percent of total allowable expenditures.[5] In fiscal year (FY) 2017, combined Federal and State expenditures for the Units totaled approximately $276 million, with a Federal share of $207 million.[6]

OIG Grant Administration and Oversight of the MFCUs

The Office of Inspector General (OIG) administers the 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, which are collectively referred to as "recertification data": 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: its adherence to published performance standards;[9] its compliance with applicable laws, regulations, and OIG policy transmittals;[10] and its case outcomes. See Appendix A for the 12 performance standards and our assessment of the New Jersey MFCU's adherence to those standards.

OIG further assesses a Unit's performance by periodically conducting onsite reviews of each Unit that may identify findings and make recommendations for improvement. During the onsite review, OIG may also make observations of Unit operations and practices, including identifying beneficial practices. In addition, OIG provides training and technical assistance to Units, as appropriate, both during onsite reviews and on an ongoing basis.

As part of its oversight responsibilities, OIG may propose amendments to the regulation governing the receipt of Federal funding by the MFCUs. In September 2016, OIG issued a notice of proposed rulemaking to revise the set of regulations established at the inception of the program and to better align the rules with policy changes and practices that have developed over time.[11] In the proposed revisions, OIG proposed to clarifiy the requirement—consistent with the prevailing practice among the MFCUs—for each MFCU to operate as a single, identifiable entity in State government, including a requirement that each Unit be a single organization reporting to a single Unit director; operate under its own budget that is separate from that of its parent division or agency; and have its headquarters office and any field offices each in its own contiguous space. Additionally, the proposed revisions would formalize the expectation that all Units employ a director to supervise—either directly or indirectly—all Unit staff.[12]

New Jersey MFCU

The New Jersey MFCU is part of the New Jersey Attorney General's Office. The MFCU Director reports to the Insurance Fraud Prosecutor, who reports directly to the Attorney General. The Insurance Fraud Prosecutor, appointed by the Governor, is also responsible for investigating and prosecuting insurance fraud in the State, such as fraud related to automobile accidents, disability benefits, and workers' compensation. The Unit has the authority to prosecute Medicaid fraud and patient abuse and neglect cases.

The Unit is headquartered in the State capital of Trenton, with this headquarters office covering the southern part of the State, and has a satellite office in Whippany covering northern New Jersey. In March 2018, the Unit had 29 employees: 16 detectives, designated as lieutenants (managers), sergeants (senior investigators), and detectives (junior investigators); 7 attorneys; 2 analysts/auditors; and 4 support staff. During our review period of FYs 2015–2017, the Unit expended approximately $12 million (with a State share of approximately $3 million).

Referrals. The Unit receives fraud referrals from private citizens; the Office of the State Comptroller's Medicaid Fraud Division (MFD), which serves as the program integrity unit for the State Medicaid agency; managed care organizations (MCOs); and other sources. The Unit receives most of its patient abuse and neglect referrals from the State's Long-Term Care Ombudsman program. When the Unit receives a referral, the Unit Director and a lieutenant together determine whether to open an investigation or to refer it to another agency for investigation. See Appendix B for numbers of Unit referrals by source for FYs 2015–2017.

Investigations and Prosecutions. Once the Unit opens an investigation, the Unit Director assigns a trial team to the case. A trial team consists of an attorney, at least one detective, an auditor, and/or support staff,

if necessary. The trial team completes a joint investigative plan, approved by the Unit Director or Assistant Unit Director, and outlines and assigns the key investigative tasks to the team members. The Unit stores all case records—including opening documentation, interviews, summaries, case file reviews, and closing requests—in the Unit's case management system. If the Unit Director decides on the basis of the full investigation to prosecute a case, the Unit Director must obtain approval from the New Jersey Insurance Fraud Prosecutor.

New Jersey Medicaid Program

The New Jersey Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) administers the State Medicaid program, known as New Jersey Family Care. In FY 2017, the New Jersey Medicaid program enrolled approximately 1.8 million beneficiaries and total program expenditures were approximately $15.6 billion.[13] In the same year, nearly all beneficiaries (99 percent) received their primary care through an MCO, a 6-percent increase from FY 2015.

Through a memorandum of understanding (MOU), DMAHS delegates to the MFD all program integrity activities, such as detection and prevention of Medicaid fraud and abuse and recovery of improperly expended Medicaid funds. The MFD has dedicated staff who generate fraud referrals, based on analysis of Medicaid data, and conduct preliminary investigations of referrals received from any source. If these preliminary investigations provide reason to believe that an incident of fraud has occurred, the MFD refers the case to the MFCU under the terms of the MOU. If an MCO wants to initiate a preliminary investigation of a provider, it must first notify the MFD to ensure that the provider is not already under investigation by the MFD, another MCO, or the MFCU. If the MFCU has an ongoing investigation, the MCO and the MFD refrain from investigating the provider. MCOs may send referrals directly to the Unit and provide a copy to the MFD.

Prior OIG Reports

In 2013, OIG issued a report following its onsite review of the Unit. OIG found that (1) the Unit's recoveries increased but felony charges and convictions decreased from FYs 2010 through 2012; (2) the Unit investigated fewer cases of patient abuse and neglect in FY 2012 than in FY 2010; (3) most case files included opening and closing documents, but half lacked documentation of supervisory review; (4) the Unit did not refer 94 percent of convictions to OIG appropriately; (5) the Unit did not meet the requirements of its training plan in FY 2012; and (6) the Unit Director did not supervise the majority of Unit staff and did not oversee part of the Unit's caseload.[14]

OIG made five recommendations to the Unit in 2013, of which the Unit implemented the following four: (1) the Unit should take steps to ensure that its case mix includes more cases of patient abuse and neglect; (2) the Unit should ensure that case files contain supervisory reviews; (3) the Unit should refer individuals to OIG for program exclusion within the required

timeframe; and (4) the Unit should ensure that staff receive at least the minimum training required in the Unit's training plan. The Unit has not implemented one remaining OIG recommendation, for the Unit should change its supervisory structure to provide the Unit Director with supervision of all Unit staff and oversight of all its caseload. In 2016, the Unit reported plans for adopting a new structure to address this recommendation, but the new structure was not put into place.

Methodology

We conducted our onsite review in November 2017. We focused our review primarily on the unimplemented recommendation from the 2013 OIG report. We also analyzed the Unit's operations and adherence to the 12 performance standards and applicable Federal laws, regulations, and policy transmittals. We based our review on an analysis of data from eight sources: (1) Unit documentation; (2) financial documentation; (3) structured interviews with key stakeholders; (4) survey of Unit staff; (5) structured interviews with Unit managers and selected staff; (6) review of a simple random sample of case files that were open at some point during FYs 2015–2017; (7) 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) observation of Unit operations. See Appendix C for a detailed methodology. In examining the Unit's operations and performance, we applied the published performance standards listed in Appendix A, but we did not assess every performance indicator for every standard.

Standards

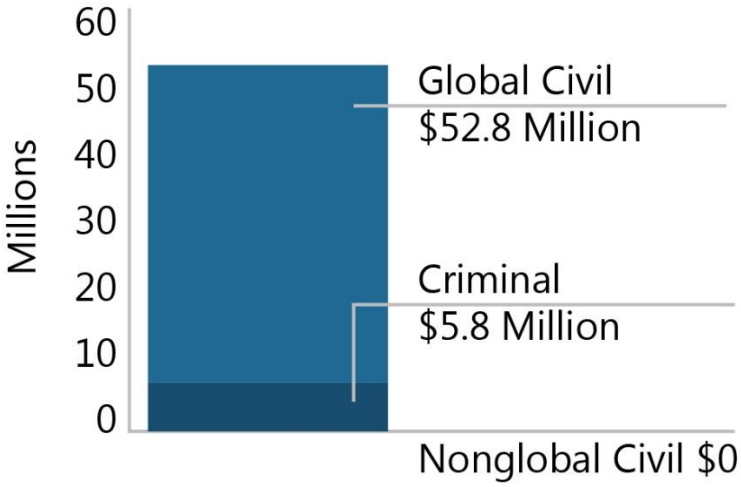
This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency. These inspections differ from other OIG evaluations in that they support OIG's direct administration of the MFCU grant program, but they are subject to the same internal quality controls as other OIG evaluations, including peer review.

CASE OUTCOMES

The Unit reported 56 indictments, 56 convictions, and 42 global civil settlements and judgments for FYs 2015–2017.
Of the 56 convictions, 42 involved provider fraud and 14 involved patient abuse or neglect.

The Unit reported $58.6 million in global civil and criminal recoveries.
The Unit reported total recoveries of $58.6 million from FYs 2015–2017, with global civil recoveries representing $52.8 million. "Global" civil 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. The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases on behalf of the States. See Exhibit 1 for the source of the recoveries.

Exhibit 1: The Unit reported combined civil and criminal recoveries of $58.6 million, FYs 2015–2017



Source: OIG analysis of Unit statistical data from FYs 2015–2017.

FINDINGS

We reviewed the previously identified area of concern from the 2013 onsite inspection related to the Unit's supervisory structure, and we assessed the Unit's adherence to the MFCU performance standards. From this review, we found that the Unit was not in compliance with all applicable laws, regulations, policy transmittals, or MFCU performance standards. Specifically, we identified six areas in which the Unit should improve and for which we are issuing recommendations. See Appendix A for our full assessment of the Unit's adherence with all 12 MFCU performance standards, including observations of Unit operations and practices.

The Unit Director lacked supervisory authority over Unit detectives and independent decision-making authority over day-to-day Unit operations

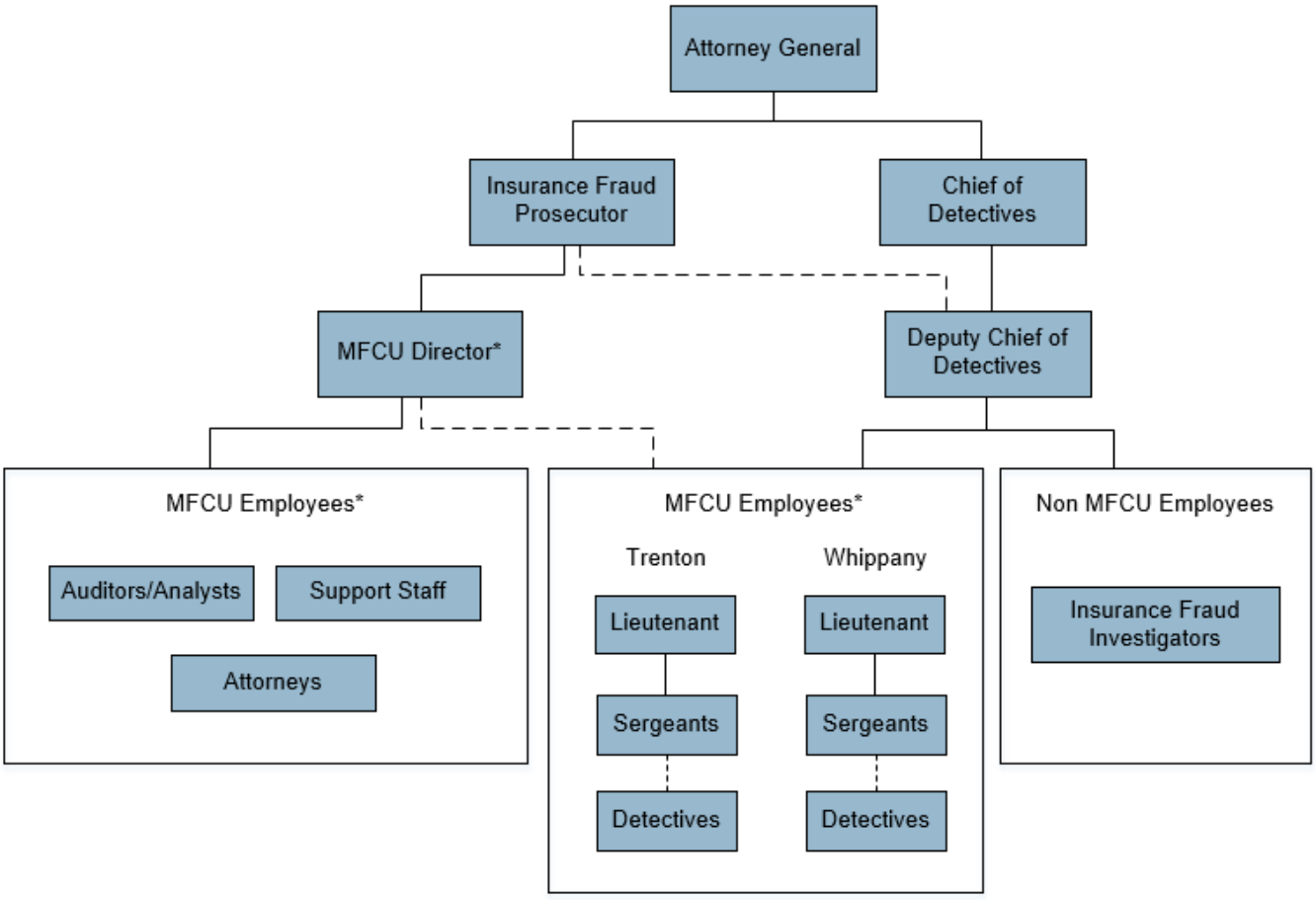
Under the Unit's reporting structure at the time of our review, the Unit Director lacked supervision over the Unit detectives

As with our previous onsite review in 2013, our current review found that Unit detectives—including the lieutenants, sergeants, and detectives—did not report to the Unit Director or to a senior detective under the Unit Director's supervision.[i] Federal law requires that Units employ personnel—including auditors, attorneys, and detectives—and be organized in a manner "to promote the effective and efficient conduct" of the Unit's activities.[15] Units must also employ a senior detective to supervise and direct the Unit's investigative activities.[16] The New Jersey Unit is the only MFCU that does not employ its own senior detective to supervise and direct the activities of the Unit. Under the New Jersey Unit's supervisory structure, more than half of Unit staff did not report to the Unit Director, as Unit detectives made up 55 percent of all Unit employees (16 of 29 Unit employees).

Although detectives were employed as part of the Unit, the chain of command did not include the MFCU Director; instead, the detectives reported to two lieutenants (assigned to the Whippany and Trenton regions). These two lieutenants reported to the Deputy Chief of Detectives, who was not a part of the Unit. The Deputy Chief of Detectives reported to the Chief of Detectives, who reported directly to the Attorney General. See Exhibit 2 for an organizational chart of the Unit's reporting structure.

[i] "Detectives" refer to both Unit investigators generally (i.e., lieutenants, sergeants, and detectives) and to the junior detectives (detectives).

Exhibit 2: Organization and reporting structure of the New Jersey MFCU (November 2017)



Source: OIG analysis of New Jersey MFCU data and interview responses, November 2017.
Note: The Unit provided OIG with an organizational chart that showed the Unit Director as supervising all Unit staff, including Unit detectives. However, our review found that the chart was inaccurate.
*MFCU employees covered under the grant administered by OIG.

Although the Unit Director reported working collaboratively with Unit detectives, we found—and the Director confirmed—that the lack of his supervision prevented him from managing the Unit effectively and overseeing its investigative activities. The Director also said that the current structure could result in investigative delays and potentially affect morale. The Director stated that the reporting structure could be particularly problematic if his investigative strategy or priorities differed from those of the detectives or the Insurance Fraud Prosecutor, in which case the work of the detectives could be in conflict with the Director or the Unit's strategy. It appeared that to avoid such conflicts, the Unit Director worked assiduously to mitigate the effects of the reporting structure.

Moreover, under the current supervisory structure, the Unit Director lacked authority to make staffing decisions (e.g., hiring, promoting), assess performance, or issue disciplinary actions regarding Unit detectives. With

regard to hiring decisions, the Unit Director reported that while he typically reviewed the resumes of applicants and participated in initial interviews with candidates, he had no role in subsequent interviews or in the final selection process. Instead, the Deputy Chief of Detectives and the Acting Insurance Fraud Prosecutor ultimately made the hiring decisions for all detectives. The Unit Director reported that the lack of involvement in the hiring decisions prevented the Unit from ensuring that selected MFCU candidates' background, training, and interest in Medicaid fraud enforcement matched the Unit's needs.

The Unit Director lacked independent decision-making authority over day-to-day Unit operations, including grant decisions

We found that the Acting Insurance Fraud Prosecutor at the time, rather than Unit management, made some routine management decisions for the Unit. For example, Unit management reported that the Acting Insurance Fraud Prosecutor made decisions—without the Unit management's approval or knowledge—about how to use the grant. The Unit Director and the Insurance Fraud Prosecutor have concurrent authority over Unit operations and can make independent decisions for the Unit. The Unit Director explained that limited information-sharing between the previous Acting Insurance Fraud Prosecutor and the Unit regarding the grant had prevented the Unit Director from managing Unit administrative activities and ensuring full compliance with Federal requirements.

The Unit pursued few nonglobal civil fraud cases, and the MOU with the MFD lacked guidance for handling such cases

Less than one percent of the Unit's cases (9 of 1,029) during FYs 2015–2017 were nonglobal civil fraud cases. Nonglobal cases involve primarily State rather than Federal litigation; are pursued separately by Units or with other law enforcement partners; and are not coordinated by the National Association of Medicaid Fraud Control Units. At the time of our review, all of the nine cases were still in the investigative stage. Performance Standard 6(e) states that Units should seek to maintain, consistent with their legal authority, a balance of criminal and civil fraud cases. New Jersey enacted a False Claims Act in 2008, providing a basis to pursue its own nonglobal cases.[17] *OIG State Fraud Policy Transmittal 99-01* addresses the ability of MFCUs to pursue State-only, or nonglobal, cases, and states that if a Unit decides to not pursue a provider fraud case criminally, the Unit should investigate and/or analyze the case for its civil potential.[18] However, we found that the Unit did not analyze cases that were not pursued as criminal matters for civil potential or refer them to another State agency.

During FY 2015, the Unit lost a significant number of staff within its False Claims division, which was established in 2008 to pursue nonglobal civil fraud cases. The staffing shortages ultimately led to the Unit's closing of the division, consequently limiting the Unit's ability to pursue nonglobal civil fraud cases. Most of the staff who left the Unit went to work for the MFD, including the lead attorney who was responsible for managing the day-to-

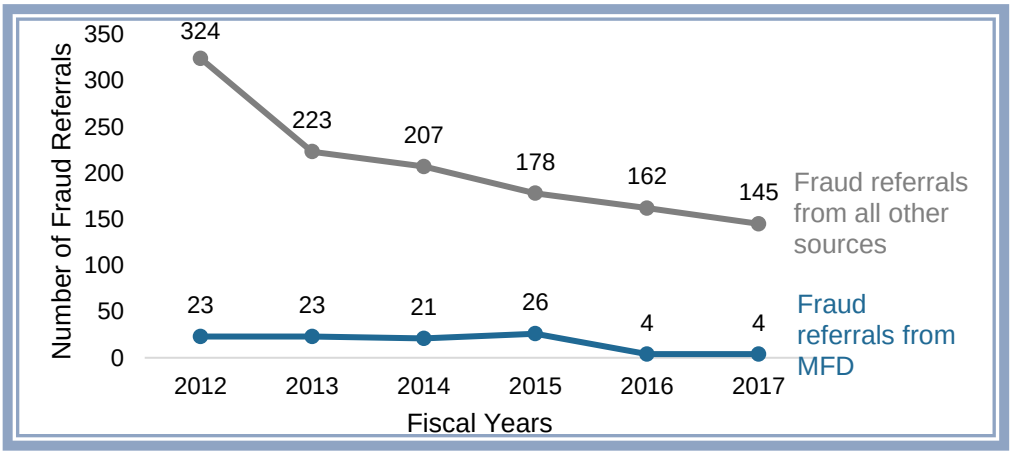
day operations of the False Claims division. The Unit Director explained that the staff departure left few skilled detectives and attorneys with knowledge and expertise in investigating and litigating civil fraud cases. At the time of our review, the Unit had not re-established the False Claims division, but it had one full-time attorney (with a newly hired attorney trainee) and one detective working the nine nonglobal civil fraud cases. Unit management noted they could give more attention to nonglobal civil fraud cases if they were able to hire more attorneys with experience in working civil cases.

We also found that the Unit's MOU with the MFD did not contain guidance regarding nonglobal civil fraud cases, which may further affect the Unit's ability to pursue such cases. Specifically, the MOU lacked information about the Unit's and the MFD's respective authorities and responsibilities in processing and investigating these types of cases.

Although the Unit and the MFD communicated regularly, fraud referrals from the MFD were low and had decreased in recent years

The Unit Director and MFD officials reported communicating on a regular basis regarding potential fraud referrals, yet the Unit only received 6 percent of its fraud referrals (34 of 601) from the MFD during FYs 2015–2017. Both agencies agreed that given the size of the State's Medicaid program, 34 fraud referrals was a low number the 3-year period. The number of referrals was particularly low in FYs 2016 and 2017, with only four referrals in each year. Performance Standard 4 states that Units should take steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources. We found that the total number of referrals from the MFD and all other sources combined decreased by 55 percent over a 6-year period, from 324 referrals in FY 2012 to 145 referrals in FY 2017. See Exhibit 3 for the total number of fraud referrals from the MFD and all sources during FYs 2012–2017, and Appendix B for the number of referrals by source for FYs 2015–2017.

Exhibit 3: Fraud referrals from the MFD were low from FY 2015 through FY 2017 and fraud referrals from all sources decreased from FY 2012 through FY 2017



Source: OIG analysis of Unit Quarterly and Annual Statistical Reports, FYs 2012–2017.

Although the Unit received fraud referrals from a number of sources, the MFD should be a significant source of quality referrals for the Unit. The MFD has dedicated staff responsible for monitoring the Medicaid program for instances of fraud, waste, and abuse, and it serves the primary role on behalf of the State Medicaid agency for referring suspected provider fraud to the MFCU. However, MFD officials explained that the New Jersey Medical Assistance and Health Services Act authorized the MFD to circumvent the MOU (which requires the MFD to refer cases of suspected fraud to the MFCU) and instead resolve cases administratively.[19] This authority allows the MFD to impose administrative penalties—including interest and up to triple damages on a per-claim basis—for engaging in fraudulent activity. This law provides the MFD with similar authority to what the False Claims Act provides the Unit for assessing penalties.

The Unit Director noted that resolving a case administratively is faster than the MFCU's conducting an investigation and pursuing criminal prosecution and/or civil action. Further, the Unit Director explained that the MFD has significantly more resources than the Unit. In addition, the MFD's administrative process allows the MFD to collect overpayment recoveries, as well as damages and administrative penalties, for the Medicaid program. However, this process prevents the Unit from determining whether cases have potential for criminal prosecution and/or civil action and whether providers should be excluded from the Medicaid program.[20]

Low staffing levels affected the Unit's ability to investigate cases and accept referrals

At the time of our review, the Unit employed 29 staff, which was less than its OIG-approved staffing level of 36 employees. According to Performance Standard 2, a Unit should employ the number of staff included in its OIG-approved budget estimate and commensurate with the State's Medicaid program expenditures.

Despite increasing State Medicaid expenditures, the Unit's number of employees decreased. New Jersey Medicaid expenditures increased from $10.6 billion in FY 2010 to $15.6 billion in FY 2017. During the same period, the Unit's staff decreased from 33 employees to 29 employees. Compared to MFCUs in States with Medicaid programs of similar size (as measured by expenditures), the New Jersey Unit employed the fewest staff in FY 2017. For example, in FY 2017 North Carolina's Medicaid program expenditures totaled approximately $14 billion and the North Carolina Unit employed 49 staff.

Unit management expressed the need for additional staff, even beyond the approved staffing levels, but reported that it was difficult to reach full staffing levels because of a lengthy hiring process and retention challenges. The entire process from hiring—led by the Division of Criminal Justice within the Office of the Attorney General—to the completion of law enforcement training (required for new detectives before joining the Unit) can take up to 10 months. Once new staff join the Unit, it is not uncommon for detectives and attorneys to leave the Unit after only a few months of employment.

The Unit Director reflected that the Unit might be able to improve staff hiring and retention if Unit management had a larger role in the hiring process, given that the Unit managers are most familiar with the Unit's work and are attuned to the skill set and other characteristics important for staff success.

The Unit Director and staff reported that the Unit's limited staff size reduces the effectiveness of investigations and prosecutions, particularly for civil fraud cases. The Unit Director explained that some cases remain stagnant because of the insufficient number of detectives on the trial teams, and that this sometimes results in the Unit being forced to close cases prematurely and refer them to other agencies, if necessary. Staffing limitations also affect the Unit's ability to work complex cases and develop expertise in areas involving nonglobal civil cases. Further, the Unit Director expressed concerns about heavy workloads for Unit staff, particularly detectives, and the Unit's inability to accept more referrals because of the insufficient number of staff.

The Unit did not always follow its internal control procedures for time and attendance

We found no significant deficiencies in the Unit's fiscal control of its resources. The Unit submitted required reports; maintained updated equipment inventory; used appropriate accounting principles to account for funding and expenditures; and employed a financial system that enabled appropriate control of resources. However, we identified an area in which the Unit's internal controls should be strengthened. Specifically, we found that supervisors did not always follow the internal control procedures for approving time and attendance records for Unit employees.[ii] Of the 46 timesheets that we reviewed, 5 timesheets did not contain supervisory approval, which in OIG's judgment represents an internal-control concern regarding the Unit's ability to follow procedures. Performance Standard 11(c) states that Units should maintain an effective time and attendance system and personnel activity records. In addition, Federal cost principles require the charges to Federal awards for salaries and wages to be based on records that accurately reflect the work performed.[21] Unit policy states that supervisors are responsible for carefully reviewing employees' time-record forms for accuracy and completeness, and for approving them in a timely manner; however, we found that the Unit did not always follow its procedures.[22]

[ii] The MFCU Director approves timecards for the attorneys and support staff, and the lieutenants approve timecards for the sergeants.

Thirty-four percent of case files lacked documentation of supervisory oversight

Thirty-four percent of case files lacked documentation of supervisory oversight for opening cases, closing cases, and/or periodic supervisory reviews.[iii] Eight percent of these case files lacked documentation of more than one type of supervisory oversight. See Appendix D for confidence intervals for the point estimates derived from our case file review.

Twenty percent of case files lacked documentation of supervisory approval to open cases, and 10 percent of closed cases lacked documentation of supervisory approval to close cases

Performance Standard 5(b) states that Unit supervisors should approve the opening and closing of all cases. Unit policy further requires the Unit Director to approve the opening and closing of cases. However, we found that 20 percent of all case files lacked documentation of the Unit Director's approval to open the case. Supervisory approval to open cases indicates that Unit supervisors are monitoring the intake of cases, thereby facilitating progress in the investigation.

An estimated 84 percent of cases were closed at the time of our review. Of these closed cases, 10 percent lacked documentation of supervisory approval to close the case and 5 percent also lacked supervisory approval to open the case. Supervisory approval to close cases helps ensure timely completion and resolution of cases.

At least 16 percent of case files that had been open longer than 90 days lacked documentation of periodic supervisory reviews

Performance Standards 5(b) and 7(a) state that supervisors should periodically review the progress of cases to ensure timely completion of each stage of the investigation and prosecution, which is also consistent with Unit policies and procedures. Unit policy further requires a supervisory review of case files every 90 days, at a minimum. Unit supervisors should note in the case files when conducting such reviews. At the time of our review, 44 percent of the Unit's cases had been open longer than 90 days. Of these open cases, at least 16 percent lacked documentation of periodic supervisory review, including initials from a supervisor and/or notes in the case files' administrative-review forms, such as the joint investigative plan. Although this was not reflected in all case files, Unit management and staff reported that the Unit Director and the senior detectives reviewed cases at least monthly.

[iii] The percentages apply to different categories of case files and therefore do not add up to the aggregate of 34 percent.

CONCLUSION AND RECOMMENDATIONS

For FYs 2015–2017, the Unit reported 56 indictments; 56 criminal convictions; 42 global civil settlements and judgments; and combined criminal and civil recoveries of $58.6 million.

From the data we reviewed, we found that the Unit did not comply with all applicable legal requirements or adhere to all performance standards. In 2013, OIG issued a recommendation regarding the Unit's supervisory structure, which at the time of this review was still unimplemented. This structure affected the Unit Director's ability to effectively manage the Unit and oversee its operations. Limitations to the Unit Director's supervisory role contributed to challenges in hiring and retaining staff, as the Unit Director had no role in selecting candidates to ensure that they would be a good fit.

The Unit received few fraud referrals from the MFD during our review period, and fraud referrals from all referral sources combined had decreased significantly in the last few years. Although the MFD would be expected to be the primary source of fraud referrals for the Unit, as governed by Federal regulations and the MOU, State law allows the MFD to circumvent the MOU and resolve cases administratively rather than referring them to the Unit.

Further, the Unit's limited staff size created challenges for the Unit to accept all referrals and effectively investigate cases, particularly nonglobal civil fraud cases. After the False Claims division closed, the Unit pursued few nonglobal civil fraud cases, which may have been further affected by the lack of guidance in the Unit's MOU with the MFD for handling such cases.

We also found that the Unit did not consistently document supervisory oversight of case files or employee time and attendance records, all of which are important to effective management of Unit operations.

To address these findings, we recommend that the New Jersey Unit:

Change the supervisory structure to provide the Unit Director with supervision of all Unit staff, oversight of all its caseload, and independence to make management decisions

To ensure that the Unit is organized in such a manner that promotes effective and efficient conduct of the Unit activities, the Unit should reorganize its supervisory reporting structure. Changes should include making the Unit Director the primary person responsible for hiring, terminating, disciplining, and evaluating the performance of all Unit staff and overseeing the Unit's day-to-day activities. The supervisory structure should also provide the Unit Director with independence to make routine management decisions that affect Unit operations, including grant decisions.

Develop and implement a plan to pursue more nonglobal fraud cases as civil matters, and revise the MOU with the MFD to include guidance for handling such cases

The Unit should develop and implement a plan to pursue appropriate fraud cases as civil matters. As part of the plan, the Unit could hire additional staff, provide training to staff, and/or further develop litigation strategies to pursue nonglobal fraud cases as civil matters. The Unit should also revise the MOU with the MFD to include guidance for nonglobal civil fraud cases. The MOU could specify the roles and responsibilities for the Unit and the MFD in sharing civil fraud referrals and handling civil fraud investigations.

Take additional steps to ensure that the Unit receives an adequate number and quality of fraud referrals from the MFD

Given that the Unit received few fraud referrals from the MFD during our 3-year review period, the Unit should take additional steps to ensure that it receives an adequate number of referrals from the MFD. The Unit could provide education to the MFD about the information needed in a quality referral of fraud and the importance of referring any suspected fraud to the MFCU, and could clarify the Unit's mission to investigate both criminal and civil provider fraud.

Assess the adequacy of existing staffing levels and, if appropriate, consider a plan to expand the size of the Unit

The Unit should assess whether staffing levels are sufficient for investigating cases of criminal and civil fraud and patient abuse and neglect in a timely manner and commensurate with the State's total Medicaid program expenditures. The Unit should share its findings with OIG, and based on its assessment, the Unit should, if appropriate, consider an expansion plan to increase the number of staff to meet the needs of the growing State Medicaid program.

Follow its internal controls for time and attendance

The Unit should take steps to ensure that supervisors follow its internal controls by carefully reviewing employees' time records for accuracy and completeness and approving them in a timely manner. This could include implementing procedures such as a systems-based reminder function or appropriate training for supervisory staff.

Ensure that all case files include documentation of supervisory oversight

The Unit should include documentation in all case files to demonstrate that supervisors approved the opening and closing of cases. The case files should also include documentation that demonstrate that supervisors conduct periodic reviews, as required by the performance standards.

UNIT COMMENTS AND OIG RESPONSE

The New Jersey Unit concurred with all six of our recommendations.

First, the Unit concurred with our recommendation to change its supervisory structure to provide the Unit Director with supervision of all Unit staff, oversight of all its caseload, and independence to make management decisions. The Unit stated that it will reorganize its supervisory structure and create a Deputy Chief of Detectives (DCD) position by March 2019. All Unit detectives will report to the DCD, who will report to the MFCU Director on all matters except those involving law enforcement training and safety.

Second, the Unit concurred with our recommendation to develop and implement a plan to pursue more nonglobal fraud cases as civil matters, and to revise the MOU with the MFD to include guidance for handling such cases. The Unit stated that it will develop a process for pursuing more nonglobal civil fraud cases. It is currently working with the MFD on revising the MOU to include a provision that the MFD must not take action on any civil matters that the Unit chooses to pursue and to make explicit that the Unit may pursue as civil matters cases that were initially referred from the MFD for criminal investigation. The Unit anticipates completion of the amended MOU in March 2019.

Third, the Unit concurred with our recommendation to take additional steps to ensure that it receives an adequate number and quality of fraud referrals from the MFD. The Unit stated that it will begin holding monthly meetings with the MFD to discuss pending MFD fraud cases. The Unit will also provide quarterly presentations regarding fraud referrals to the MFD investigative staff and during MCO meetings. The presentations will include information about the elements of common criminal cases and the requirement to refer all cases involving credible allegations of fraud to the Unit. The Unit will hold the first monthly meeting and presentation in October 2018.

Fourth, the Unit concurred with our recommendation to assess the adequacy of existing staffing levels, and if appropriate, consider a plan to expand the size of the Unit. The Unit stated that it will take steps within the next 6 months to fill vacant positions. The Unit should also conduct an assessment of its staffing levels and consider a plan to expand Unit resources, if deemed appropriate.

Fifth, the Unit concurred with our recommendation to follow its internal controls for time and attendance. The Unit stated that all employees will transition to a new mandatory time and attendance system, eCATS, which will ensure that all time and attendance procedures are followed.

Finally, the Unit concurred with our recommendation to ensure that all case files include documentation of supervisory oversight. The Unit stated that on August 6, 2018, it changed its supervisory review procedures to require documented evidence of supervisory oversight for all case files.

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

APPENDIX A: Performance Assessment

We assessed the New Jersey Unit's adherence to the 12 MFCU performance standards, including its compliance with applicable laws, regulations, and policy transmittals. From this review, we identified six areas in which the Unit should improve its adherence to program requirements, and made other observations about Unit operations and practices.

A complete publication of the performance standards, including performance indicators, may be found at 77 Fed. Reg. 32645 (June 1, 2012), and also on OIG's website at https://oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf

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

Finding

The Unit Director lacked supervisory authority over Unit detectives and independent decision-making authority over day-to-day Unit operations. See page 6.

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.

Finding

Low staffing levels affected the Unit's ability to investigate cases and accept referrals. See page 10.

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 policies and procedures. The Unit relies on policies and procedures for general law enforcement matters from the New Jersey Division of Criminal Justice, a component of the Office of the Attorney General. The Unit also has its own MFCU Standard Operating Procedures manual with specific guidelines for Unit operations and for investigating cases of Medicaid fraud and patient abuse or neglect.

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

Observation

The Unit conducted outreach to increase Unit visibility and generate more referrals of patient abuse and neglect allegations. The Unit reported several outreach efforts, implemented in January 2016, which collectively increased the number and quality of patient abuse and neglect referrals during our review period. The Unit received 105 referrals during FYs 2015–2017, compared to 35 referrals during FYs 2012–2014. One of these efforts included an outreach program with local law enforcement agencies. This program allows the Unit to investigate allegations of Medicaid patient abuse or neglect concurrently with local law enforcement agencies. If a local law enforcement agency receives an allegation of patient abuse or neglect, it immediately notifies one of the two designated Unit detectives. The detective then responds to the allegation on the scene (e.g., at a nursing home) and works with local law enforcement to investigate the allegation.

Another outreach effort involved educating State judges who are "legal surrogates"—i.e., who have legal guardianship over elders—about elder abuse and exploitation. Unit management noted that some judges had previously not been aware of the Unit's authority to investigate and prosecute cases of patient abuse and neglect involving elders. Unit staff also reported attending an annual conference for legal surrogates in New Jersey, during which the Unit provided education on the Unit's mission and information about when allegations of patient abuse or neglect allegations should be referred to the Unit.

Finding

Although the Unit and the MFD communicated regularly, fraud referrals from the MFD were low and had decreased in recent years. See page 9.

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.

Finding

Thirty-four percent of case files lacked documentation of supervisory oversight. See page 11.

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 fraud and patient abuse or neglect cases, covering a broad mix of provider types. At the end of FY 2017, the Unit's cases included 46 provider types. During our review period, 81 percent of the Unit's cases involved fraud and 19 percent involved patient abuse or neglect.

Finding

The Unit pursued few nonglobal civil fraud cases, and the MOU with the MFD lacked guidance for handling such cases. See page 8.

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.

Observation

The Unit's electronic case management system allowed efficient access to case information, and the Unit's case files were adequately maintained. The Unit uses an electronic case management system—InfoShare—that records and tracks all case information. The system allows the Unit to generate Unit performance data, such as statistical reports required by OIG. We judged that the case files were adequate, but we provided the Unit with technical assistance to further enhance its system.

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

Observation

Although the Unit participated in "de-confliction" activities with the U.S. Attorney's Office, the Unit did not communicate regularly with OIG or investigate cases jointly with the U.S. Attorney's Office. Performance Standard 8(a) states that a Unit should communicate with OIG and other Federal agencies on a regular basis about Medicaid fraud in its State. However, we found that the Unit had no regular contact with OIG and that some staff were hesitant about collaborating with Federal law enforcement agencies.

Unit staff reported that they routinely "de-conflicted" cases with the U.S. Attorney's Office. De-confliction is a process to identify and avoid any duplicative and overlapping actions by different law enforcement agencies. Although we did not identify any de-confliction activities in the case files, staff in the U.S. Attorney's Office confirmed that it regularly communicates with the Unit to share information and engage in de-confliction of cases.

Performance Standard 8(b) states that Units should cooperate and coordinate with OIG's Office of Investigations on joint cases—i.e., cases involving the same suspects or allegations—and on cases referred to the Unit by OIG or another Federal agency. Although the Unit had a few joint cases with OIG, the Unit had no joint cases with the U.S. Attorney's Office during our review period. The lack of communication and coordination between the Unit and Federal partners, including OIG, may have limited referrals of fraud and patient abuse to the Unit, and consequently, limited the Unit's criminal convictions and civil settlements and judgments. See Appendix B for a list of the number of referrals that the Unit received from OIG.

Observation

The Unit reported convictions and adverse actions to Federal partners within the established timeframes. The Unit reported all 33 convictions to OIG within 30 days after sentencing. Standard 8(f) states that the Unit should transmit information on convictions to OIG within 30 days of sentencing for the purpose of exclusion from Federal health care programs.[iv] OIG had previously found deficiencies with the Unit's reporting of convictions to OIG, but the Unit successfully addressed these deficiencies in one of its policies. According to the policy, the Unit's recordkeeper is responsible for ensuring that the Unit attorneys notify the appropriate staff of convictions and for tracking the time from conviction to submission to OIG.

Similarly, the Unit reported all 19 adverse actions to the NPDB. Federal regulations require that Units report any adverse actions resulting from investigations or prosecution of health care providers to the NPDB within 30 calendar days of the date of the final adverse action.[v]

STANDARD 9

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

Observation

The Unit did not make any programmatic recommendations during our review period. Performance Standard 9 states, in part: "[T]he Unit, when warranted and appropriate, makes statutory recommendations to the State legislature [...] or makes regulatory or administrative recommendations regarding program integrity issues to the State Medicaid agency." The Unit stated that during our review period, it did not identify any reasons or circumstances that warranted its making a programmatic recommendation.

[iv] Late reporting of convictions to OIG delays the initiation of the program exclusion process, which may result in improper payments to providers by Medicaid or other Federal health care programs or possible harm to beneficiaries.

[v] 45 CFR § 60.5. Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions. See SSA § 1128E(g)(1) and 45 CFR § 60.3.

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.

Finding

The Unit pursued few nonglobal civil fraud cases, and the MOU with the MFD lacked guidance for handling such cases. See page 8.

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

Finding

The Unit did not always follow its internal control procedures for time and attendance. See page 11.

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

Observation

Unit staff met the Unit's training requirements. All staff met the requirements of the Unit's training plan, and Unit staff and management reported good training opportunities. The Unit's training plan requires each professional discipline to participate in 3 hours of MFCU in-house training, which includes training on Medicaid fraud or on the False Claims Act. Each employee must also attend Medicaid fraud training offered by the National Association of Medicaid Fraud Control Units, subject to availability of funding and supervisory approval. In addition, each professional discipline has its own training requirements. For example, attorneys must attend 24 hours of qualifying legal education over a 2-year period, of which 4 hours must be in the areas of ethics and/or professionalism.

APPENDIX B: Unit Referrals by Source for Fiscal Years 2015–2017

	FY 2015		FY 2016		FY 2017	
Referral Source	**Fraud**	**Abuse & Neglect[1]**	**Fraud**	**Abuse & Neglect**	**Fraud**	**Abuse & Neglect**
Adult Protective Services	0	2	0	0	0	1
Anonymous	19	2	19	1	22	2
HHS–Office of Inspector General (OIG)	0	1	0	0	0	0
Long-Term Care Ombudsman	1	13	0	20	1	17
Managed Care Organization	33	0	8	1	10	0
Medicaid Agency and Medicaid Fraud Division (MFD)[2]	26	0	4	0	4	1
Other Law Enforcement	3	3	9	3	11	0
Private Citizens	79	11	111	8	89	3
Private Health Insurer	0	1	4	0	0	0
Provider	1	2	1	1	2	0
State Agency–Other	5	8	2	3	6	12
Other	11	0	4	0	0	0
Total	**178**	**43**	**162**	**37**	**145**	**36**
Annual Total	**221**		**199**		**181**	

Source: OIG analysis of Unit Annual Statistical Reports FYs 2015–2017.

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

[2] DMAHS, the State's Medicaid agency, delegated to the MFD its authority to detect, prevent, and investigate Medicaid fraud and abuse; recover improperly expended Medicaid funds; and enforce Medicaid rules and regulations.

APPENDIX C: Detailed Methodology

Data Collection

We used data collected from the eight sources below to assess the performance of the New Jersey MFCU.

Review of Recertification Data, Case Outcome Data, and Unit Documentation. Prior to the onsite review, we collected recertification data and other documentation, such as the Unit's annual statistical reports, which illustrate and describe the Unit's case outcomes for FYs 2015–2017. This included information about indictments, investigations, criminal convictions, civil settlements and judgments, and monetary recoveries (criminal, global, and nonglobal civil). We also reviewed data from the previous OIG onsite reviews of the Unit. Further, we obtained the Unit's MOU with the State Medicaid agency and the MFD. We also obtained the Unit's policies and procedures and held discussions with Unit management during the onsite visit to gain understanding of those policies and procedures. We confirmed with the Unit Director that the information we had was current, and we requested additional data and clarification as needed.

Review of Unit Financial Documentation. To evaluate the Unit's internal control over its fiscal resources, we reviewed policies and procedures and analyzed the Unit's response to a questionnaire about its accounting; budgeting; personnel; procurement; and property and equipment. While onsite, we followed up with Unit officials to clarify issues identified in the internal controls questionnaire. We reviewed records from HHS's Payment Management System (PMS)[23] and revenue accounts to determine the accuracy of the Federal Financial Reports (FFRs) for FYs 2014–2016. 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 sample of 30 transactions totaling $322,507 and reviewed supporting documentation to determine whether the costs claimed were allowable, allocable, and reasonable, in accordance with Federal regulations.[24]
2. To assess inventory, we selected and verified a sample of 30 fixed assets (15 equipment items and 15 vehicles) from a total of 102 items (78 equipment items and 24 vehicles) maintained in the Unit's Trenton office.
3. To assess employee time and effort, we also selected and verified a sample of 50 payroll transactions from the Unit's salary details and reviewed supporting documentation. These transactions consisted of 46 timesheets and 4 payroll adjustments.

Interviews with Key Stakeholders. In October and November 2017, we interviewed key stakeholders, including officials in DMAHS, the MFD, and the U.S. Attorney's Office. We also interviewed the Special Agent from OIG's Office of Investigations' Region II office who interacts with the Unit. We focused these interviews on the Unit's relationship and interaction with the stakeholders as well as opportunities for improvement. We used the information collected from the interviews to develop subsequent interview questions for Unit management.

Survey of Unit Staff. We surveyed Unit staff within each professional discipline (i.e., detectives, auditors, and attorneys), as well as administrative staff. We asked about the Unit's adherence to the 12 performance standards, beneficial practices, and needs for improvement. We also asked about the effects of the current supervisory structure on the Unit's operations, and benefits and barriers to reorganizing the supervisory structure.

Onsite Interviews with Unit Management and Selected Staff. With the assistance of OIG Special Agents, we conducted structured onsite interviews with Unit management, including the Director and Assistant Director, and selected staff, such as the lieutenants (manager-level detectives) and attorneys. The interviews focused on our targeted area of the supervisory structure, Unit operations, training, and technical assistance. We also followed up on any issues identified from the staff survey, key stakeholder interviews, and our analysis of Unit documentation.

Onsite Review of Case Files. We requested a list of cases from the Unit that were open at any time during FYs 2015–2017, and we asked the Unit to include the current status of the case; whether the case was criminal, civil, or global; and the date on which the case was opened and closed, if applicable. The total number of cases was 1,029. We then excluded 525 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. From the 504 remaining case files, we selected a simple random sample of 50 cases. With the assistance of OIG Special Agents, we reviewed the Unit's processes for monitoring the opening, status, and outcomes of these cases. We also reviewed the Unit's approach to investigating and prosecuting these cases and reviewed them for adherence to the relevant performance standards and compliance with statute, regulation, and policy transmittals.

Review of Unit Submissions to OIG and the NPDB. We also reviewed all convictions (33) submitted to OIG for program exclusion during the review period, and all adverse actions (19) submitted to the NPDB during the review period. We reviewed whether the Unit submitted information on all sentenced individuals and entities to OIG for program exclusion and all adverse actions to the NPDB for FYs 2015–2017. We also assessed the timeliness of the submissions to OIG and the NPDB. While onsite, we

followed up with Unit staff to obtain documentation of submissions when needed.

Onsite Review of Unit Operations. During the onsite review, we observed the Unit's workspace and operations of the Unit's Trenton office. Specifically, we observed the Unit's offices and meeting spaces; security of data and case files; location of select equipment; and the general functioning of the Unit.

Data Analysis

We analyzed the data to assess the impact of the unimplemented recommendation on Unit staff and operations and to explore ways in which the Unit could implement the recommendation. We also analyzed the data to assess the Unit's adherence to the performance standards and applicable laws, regulations, or policy transmittals.[25] In addition, we used the data to make observations about the Unit's case outcomes and practices.

APPENDIX D: Point Estimates and 95-Percent Confidence Intervals of Case File Reviews

Exhibit D-1: Estimates for All Case Files

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of All Cases That Lacked Documentation of At Least One Type of Supervisory Oversight (i.e., supervisory approval to open cases/close cases or periodic supervisory review)	50	34.0%	21.6%	48.2%
Percentage of Cases That Lacked More Than One Type of Supervisory Oversight Documentation	50	8.0%	2.4%	18.8%
Percentage of All Cases That Lacked Supervisory Approval To Open or Supervisory Approval To Close	50	24.0%	13.5%	37.5%
Percentage of All Cases That Lacked Supervisory Approval To Open	50	20.0%	10.3%	33.1%
Percentage of All Cases That Were Closed	50	84.0%	71.4%	92.7%
Percentage of All Cases That Were Open Longer Than 90 Days	50	44.0%	30.6%	58.1%

Source: OIG analysis of New Jersey MFCU case files, 2017.

Exhibit D-2: Estimates for Closed Case Files

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of Closed Cases That Lacked Supervisory Approval to Close	42	9.5%	2.8%	22.0%
Percentage of Closed Cases That Lacked Both Supervisory Approval To Open and Supervisory Approval To Close	42	4.8%	0.5%	15.8%

Source: OIG analysis of New Jersey MFCU case files, 2017.

Exhibit D-3: Estimates for Case Files Open Longer Than 90 Days

Estimate Description	Sample Size	Point Estimate	One-Tailed Lower* 95-Percent Confidence Interval	
			Lower	Upper
Percentage of Cases Open for Longer Than 90 Days That Lacked Documentation of Periodic Supervisory Review	22	31.8%	16.2%	100%

Source: OIG analysis of New Jersey MFCU case files, 2017.

* Because of the small sample size and low precision of this point estimate, we did not project the point estimate of 31.8% in our findings. Instead, we used the lower limit of this one-tailed confidence interval to support that this estimate is at least 16%. A one-tailed lower confidence interval allows us to estimate a value that we are 95-percent confident the true percentage exceeds.

APPENDIX E: UNIT COMMENTS

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
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Acting Insurance Fraud Prosecutor

September 13, 2018

Suzanne Murrin
Deputy Inspector General for Evaluations and Inspections
Office of the Inspector General
Room 5660, Cohen Building
330 Independence Avenue, SW
Washington, DC 20201

Re: *New Jersey Medicaid Fraud Unit: 2017 Onsite Review, OEI-06-17-00520*

Dear Ms. Murrin,

We appreciate the opportunity to respond to the Office of the Inspector General (OIG) 2017 Onsite Review, OEI-06-17-00520. The Office of the Insurance Fraud Prosecutor recognizes and respects the role of the OIG, and has taken this review as an opportunity to improve our Unit as a whole, with emphasis on the areas recommended in the report.

We appreciate the dedication and insight the OIG staff has shown during this review process, and we look forward to continuing the professional relationship we have developed going forward.

The Office of the Inspector General has respectfully requested our comments on each of the recommendations in the report. It has been asked that our comments include whether we concur with the recommendations and statements in the report, along with the actions and any timelines associated with those actions.

In the enclosed response, we have included the summary recommendation from the Onsite Review, our plan to comply with the recommendation, and our timeline to implement the changes stated.

Should you have any questions related to this response, or require further information, please feel free to contact me.

Sincerely,

Tracy M. Thompson
Acting Insurance Fraud Prosecutor

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Finding:

The Unit Director lacked supervisory authority over Unit detectives and independent decision-making authority over day –to-day operations.

Recommendation:

Change the supervisory structure to provide the Unit Director with supervision of all Unit staff, oversight of all its caseload, and independence to make management decisions.

Response:

We concur with the recommendation. The Office of the Insurance Fraud Prosecutor (OIFP) will reorganize the Unit as needed. A Deputy Chief of Detectives (DCD) position will be created solely for the MFCU. All detectives will report to the MFCU DCD. The MFCU DCD will report to the Director of the MFCU on all matters except those involving training and safety. For those limited matters, the MFCU DCD will report to the Chief of Detectives. We have provided the new Table of Organization with this response, which will be effective March 2019.

Finding:

The Unit pursued few nonglobal civil fraud cases, and the memorandum of understanding (MOU) with the Office of the State Comptroller, Medicaid Fraud Division (MFD) lacked guidance for handling such cases.

Recommendation:

The Unit should develop and implement a plan to pursue more nonglobal fraud cases as civil matters, and revise the MOU with MFD to include guidance for handling such cases.

Response:

We concur with the recommendation. For all matters criminally investigated and closed due to a lack of criminal proofs, the MFCU will look to pursue the matter as a nonglobal civil matter. We have met with MFD and are working toward amending the MOU with MFD in two ways: 1) to include that for all civil matters the MFCU chooses to pursue, the MFD must stand down and take no further action; and 2) to make explicit that the MFCU may pursue as civil matters cases initially referred from MFD for criminal investigation. We anticipate having the amended MOU completed by March 31, 2019.

Finding:

Although the Unit and MFD communicated regularly, fraud referrals from MFD were low and decreased in recent years.

Recommendation:

Take additional steps to ensure the Unit receives an adequate number and quality of fraud referrals from MFD.

Response:

We concur with the recommendation. We have met with MFD and will institute monthly meetings with MFD beginning in October 2018. We expect to have a detective and DAG designated by the end of September, to attend these meetings and discuss all pending MFD cases for credible allegations of criminal fraud. The MFCU will give quarterly presentations to investigative staff at MFD and at all of the MCOs regarding the elements of common criminal cases and the requirement to refer all cases presenting credible allegations of fraud to the MFCU. The first training has been scheduled for October 2018.

Finding:

Low staffing levels affected the Unit's ability to investigate cases and accept referrals.

Recommendation:

Assess the adequacy of existing staffing levels and, if appropriate, consider a plan to expand the size of the Unit.

Response:

We concur with the recommendation. The Unit will take steps over the next 6 months to fill the vacant positions within the unit in order to properly investigate cases and accept referrals.

Finding:

The Unit did not always follow its internal control procedures for time and attendance.

Recommendation;

Follow its internal controls procedures for time and attendance.

Response:

We concur with the recommendation. The Department of Law and Public Safety has implemented a new mandatory time and attendance system, eCATS. All employees will be

transitioned to the new system by December 31, 2018. This transition will ensure that all time and attendance procedures will be followed.

Finding:

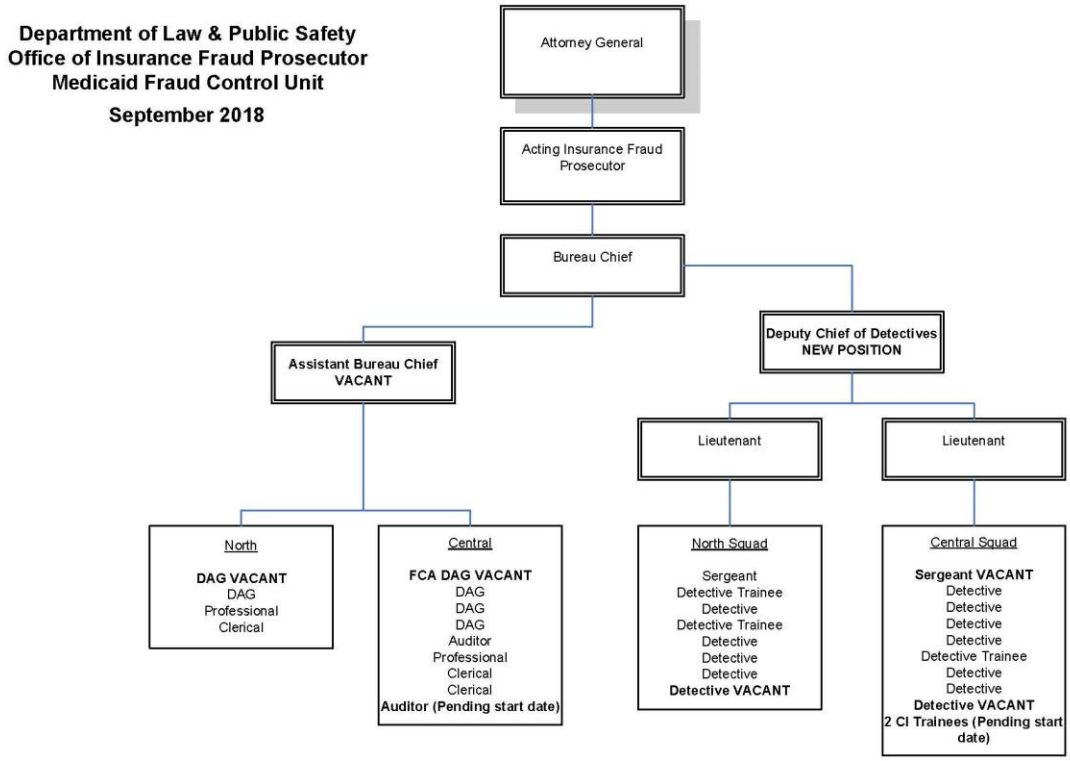
Thirty-four percent of case files lacked documentation of supervisory oversight.

Recommendation;

Ensure all case files include documentation of supervisory oversight.

Response:

We concur with the recommendation. On August 6, 2018, the Unit changed the review procedures to include documented evidence of supervisory oversight of all case files.


Department of Law & Public Safety
Office of Insurance Fraud Prosecutor
Medicaid Fraud Control Unit
September 2018
Attorney General
Acting Insurance Fraud Prosecutor
Bureau Chief
Assistant Bureau Chief
VACANT
Deputy Chief of Detectives
NEW POSITION
Lieutenant
Lieutenant
North
DAG VACANT
DAG
Professional
Clerical
Central
FCA DAG VACANT
DAG
DAG
DAG
Auditor
Professional
Clerical
Clerical
Auditor (Pending start date)
North Squad
Sergeant
Detective Trainee
Detective
Detective Trainee
Detective
Detective
Detective
Detective VACANT
Central Squad
Sergeant VACANT
Detective
Detective
Detective
Detective
Detective Trainee
Detective
Detective
Detective VACANT
2 CI Trainees (Pending start date)

ACKNOWLEDGMENTS

Anthony Soto McGrath served as the team leader for this study and Ben Gaddis served as the lead analyst. Others in the Office of Evaluation and Inspections who conducted the study include Richard Stern, the Director of the Medicaid Fraud Policy and Oversight Division. Office of Evaluation and Inspections staff who provided support include Kevin Farber and Christine Moritz.

We would like to acknowledge the contributions of Office of Audit Services staff, including Julio Agosto and Rafael Echevarria, and staff from the Office of Investigations.

This report was prepared under the direction of Ruth Ann Dorrill, Regional Inspector General for Evaluation and Inspections in the Dallas regional office, and Petra Nealy, Deputy Regional Inspector General.

ENDNOTES

[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.
[6] OIG analysis of FY 2017 MFCU annual statistical reporting data.
[7] As part of grant administration, OIG receives and examines financial information from Units, such as budgets and quarterly and final Federal Financial Reports, which 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.
[9] MFCU performance standards are published at 77 Fed. Reg. 32645 (June 1, 2012). The performance standards were developed by OIG, in conjunction 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] 81 Fed. Reg. 64383 (Sept. 20, 2016).
[12] 81 Fed. Reg. at 64387.
[13] 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 March 28, 2018.
[14] OIG, *New Jersey State Medicaid Fraud Control Unit: 2013 Onsite Review (OEI-02-13-00020)*. Accessed at https://www.oig.hhs.gov/oei/reports/oei-02-13-00020.pdf.
[15] SSA § 1903(q)(6).
[16] 42 CFR § 1007.13.
[17] New Jersey Statutes §§ 2A:32C-1 through 2A:32C-17 (2008).
[18] OIG, *State Fraud Policy Transmittal 99-01*, p.2. This policy transmittal further states that Units should either try meritorious civil cases "under State law" or refer them to the U.S. Department of Justice or the U.S. Attorney's Office.
[19] New Jersey Statutes § 30:4D-17 (2017).
[20] The State Medicaid Director may exclude providers from the Medicaid program. (See NJ Stat. §30:4D-17.1(a).)
[21] 45 CFR § 75.430(i).
[22] The Unit's policy is derived from the Division of Criminal Justice, which is under the Office of the Attorney General and oversees the Unit. Division of Criminal Justice, *Policy & Procedure No. 2006-06, Employee Timekeeping*.
[23] The PMS is a grant payment system operated and maintained by HHS 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.
[24] The transaction detail included multiple accounting entries related to each of the reported expenditures. We selected 30 transactions from four Federal cost categories. Transactions varied in amount from $1,037 to $123,540.
[25] All relevant regulations, statutes, and policy transmittals are available online at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp.

ABOUT THE OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.