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Mississippi Medicaid Fraud Control Unit: 2020 Inspection

Suzanne Murrin
Deputy Inspector General for Evaluation and Inspections
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Report in Brief
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Unit Case Outcomes

Federal fiscal years (FYs) 2017 through 2019:

- 139 indictments
- 167 convictions (152 of patient abuse or neglect and 15 of Medicaid provider fraud)
- 35 civil settlements and judgments
- $24 million in recoveries

Unit Snapshot

At the time of the inspection in August 2020, the Mississippi Medicaid Fraud Control Unit (MFCU or Unit) had 34 staff, primarily located in Jackson, Mississippi.

During FYs 2017 through 2019, 90 percent (2,047) of the Unit's cases involved patient abuse or neglect and 10 percent (224) involved fraud.

The Mississippi Vulnerable Persons Act mandates that staff at "care facilities" and home health agencies, as well as any other individuals with knowledge of patient abuse or neglect in care facilities, make a report both to the MFCU and the Mississippi State Department of Health. As a result of the reporting mandate, the Unit received 5,996 complaints of patient abuse or neglect during the review period.

What OIG Found

Our inspection of the Mississippi MFCU for FYs 2017 through 2019 found that reporting requirements contained in the Mississippi Vulnerable Persons Act imposed a significant workload on the Unit that led to many convictions of patient abuse or neglect but also presented challenges to Unit operations. The Unit received about 2,000 complaints of patient abuse or neglect for each year of the review period and devoted half of its investigative staff and 90 percent of its caseload to patient abuse or neglect. The Unit's chief investigator devoted more than half of his time to screening complaints and encountered difficulties conducting periodic supervisory reviews of the large caseload. We also found significant unexplained investigative delays in 18 percent of cases.

We observed a different picture with the Unit's fraud cases. During the review period, the Unit's fraud caseload and numbers of fraud convictions were low, compared to those of similarly sized MFCUs. We found that the Unit took some steps to maintain an adequate volume and quality of fraud referrals, but its efforts to maintain fraud referrals from the Medicaid agency were inconsistent and the Unit received few fraud referrals. We also found that the Unit maintained limited communication and coordination with OIG and that the Unit stopped working joint cases with Federal partners in 2018.

We also found that certain operational issues have persisted since OIG's prior onsite review in 2014. We found that the Unit's policies and procedures manual did not reflect all aspects of Unit operations, including for periodic supervisory reviews. We also found that the Unit did not timely report a substantial number of convictions to OIG for purposes of excluding providers from Federal health care programs, and that the Unit's timeliness declined significantly since OIG's 2014 onsite review.

What OIG Recommends and How the Unit Responded

To address the findings about cases of patient abuse or neglect and fraud, we recommend that the Unit (1) examine the Unit's intake process for complaints of patient abuse or neglect and identify improvements; (2) take steps to avoid investigative delays and ensure that delays are documented in the case management system; (3) develop and implement a plan to increase fraud referrals from the Medicaid agency and other sources; and (4) improve communication and coordination with OIG investigators and other Federal partners. We also make eight recommendations to address other findings related to the Unit's compliance with legal requirements and adherence to MFCU performance standards. The Unit concurred with 11 of our recommendations and did not concur with 1 recommendation.

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BACKGROUND

Objectives

To examine the performance and operations of the Mississippi Medicaid Fraud Control Unit (MFCU or Unit).

Medicaid Fraud Control Units

MFCUs investigate (1) Medicaid provider fraud and (2) patient abuse or neglect in facility settings, and prosecute those cases under State law or refer them to other prosecuting offices.[1, 2, 3] Under the Social Security Act (SSA), a MFCU must be a "single, identifiable entity" of State government, "separate and distinct" from the State Medicaid agency, and employ one or more investigators, attorneys, and auditors.[4] Each State must operate a MFCU or receive a waiver.[5]

Currently, 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operate MFCUs.[6] Each Unit receives a Federal grant award equivalent to 90 percent of total expenditures for new Units and 75 percent for all other Units.[7] In Federal fiscal year (FY) 2020, combined Federal and State expenditures for the MFCUs totaled approximately $306 million.[8]

[1] SSA § 1903(q)(3). Regulations at 42 CFR § 1007.11(b)(1) clarify that a Unit's responsibilities include the review of complaints of misappropriation of patients' private funds in health care facilities.

[2] As of December 27, 2020, MFCUs may also receive Federal financial participation to investigate and prosecute abuse or neglect of Medicaid beneficiaries in a noninstitutional or other setting. Consolidated Appropriations Act, 2021, Public Law 116-260, Division CC, Section 207.

[3] References to "State" in this report refer to the States, the District of Columbia, and the U.S. territories.

[4] SSA § 1903(q).

[5] SSA § 1902(a)(61).

[6] The territories of American Samoa, Guam, and the Northern Mariana Islands have not established Units.

[7] 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. Thereafter, the Federal Government contributes 75 percent and the State contributes 25 percent.

[8] OIG analysis of MFCU annual statistical reporting data for FY 2020. The Federal FY 2020 was from October 1, 2019, through September 30, 2020.

OIG Grant Administration and Oversight of Medicaid Fraud Control Units

The Office of Inspector General (OIG) administers the grant award to each Unit and provides oversight of Units.[9, 10] As part of its oversight, OIG conducts a desk review of each Unit as part of the annual recertification process. OIG also conducts periodic inspections and reviews. Finally, OIG provides ongoing training and technical support to the Units.

In its annual recertification review, OIG examines the Unit's reapplication materials, case statistics, and questionnaire responses from Unit stakeholders. Through the recertification review, OIG assesses a Unit's performance, as measured by the Unit's adherence to published performance standards;[11] the Unit's compliance with applicable laws, regulations, and OIG policy transmittals;[12] and the Unit's case outcomes.

OIG further assesses Unit performance by conducting inspections and reviews on selected Units. These inspections and reviews result in public reports of findings and recommendations for improvement. OIG reports may also include observations regarding Unit operations and practices, including beneficial practices that may be useful to share with other Units. Finally, OIG provides training and technical assistance to Units during inspections and reviews, as appropriate.

Mississippi MFCU

The Mississippi Unit is located within the Mississippi Attorney General's Office (AGO) in Jackson. At the time of our August 2020 inspection, the Unit director served as the chief attorney and directly supervised the five Unit attorneys, and also supervised the chief investigator, another supervisor (Bureau Director II), and Unit support staff.[13] The chief investigator supervised the fraud supervisor and nine Unit investigators who were assigned to conduct patient abuse or neglect investigations. The fraud

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

[10] 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.

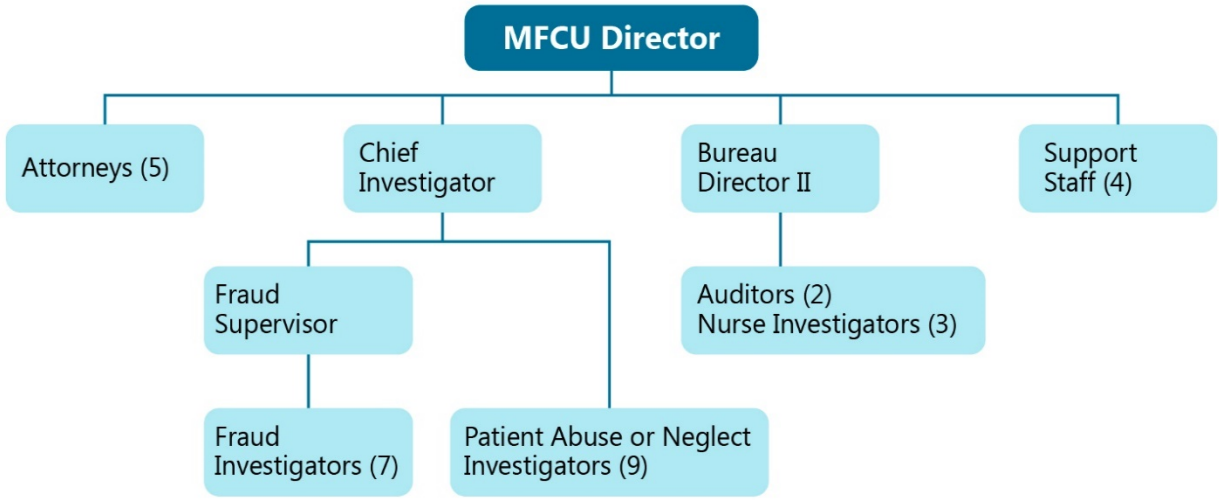
[11] MFCU performance standards are published at 77 Fed. Reg. 32645 (June 1, 2012). The performance standards were developed by OIG in conjunction with the MFCUs and were originally published at 59 Fed. Reg. 49080 (Sept. 26, 1994).

[12] OIG occasionally issues policy transmittals to provide guidance and instruction to MFCUs. Policy transmittals are located at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp.

[13] The Unit had two directors during the inspection's review period of FYs 2017 through 2019: the first director commenced employment in March 2010 and departed the Unit in October 2018, and the subsequent director was promoted to the position in October 2018 and retired in January 2020. A new director began in February 2020 but stayed in the position for 1 month and was replaced by another director who was in place at the time of the inspection in August 2020.

supervisor oversaw the seven Unit investigators who were assigned to conduct provider fraud investigations, and carried his own fraud caseload. The Bureau Director II supervised the two Unit auditors and the three nurse investigators, and also was classified as a fraud investigator and carried a fraud caseload. (See Exhibit 1 for an organizational chart of the Unit at the time of the inspection.)

Exhibit 1: Organizational chart of the Mississippi Medicaid Fraud Control Unit



Referrals

The Mississippi Vulnerable Persons Act mandates that staff at care facilities and home health agencies and any other individuals with knowledge of patient abuse or neglect in facilities make a report to the Mississippi State Department of Health (MSDH) and the MFCU.[14, 15] The Mississippi Vulnerable Persons Act requires the MSDH and the MFCU to conduct an initial review of the complaint to determine whether there is "substantial potential for criminal prosecution," and if so, "the unit [MFCU] will investigate and prosecute the complaint or refer it to an appropriate criminal investigative or prosecutive authority."[16] The chief investigator reviews these complaints of abuse or neglect and determines whether to open a case. The chief investigator also assigns a priority level to all opened cases.[17]

[14] MS Code § 43-47-37 (2019).

[15] The MSDH includes the Division of Health Facilities Licensure and Certification. The Division is responsible for licensing and certifying health facilities for participation in the Medicare and Medicaid programs and for ensuring health facilities' compliance with State and Federal standards, including protecting patients and residents from abuse and neglect.

[16] MS Code § 43-47-37(2)(d) (2019).

[17] Cases that involve a death or alleged sexual assault are assigned the highest priority and receive an immediate response by the assigned investigator. Other cases that involve abuse, neglect, or exploitation allegations are assigned second priority, and within those priority cases, felony cases take priority over misdemeanor cases.

When the Unit receives fraud referrals, the fraud supervisor and the Bureau Director II, in consultation with the Unit director, review all referrals and make a joint decision on whether to open a case.

Investigations and Prosecutions

The Unit has different procedures for assigning staff to investigate and prosecute fraud cases and patient abuse or neglect cases. For newly opened fraud cases, the fraud supervisor assigns the case to a two-person investigative team with one investigator designated as the lead. The director assigns an attorney to the case who remains involved during both the investigative and prosecutive phases.

For newly opened cases of patient abuse or neglect, the chief investigator makes an assignment to an investigator, usually on the basis of the regional assignment of the investigator. Following the investigation, the chief investigator reviews the case and, if appropriate, submits it to the director for prosecution consideration. Once the director approves a case for prosecution, he or she assigns the case to a Unit attorney.

Mississippi Medicaid Program

The Mississippi Division of Medicaid (DOM) administers Mississippi's Medicaid program. In March 2020, a total of 670,300 beneficiaries were enrolled in Medicaid.[18] In State FY 2019, approximately 65 percent of beneficiaries were enrolled in a managed care plan for most services.[19, 20] In FY 2019, total Medicaid expenditures were $5.7 billion.[21]

The DOM's Office of Program Integrity (OPI) is responsible for Medicaid program integrity efforts, including the referral to the MFCU of suspected fraud, some of which originates with the managed care plans.

Prior OIG Report

OIG conducted a previous onsite review of the Mississippi Unit in 2014.[22] In that review, OIG found that:

[18] Division of Medicaid, *Medicaid Enrollment Report Calendar Year 2020*, https://medicaid.ms.gov/wp-content/uploads/2020/05/2020-Enrollment-Reports.pdf. Accessed on May 20, 2020.

[19] The State of Mississippi's FY 2019 was July 1, 2018, through June 30, 2019.

[20] Division of Medicaid, *2019 Annual Report*, page 8, https://medicaid.ms.gov/wp-content/uploads/2019/09/Fiscal-Year-2019-Annual-Report.pdf. Accessed on June 3, 2021.

[21] OIG, *MFCU Statistical Data for FY 2019*, https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2019-statistical-chart.pdf. Accessed on May 20, 2020.

[22] OIG, *Mississippi State Medicaid Fraud Control Unit: 2014 Onsite Review*, https://oig.hhs.gov/oei/reports/oei-09-13-00700.asp. Accessed on May 20, 2020.

1. A Unit supervisor approved the opening and closing of most case files; however, 44 percent of case files lacked documentation of periodic supervisory reviews.
2. The Unit did not adequately safeguard some of its case files.
3. The Unit did not investigate 5 percent of cases before the statute of limitations expired.
4. The Unit may not have had enough investigators assigned to patient abuse or neglect cases.
5. The Unit also did not refer 11 sentenced individuals to OIG for program exclusion within an appropriate timeframe.
6. The Unit's policies and procedures manual did not reflect current Unit operations.

OIG recommended that the Mississippi Unit (1) ensure that supervisors approve the opening and closing of cases and that periodic supervisory reviews are conducted and documented in Unit case files; (2) ensure that case files are secure; (3) ensure that all cases are investigated or closed, as appropriate, before the statute of limitations expires; (4) assess the allocation of existing staff levels; (5) ensure that it refers all sentenced individuals for exclusion to OIG within an appropriate timeframe; and (6) revise its policies and procedures manual to reflect current operations. On the basis of information received from the Unit in 2015, OIG considered the recommendations implemented. As we discuss further below, several issues from the prior OIG report continue to exist in this inspection.

Methodology

OIG conducted the inspection of the Mississippi MFCU in August 2020. Because of the COVID-19 public health emergency, the OIG team was not able to conduct the inspection onsite as planned and instead conducted the inspection using a remote format. Our inspection covered the 3-year period of FYs 2017 through 2019.

We based our inspection on an analysis of data and information from 6 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 review of a random sample of 100 case files from the 2,250 nonglobal case files that were open at some point during the review period; and (6) 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. (See the Detailed Methodology on page 31.) In examining the Unit's operations and performance, we applied the published performance standards, but we did not assess adherence to every performance indicator for every standard.

Standards

We conducted this inspection 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 are other OIG evaluations, including internal and external peer review.

PERFORMANCE ASSESSMENT

In assessing the performance and operations of the Mississippi Unit, OIG identified the Unit's case outcomes, evaluated whether the Unit complied with legal requirements, and assessed whether the Unit adhered to each of the 12 performance standards. We identified a series of findings and observations regarding the Unit's performance and operations, with a total of 12 recommendations for improvement.

CASE OUTCOMES

Observations

The Unit reported 139 indictments, 167 convictions, and 35 civil settlements and judgments for FYs 2017 through 2019. Of the 167 convictions, 152 involved patient abuse or neglect and 15 involved Medicaid provider fraud. Compared to those of similarly sized MFCUs, the number of patient abuse or neglect convictions was significantly higher, while the number of fraud convictions was low.[23, 24, 25, 26]

The Unit reported total recoveries of $24 million for FYs 2017 through 2019. (See Exhibit 2 for the sources of those recoveries.)

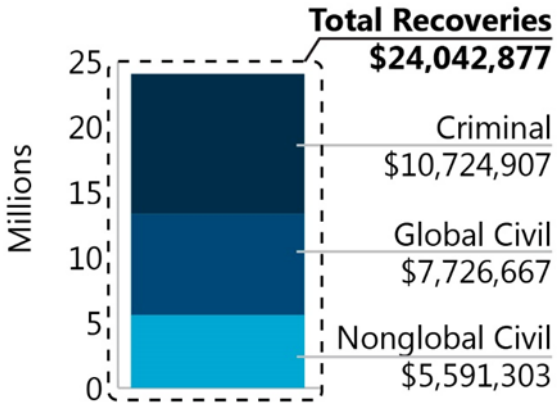
[23] In FY 2019, 10 MFCUs had staff sizes ranging from 30 to 44 employees, including the Mississippi Unit with 37 staff.

[24] Of similarly sized MFCUs, convictions of patient abuse or neglect ranged from zero to 31 during the review period. Of all MFCUs, only the California MFCU with 199 staff in FY 2019 had more convictions of patient abuse or neglect (178) during the review period than the Mississippi Unit. Of similarly sized MFCUs, convictions of provider fraud ranged from 23 to 118. Many factors other than a MFCU's staff size can affect case outcomes.

[25] OIG provides information on MFCU operations and outcomes but does not direct or encourage MFCUs to investigate or prosecute a specific number of cases. MFCU investigators and prosecutors should apply professional judgment and discretion in determining what criminal and civil cases to pursue.

[26] In FY 2020, the Unit reported 10 fraud convictions, a significant increase from each previous year of the review period.

Exhibit 2: The Unit reported combined civil and criminal recoveries of $24 million (FYs 2017 through 2019).



Source: OIG analysis of Unit statistical data, FYs 2017 through 2019.

Note: "Global" civil recoveries derive from civil settlements or judgments in global cases, which are cases that involve the Department of Justice and a group of State MFCUs and are facilitated by the National Association of Medicaid Fraud Control Units.

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

Finding

Two cases were ineligible for Federal matching funds during the review period. According to statutes and regulations in effect during the review period, MFCUs can receive Federal funds only for the investigation and prosecution of cases of patient abuse or neglect that occur in Medicaid-funded health care facilities or in board and care facilities.[27] From our review of a sample of case files open during the review period, we found that two cases of patient abuse or neglect did not involve alleged abuse or neglect in a Medicaid-funded facility or board and care facility, and were therefore—according to Federal grant statutes and regulations—not eligible for Federal financial participation (FFP).[28] One investigation involved alleged abuse occurring in a private residence and the other investigation involved alleged abuse occurring as a patient was being

[27] SSA § 1903(q)(4)(A) and (a)(6). 42 CFR §§ 1007.11(b) and 1007.19(d)(1).

[28] Although the two cases identified in the inspection were not eligible for FFP under existing statute during the review period, Division CC, Section 207 of the Consolidated Appropriations Act, 2021, Public Law 116-260 (December 27, 2020), amended Section 1903(q)(4)(A)(ii) of the SSA to expand MFCU statutory grant authority to investigate and prosecute patient abuse or neglect of Medicaid beneficiaries in noninstitutional or other settings.

transported from the hospital to the patient's home. Costs associated with these cases were not eligible for FFP.

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 was nearly fully staffed at the time of our inspection but experienced significant turnover during the review period. The Unit was approved by OIG for 36 staff in FYs 2017 through 2018 and 37 staff in FY 2019. At the time of our review, the Unit was staffed at 34 and had two vacant attorney positions and one vacant investigator position.

During the review period and before our inspection, the Unit experienced significant turnover of staff: eight attorneys, six investigators, and two auditors left the Unit. As a result of the departures of staff and prior vacancies, the Unit hired six attorneys, seven investigators, and two auditors.

Attorney turnover included turnover of Unit directors. During the review period, the Unit had two directors—one long-time director who left the Unit in 2018 and a subsequent director who was promoted to the position from within the MFCU and retired after the review period in early 2020. A new director was hired and remained in place for only 1 month after being appointed by the governor to another position. The current director was hired in April 2020.

In explaining the cause of the turnover, Unit management and staff reported that low compensation levels by the AGO made it difficult to retain staff. Management and staff also attributed the turnover to a lack of career advancement opportunities in the MFCU as well as general attrition.

Unit managers and staff further reported that staff turnover affected the Unit's cases. Managers and staff reported that reassignment of cases led to delays in both the investigation and prosecution of cases.

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.

Finding

The Unit's policies and procedures manual did not reflect all aspects of Unit operations. Performance Standard 3(a) states that the Unit should have written guidelines or manuals that contain current policies and procedures, consistent with the performance standards, for the investigation and prosecution of Medicaid fraud and patient abuse or neglect. The Unit maintained a policies and procedures manual, which contained general procedures for investigations, such as procedures for arrests, evidence, and firearms, but it did not address key Unit operations, such as procedures for the intake of referrals and assignment of cases. Consistent with findings from our 2014 onsite review, the manual also did not contain policies and procedures for supervisors approving opening of cases or for conducting and documenting periodic supervisory review of cases.

In response to the 2014 report recommendations, the Unit provided OIG with excerpts from an amended policies and procedures manual, showing policies and procedures for those areas found lacking. OIG closed the 2014 recommendations on the basis of a review of those amended provisions. However, we found during this inspection that the Unit did not incorporate those changes to its manual and was still operating with the same manual from 2014.

In addition to the many gaps in the policies and procedures manual, we found the manual to be disorganized, with no logical order to its contents, minimal formatting to aid a reader, and no table of contents or page numbers. The Unit director, who came on board in April 2020, reported taking steps to improve the manual.

A policies and procedures manual that reflects current operations and is user friendly is critical, especially given the high level of turnover of staff at the Unit and the need to inform new staff of Unit operations.

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

Finding

Although the Unit took some steps to maintain an adequate volume and quality of fraud referrals, its efforts to maintain fraud referrals from the Medicaid agency were inconsistent. The Unit received 143 fraud referrals from all sources during the review period, which we determined to be low compared to those of other MFCUs, as measured by Medicaid program expenditures. We also found that the Unit received only 29 referrals from the DOM's OPI, which is typically a major source of MFCU fraud referrals. The Unit received 7 fraud referrals from OPI in FY 2017, 2 in FY 2018, and 20 in FY 2019.[29, 30] See Appendix A for all sources of referrals involving fraud as well as patient abuse or neglect during FYs 2017 through 2019.

Performance Standard 4 states that a Unit will take steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources. OIG found, consistent with this standard, that the Unit took some steps to encourage fraud referrals during the review period. To encourage fraud referrals, the Unit gave presentations to the Board of Licensing, the Board of Pharmacy, hospice organizations, and managed care organizations (MCOs). The Unit also maintained a hotline telephone number and an online form for reporting referrals of suspected fraud to the Unit.

However, with respect to OPI, we found that the Unit's efforts to maintain an adequate volume and quality of fraud referrals were inconsistent. On one hand, we found that the Unit and OPI maintained a good relationship and that Unit representatives, such as the fraud supervisor, had regular, informal communications with OPI personnel. On the other hand, we also found that a previous Unit director had no contact with the OPI director. Additionally, the Unit and OPI did not hold regular monthly meetings during the review period to discuss new complaints and possible referrals, as was specified in the memorandum of understanding (MOU) between the Unit and the DOM.[31]

The program integrity director stated to us his belief that holding regularly scheduled meetings between the two agencies and including the

[29] The increase in referrals in FY 2019 was the result of OPI focusing on personal care services providers.

[30] The OPI referral data may include referrals originating from managed care organizations (MCOs). Unit management estimated that it had received a total of three to four referrals in recent years from OPI originating from MCOs.

[31] The Unit and the DOM amended their MOU in March 2020 to require quarterly rather than monthly meetings.

Unit's director in those meetings would enhance their working relationship. Monthly meetings were planned to commence during 2020, but the meetings had not commenced at the time of the inspection.

The Unit also had limited contact with MCOs during the review period and until the time of our inspection. A Unit manager reported to us that he asked to participate in meetings that OPI holds with MCOs and had attended one such meeting in October 2019.

Finally, we found another possible factor in the low number of fraud referrals from OPI to the Unit, in that the two agencies had not provided cross-training for staff in more than 4 years. Performance Standard 12(e) states that a Unit will participate in cross-training with the program integrity unit staff, and as part of such training, a Unit should provide training on the elements of successful fraud referrals. The MOU between the agencies was amended in 2020 to require the MFCU to provide annual training to OPI staff on "the progression of cases from investigation through prosecution." Although an expectation of annual training is useful, we observed that the training would be especially useful if, as suggested by the performance standard, the training included information about the elements of successful fraud referrals.

OIG found that the Unit's efforts to encourage referrals would be enhanced by meeting regularly with OPI and MCOs and providing cross-training to OPI, and that the failure to take these steps constituted a missed opportunity. Meetings with stakeholders and providing training to OPI would allow the MFCU to educate the organizations about its role, provide guidance on the information needed in a good fraud referral, and build working relationships.

Finding

The Unit received an unusually large number of patient abuse or neglect complaints because of reporting requirements contained in the Mississippi Vulnerable Persons Act, which in turn imposed a significant workload on the Unit. The Mississippi Vulnerable Persons Act mandates that staff at "care facilities" and home health agencies, as well as any other individuals with knowledge of patient abuse or neglect in care facilities, make a report both to the Mississippi State Department of Health (MSDH) and to the MFCU. The Mississippi Vulnerable Persons Act requires the MSDH and the MFCU to conduct an initial review of the complaint to determine whether there is "substantial potential for criminal prosecution," and if so, "the unit [MFCU] will investigate and prosecute the complaint or refer it to an appropriate criminal investigative or prosecutive authority."

As a result of this reporting mandate, the Unit received 5,996 complaints of patient abuse or neglect during the review period, or approximately 2,000 complaints in each year of the review period. With such a

significant volume of incoming complaints, the Unit's chief investigator reported spending 50 percent or more of his time screening and prioritizing these complaints.

In the judgment of OIG's investigative staff, assigning the chief investigator to be the sole person responsible for reviewing such a large volume of incoming complaints presented a management challenge for the Unit. In addition to the sheer volume of complaints assigned to one person, we found that the review function impeded the chief investigator's ability to spend time on other responsibilities. The chief investigator acknowledged that he found it challenging to conduct regular periodic supervisory reviews on the Unit's large caseload of patient abuse or neglect. (See also Performance Standards 6 and 7.)

We observed that conducting the initial screening of all incoming complaints of patient abuse or neglect was an unusual role for a MFCU. Typically, State agencies other than the MFCU will review incoming complaints and determine which of these complaints have potential for criminal prosecution within the MFCU's jurisdiction and refer those complaints to the MFCU. In Mississippi, however, both the MFCU and MSDH staff screened the same incoming complaints.

We asked questions about whether the Unit and MSDH coordinated their reviews of the same set of allegations. According to MSDH staff, MSDH reviewed the complaints to identify potential deficiencies in quality of care, following protocols of the Centers for Medicare & Medicaid Services (CMS).[32] The Unit reviewed the complaints to identify potential criminal acts. Although the two agencies did not coordinate the initial screening of complaints, Unit managers and staff stated that investigators coordinated regularly with MSDH staff before opening a case for investigation and would request the MSDH report that might be relevant to the Unit's investigation.

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

Some of the Unit's cases had significant unexplained delays in the investigation phase. According to Performance Standard 5, a MFCU should take steps to maintain a continuous case flow and to complete

[32] According to the CMS State Operations Manual, a State survey agency reviews a complaint—an allegation of noncompliance with Federal and/or State requirements—and determines the severity and urgency of the allegations, so that appropriate and timely action can be pursued. The survey agency investigates the complaint, determines whether the allegations are substantiated, and takes administrative actions to remedy the noncompliance.

cases in an appropriate timeframe based on the complexity of the cases. In addition, Performance Standard 5(c) states that delays in investigation and prosecution should be "limited to situations imposed by resource constraints or other exigencies." Our review found that 18 percent of investigations had significant delays during the investigation phase that were not explained in the case file.[33] Of the 18 (of 100) cases in our sample that had unexplained delays, all 18 involved allegations of patient abuse or neglect, 5 had delays of 9–11 months, 8 had delays of 12–18 months, and 6 had delays of 18–36 months.[34] As one example of a case with an extended unexplained delay, the Unit opened a case in early August 2016 and the assigned investigator appeared to complete his investigation in less than 2 weeks. The case file showed no further investigative activities (nor explanations for the delay) until the day before the case was submitted for prosecution in August 2018. The case was scheduled to go to grand jury in March 2019 when it was discovered that the victim, whose testimony would have been critical to the case, had died.

As a possible explanation for the delays, and as also observed under Performance Standard 2, managers and staff reported that reassignment of cases due to turnover of staff led to delays in the investigation and prosecution of cases.

Observation

Nearly all case files contained documentation of supervisory approval to open and, as appropriate, supervisory approval to close. Ninety-eight percent of cases contained documentation of supervisory approval to open them, and 97 percent of the cases that were closed at the time of our review (73 percent) contained documentation of supervisory approval to close them.

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 was skewed heavily toward cases of patient abuse or neglect, attributable to the large number of complaints of patient abuse or neglect received and the resulting cases opened. Performance Standard 6(d) states that a Unit should maintain a balance of fraud and patient abuse or neglect cases. The Unit's caseload consisted predominantly of cases of patient abuse or neglect. Of the 2,271 cases that were open during FYs 2017 through 2019, we found that 90 percent

[33] For the purposes of this report, we defined a "delay" as a period of at least 9 months with no documented activity in the case file.

[34] Of the 18 cases, one had two separate significant delays—of 10 months and 12 months, respectively—so that case is included twice in these data.

(2,047 cases) involved allegations of patient abuse or neglect and 10 percent (224) involved allegations of Medicaid provider fraud. This was an unusual case mix compared to other MFCUs; in FY 2019, the average case mix of all MFCUs was 17 percent patient abuse or neglect cases and 83 percent fraud cases.[35]

We found that the MFCU reviewed an unusually large volume of patient abuse or neglect complaints because of mandatory reporting requirements of the Mississippi Vulnerable Persons Act (see Performance Standard 4) and opened a large number of those complaints as cases. After the Unit's chief investigator reviewed the 5,996 complaints received during the review period, the Unit opened 21 percent of the complaints (1,263 cases) for investigation. Consequently, over the 3-year review period, the Unit carried an average of 609 open cases of patient abuse or neglect per year, which constituted the highest number of patient abuse or neglect cases of the 52 MFCUs operating during the review period.

We observed that the high number of total patient abuse or neglect cases resulted in large caseloads for individual investigators, as with the finding in the 2014 onsite review. In that review, OIG found that the Unit had 7 investigators investigating cases of patient abuse or neglect, with caseloads of 60–80 cases each. During that review, Unit management stated its opinion that the ideal caseload would be 50 or fewer cases and reported taking steps to get the caseload for each investigator to a "manageable level," including implementing a new intake procedure to screen complaints for sufficiency of evidence. OIG recommended that the Unit assess the allocation of existing staff levels and take appropriate action. In response to the OIG recommendation, the Unit hired two additional patient abuse or neglect investigators.

In our current inspection, we observed that the Unit's investigator caseload had declined but remained relatively high. The Unit employed 9 patient abuse or neglect investigators at the time of the inspection (half its investigative staff), each of whom carried a caseload of approximately 50–60 cases.

Despite the apparently large patient abuse or neglect caseloads, investigators and the Unit director reported the caseloads to be manageable. Investigators reported that they managed their caseloads according to priority designations. On the other hand, the chief investigator expressed concern that the large caseload did not always allow the Unit to meet its goals for concluding investigations of patient abuse or neglect.

[35] Analysis of case mix derived from data reported by all MFCUs with cases open at the end of FY 2019. At the end of FY 2019, the Mississippi Unit reported a case mix of 87 percent patient abuse or neglect cases and 13 percent fraud cases.

We observed that the Unit had mechanisms for handling the large caseloads. To ensure that investigators prioritized their caseloads appropriately, the chief investigator assigned a priority level to each case. To investigate cases efficiently, the chief investigator assigned each patient abuse or neglect investigator to investigate only cases in a particular geographic region of the State. On the other hand, we found that some of the Unit's cases had significant unexplained delays in the investigation phase (see Performance Standard 5). We did not find the relatively high caseloads for each of the investigators to raise other performance issues for the Unit, and the Unit achieved many successful resolutions to the cases (see Case Outcomes).

Observation

The Unit investigated few cases of Medicaid provider fraud, as compared to those of similarly sized MFCUs. Over the 3-year period, the Unit carried an average of 113 open cases of Medicaid provider fraud per year. We observed that this was the lowest average number of fraud cases, compared to those of similarly sized MFCUs. Each of the 7 fraud investigators, as well as the fraud supervisor and the Bureau Director II, carried a caseload of approximately 8–20 cases.

As one explanation for the relatively few cases of provider fraud investigated by the Unit, we found under Performance Standard 4 above that the Unit received few fraud referrals during the review period. As another explanation, we found under Performance Standard 8 below that the Unit had stopped opening joint cases with OIG after 2017.

The Unit's fraud cases covered 32 different provider types in FY 2019, the most common of which were personal care services attendants or agencies (22 percent), hospice (12 percent), and clinical social workers (9 percent).

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 case management system lacked some capabilities but was adequate for monitoring case progression. Performance Standard 7(f) states that a Unit should have a system that allows for the monitoring and reporting of case information. The Unit's case management system had been used by the AGO since 2006. Unit management and staff reported that the system allowed for monitoring of case progression. However, the Unit had difficulties reporting accurate data to OIG because of limitations

of the system.[36] Some Unit managers and staff described other concerns with the case management system, such as storage limits that did not allow staff to upload audio and video recordings into the case management system. As a result, staff stored these materials outside of the case management system in different ways.

Finding

The Unit lacked a policy for periodic supervisory review and procedures for conducting and documenting supervisory reviews in the Unit's case management system. Performance Standard 7(a) states that supervisory reviews should be conducted periodically, consistent with MFCU policies and procedures, and noted in the case file. Periodic supervisory review of cases during the investigation and prosecution phases can help ensure timely completion of cases, and documenting those reviews in the case files can help ensure that cases are properly managed.

In response to OIG's 2014 recommendation, the Unit agreed to establish policies and procedures for periodic supervisory review of the Unit's cases. In 2015, the Unit provided OIG with an excerpt from an amended policies and procedures manual stating that supervisory reviews were to be conducted quarterly and noted in the case management system. The Unit also reported adding a supervisory review "event" to its case management system for purposes of recording and labeling supervisory reviews in the system. In our current inspection, we found that the Unit had not incorporated the amendment into its policies and procedures manual and still lacked a written policy or procedure for supervisory review, but that the Unit's case management system had been modified to include a supervisory review event.

We found that the Unit's practice of conducting and documenting supervisory review of case files varied depending on whether the case involved fraud or involved patient abuse or neglect. For the Unit's cases of patient abuse or neglect, the chief investigator reported to us that he tried to review the cases in-depth once per year, but that this was challenging with the caseloads of 50–60 cases for each investigator. The chief investigator also reported that under some circumstances, he documented the periodic supervisory review in the case management system, but under other circumstances the investigator handled this task.

For the Unit's fraud cases, the fraud supervisor reported to us that before 2019, he conducted quarterly supervisory reviews but did not always document the reviews in the case management system. On the other hand, Unit investigators stated that supervisory reviews were not conducted on a regular basis, but that they met with the fraud supervisor as needed to discuss particular cases. In 2019, one Unit attorney started

[36] MFCU regulations require statistical reporting to OIG annually on the MFCU's staffing, caseload, outcomes, collections, and referrals. 42 CFR § 1007.17(a)(2).

holding monthly meetings with the fraud teams to discuss all active cases. The fraud supervisor actively participated in the monthly meetings, and he believed that the meetings helped ensure timely investigations. He discontinued the separate quarterly supervisory reviews once the monthly meeting practice began.

We also found that the Unit did not conduct periodic supervisory reviews during the prosecution phase. We identified no documentation demonstrating that these reviews were conducted, and the current director reported that his engagements with prosecutors during that phase of a case was limited to informal meetings. The director stated that he planned to improve the supervisory review process with prosecutors, and that process would include documenting the reviews in the case file.

In evaluating whether supervisory reviews were being conducted and documented during the review period, we applied a quarterly standard, which was reported to OIG as the standard in 2015 and appeared to be the intended practice for fraud cases before 2019. We found that 86 percent of case files open more than 3 months contained documentation of at least 1 supervisory review. However, of those files that contained at least 1 documented review, we found that 69 percent lacked regular, quarterly documentation of reviews. OIG's 2014 onsite review found that 44 percent of case files lacked documentation of supervisory reviews.[37]

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

Finding

The Unit maintained limited communication and coordination with OIG, and the Unit's joint case work with Federal partners ceased during the review period. Performance Standard 8 states that a Unit should communicate regularly and coordinate with OIG and other Federal partners.[38] Routine communication and coordination between the Unit and OIG's Office of Investigations was lacking. In particular, the Unit's director and chief investigator and OIG managers did not meet or communicate, and the Unit did not deconflict its "Medicaid-only" cases with the local OIG agent. However, coordination with OIG did occur when the Unit found that cases also involved Medicare. The Unit fraud supervisor referred these cases to the OIG agent and instructed Unit

[37] During the 2014 onsite review, Unit management reported that the chief investigator conducted supervisory reviews three times per year, so OIG applied that standard to its review of case files, rather than a quarterly standard. As a result, we were unable to compare the results from the two reviews.

[38] Current Federal regulations, which were effective May 21, 2019, also state that the Unit will coordinate with and establish a practice of regular meetings or communication with OIG and other Federal partners (42 CFR § 1007.11(e)(2) and (3)).

investigators to periodically contact the OIG agent for updates on these referred cases. The Unit kept these referred cases open, but the Unit investigators did not actively work these cases.

Although the Unit and OIG reported limited coordination on cases with Medicaid and Medicare fraud allegations, both agencies acknowledged that as of 2018 they were not opening joint cases. During FYs 2017 through 2019, the Unit reported 24 joint cases open with OIG, but the Unit opened only 3 new joint cases during that period, all in December 2017. Joint case work stopped in 2018 when a MFCU investigator, who had worked closely with the local OIG agent on the joint cases, left the Unit. Unit investigators, however, remained cooperative and continued to provide support to OIG when requested such as assisting with search warrants and transporting patients to trial. We identified a similar history of interactions between the Unit and the two United States Attorney's Offices (USAOs) in the State, both of which had no joint cases with the MFCU after the MFCU investigator departed in 2018.

OIG management expressed a desire to increase its partnership with the Unit and suggested that the Unit join the Gulf Coast Strike Force. During our inspection, both the Unit director and AGO management expressed an interest in becoming involved with Federal partners through the Gulf Coast Strike Force.

Finding

The Unit did not timely report a substantial number of convictions and adverse actions to Federal partners as required. Performance Standard 8(f) states that the Unit should transmit information on convictions to OIG within 30 days of sentencing so that convicted individuals can be excluded from Federal health care programs.[39] The Unit did not report 49 percent of convictions (93 of 190) to OIG within 30 days of sentencing.[40] This represents a significant decline in timeliness of the Unit's reporting of convictions to OIG from the 2014 onsite review, which found that the Unit did not report timely 6 percent of sentenced individuals (11 of 174). In addition to untimely reporting of convictions, the Unit did not report to OIG 5 of the 190 convictions; all 5 were joint cases with OIG. The Unit believed that it did not need to submit those convictions because OIG

[39] Effective May 21, 2019, 42 CFR 1007.11(g) required the Unit to transmit information on convictions within 30 days of sentencing, or as soon as practicable if the Unit encounters delays in receiving the necessary information from the court.

[40] Specifically, the Unit reported 51 convictions from 31–60 days after sentencing, 14 convictions from 61–90 days after sentencing, and 28 convictions more than 90 days after sentencing.

would submit them for exclusion.[41] However, the Unit should report all convictions to OIG, even joint cases with OIG.[42]

Federal regulations also 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. Performance Standard 8(g) also states that the Unit should report qualifying cases to the NPDB. During the review period, we found that the Unit did not report 31 percent of its adverse actions (59 of 190) within established timeframes.

Although the Unit had written procedures to ensure reporting to OIG and the NPDB, Unit staff did not always follow the procedures and the procedures did not specifically address timeliness. The Unit's policies and procedures manual required the attorney, upon disposition of a case, to submit the file to the administrative assistant for purposes of notifying the Federal Government of all convictions and adverse actions. However, as Unit management explained, in some instances Unit attorneys did not provide the case information to the administrative assistant within appropriate timeframes, but in many other instances, the administrative assistant, despite having received the case information timely, did not submit to OIG and the NPDB within the appropriate timeframes.

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

Observation

The Unit made no program recommendations to the State Medicaid agency during the review period.

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's MOU did not reflect two recent requirements. The MFCU and the DOM had a current MOU, amended in March 2020. OIG regulations were amended in 2019 to require the Unit and the Medicaid agency to establish procedures for the referrals of potential fraud from MCOs.[43] Although the Unit and OPI reported establishing procedures

[41] We found that OIG staff had submitted the five sentenced individuals who were then excluded.

[42] During the review period, State Fraud Policy Transmittal No. 2014-2 provided guidance to report *all* convictions to OIG, which included joint cases.

[43] 42 CFR § 1007.9(d)(3)(iv).

for MCO referrals, those procedures were not included in the 2020 amended MOU. In State FY 2019, 65 percent of Medicaid beneficiaries in Mississippi were enrolled in a managed care plan. Memorializing the established procedures in the MOU could help encourage the referral of potential fraud from MCOs.[44]

OIG regulations were also amended to require the Unit and the Medicaid agency to agree to "review and, as necessary, update the MOU no less frequently than every [5] years to ensure that the agreement reflects current law and practice."[45] In contrast, the current MOU between the Unit and the DOM does not require the parties to agree to review the MOU at least every 5 years, but rather the MOU automatically renews for 1-year periods until one of the parties desires to make a change, at which time the agreement may be amended by mutual consent.

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

Finding

The Unit did not properly report program income during the review period. Program income, defined as gross income earned as the result of a grant activity,[46] must be used to pay the Unit's current costs before the Unit may use Federal funds.[47] A Unit must report program income on its Federal financial report (FFR) to OIG to properly account for the Unit's reduced need for Federal funds.[48] During FYs 2017 through 2019, the Unit did not report any of its program income, which totaled $7,645 ($5,734 Federal share), on its FFRs.[49] As a result, the Unit withdrew $5,734 in Federal funds from the Department of Health and Human Services' (HHS's) Payment Management System to pay costs that should have been paid by the Unit's program income.[50] To rectify the reporting error, the

[44] Since the 2019 amendments to the OIG regulations, OIG has observed that MFCUs in States with Medicaid managed care report that procedures exist by which the MFCU receives MCO referrals, and although some MFCUs have updated their MOUs to reflect the procedures, others plan to add the procedures to the MOU when the parties next review and update their MOU.

[45] 42 CFR § 1007.9(d)(3)(v).

[46] 45 CFR § 75.2.

[47] 45 CFR § 75.307(e)(1).

[48] A Unit's expenditures and indirect costs are also reported on the FFR, in addition to its program income.

[49] The Unit's program income derived from the reimbursement of investigative costs it incurred investigating patient abuse or neglect cases that did not involve Medicaid funds.

[50] The Payment Management System is a portal for Federal grant payments and recipient reporting.

Unit reported the program income and adjusted its costs on its final FFR for FY 2020.

Finding

The Unit reported retaining certain settlement proceeds rather than working with the State Medicaid agency to ensure the appropriate return of the Federal Government's share of those recoveries. According to CMS policy, amounts recovered by a State through a State false claims action or other State action must be refunded at the Federal Medical Assistance Percentage (FMAP) rate.[51, 52] The State Medicaid agency is responsible for returning the Federal share of those recoveries to the Federal Government. The Unit reported submitting all settlement proceeds identified as Medicaid restitution to the DOM as required, but—contrary to the CMS guidance—the Unit retained any penalties, fees, or investigative costs that were part of civil settlements and used these funds for purposes of the State match requirement for the MFCU grant, rather than returning the FMAP portion of those amounts to the Federal Government.

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

Finding

Unit staff received training, but the Unit's training plan did not clearly specify annual training hours for each professional discipline. According to Performance Standard 12, a Unit should conduct training that aids the mission of the Unit. MFCU regulations more specifically require that a Unit provide training for its professional employees for the purpose of establishing and maintaining proficiency in Medicaid fraud and patient abuse or neglect matters.[53] Unit staff and managers reported that the Unit supported training opportunities and that staff received appropriate training.

Although Unit staff received training, the Unit's training plan did not clearly specify the annual training hours required for each professional discipline. Performance Standard 12(a) states that the Unit should maintain a training plan for each professional discipline that includes an

[51] CMS State Health Official Letter No. 08-004. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/policy_transmittals/SHO%20Letter%2008-004.pdf on November 3, 2020.

[52] OIG State Fraud Policy Transmittal No. 10-01, Program Income, relied on and summarized the content of the CMS policy statement outlined in SHO Letter No. 08-004. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/policy_transmittals/2010-1%20State%20Fraud%20Policy%20Transmittal%20Number%2010-01%20Program%20Income%203-22-2010.pdf on November 3, 2020.

[53] 42 CFR § 1007.13(h).

annual minimum number of training hours and is at least as stringent as required for professional certification. The Unit's training plan specified that licensed professional staff (attorneys, nurse investigators, and any other staff holding licenses or certifications) obtain training to at least minimally comply with requirements of their licenses, but it did not specify the annual minimum number of training hours required for these licensed professional staff. The training plan specified that "unlicensed staff" were to receive at least 12 hours of training per year, but it did not specify which staff were included in this category. Additionally, we found that staff and managers were not aware of what the annual training hour requirements were for their professional disciplines but believed that they met the requirements.

CONCLUSION and RECOMMENDATIONS

We found that the Unit reported 139 indictments, 167 convictions, 35 civil settlements and judgments, and $24 million in recoveries in FYs 2017 through 2019. We found that these high levels of outcomes were attributable to the Unit's concentration on patient abuse or neglect cases and that the Unit could take steps to increase its presence in combating Medicaid provider fraud.

We found that mandatory reporting requirements imposed by the Mississippi Vulnerable Persons Act created a significant workload for the Unit that led to many convictions of patient abuse or neglect but also presented challenges to Unit operations. The Unit received about 2,000 complaints of patient abuse or neglect each year and devoted half its investigative staff and 90 percent of its caseload to patient abuse or neglect. As a result of this focus, 152 of the Unit's 167 convictions involved defendants who committed patient abuse or neglect. We found operational challenges to this focus: The Unit's chief investigator devoted more than half of his time to screening and prioritizing patient abuse or neglect complaints and encountered difficulties conducting periodic supervisory reviews of the large caseload. We also found significant unexplained investigative delays in 18 percent of cases.

From the Unit's fraud referrals, caseload, and outcomes, we observed a different picture. We observed that during the review period, the Unit's fraud caseload and numbers of fraud convictions (15) were low, compared to those of similarly sized MFCUs. We found that although the Unit took some steps to maintain an adequate volume and quality of fraud referrals, its efforts to maintain fraud referrals from the Medicaid agency were inconsistent and the Unit received few fraud referrals. Further, we found that the Unit maintained limited communication and coordination with OIG and that during the review period the Unit stopped actively working joint cases with Federal partners, which would be a way to increase its involvement in fraud cases. Following the review period, in FY 2020, the Unit reported a total of 10 fraud convictions, which was a significant increase from an average of 5 fraud convictions each previous year of the review period.

We also found that some operational issues have persisted since OIG's prior onsite review in 2014. We found that the Unit's policies and procedures manual did not reflect all aspects of Unit operations. We found that the Unit still lacked a policy for periodic supervisory review and procedures for conducting and documenting supervisory reviews in the Unit's case management system. We also found that the Unit did not timely report a substantial number of convictions and adverse actions to Federal partners as required. In fact, the Unit's timeliness in reporting convictions to

OIG for purposes of excluding providers from Federal health care programs declined significantly since the 2014 review.

To address the findings identified in this report, we make recommendations in categories related to the Unit's (1) patient abuse or neglect cases; (2) fraud cases; (3) compliance with legal requirements; and (4) adherence to MFCU performance standards.

To address the findings, we recommend that the Mississippi Unit:

Patient abuse or neglect cases

1. Examine the Unit's intake process for complaints of patient abuse or neglect and identify improvements.

To alleviate the burden on the chief investigator, the Unit should consider ways to improve the screening of the large volume of complaints of patient abuse or neglect. The intake function could be assigned to or rotated among several investigators, perhaps in addition to or in place of the chief investigator's role. Alternatively, the Unit could designate and train support staff to conduct or support the intake function. The Unit should also consider whether additional coordination with the MSDH or local police is warranted for incoming complaints.

2. Take steps to avoid investigative delays and ensure that delays are documented in the case management system.

The Unit should take steps to ensure that it avoids unnecessary delays during the investigative phase of cases, unless delays are caused by resource constraints or other exigencies. Unit managers should conduct regular periodic supervisory reviews of all cases to allow managers and investigators to plan for case progression (see also related Recommendation 11). To demonstrate that extended delays were imposed by resource constraints or other exigencies, the Unit should document and explain such occurrences in the case management system. OIG's 2014 report included a similar recommendation regarding case delays that resulted in expiration of the statute of limitations.

Fraud cases

3. Develop and implement a plan to increase fraud referrals from the Medicaid agency and other sources.

As part of the plan, the Unit and the DOM's OPI should hold regularly scheduled meetings, as required by the MOU, that includes the management teams of each party. The meetings should include discussions of possible referrals and feedback from the Unit on referrals. The Unit should provide training to OPI on the elements of successful fraud referrals. As part of this plan, the MFCU could also assess its outreach efforts and identify ways to improve the volume of fraud referrals from other potential sources, including MCOs.

4. Take steps to improve communication and coordination with OIG investigators and other Federal partners.

The Unit should establish a practice of regular meetings or communication with OIG investigators which should include deconfliction of all cases. Additionally, the Unit should seek opportunities, as appropriate, to pursue joint cases with OIG investigators and the U.S. Attorney's Office, including participating in the Gulf Coast Strike Force.

Compliance with legal requirements

5. Implement processes to ensure that it reports convictions and adverse actions to Federal partners within the appropriate timeframes.

The Unit should take steps to ensure that it reports all convictions to OIG within 30 days of sentencing, or as soon as practicable if the Unit encounters delays in receiving the necessary information from the court, and adverse actions to the NPDB within 30 days of the action. These steps should include developing procedures and expectations for Unit attorneys to provide conviction information in a timely manner to administrative staff, so that the submissions to OIG and the NPDB can be made within appropriate timeframes. The Unit could implement a system of automated reminders, if feasible, to alert attorneys of this time-sensitive responsibility.

6. Revise its MOU with the Mississippi Division of Medicaid to reflect current law.

The Unit should revise its MOU with the DOM to establish procedures by which the Unit will receive referrals of potential fraud from MCOs either directly or through the

DOM. The Unit should also revise its MOU to include the requirement that the Unit and the DOM agree to review and, as necessary, update the MOU no less frequently than every 5 years to ensure that the agreement reflects current law and practice.

7. Repay Federal matching funds spent on cases that were ineligible for Federal funding.

The Unit should work with OIG to identify staff hours and expenditures associated with investigating the ineligible cases and repay those Federal matching funds.

8. Develop a procedure to ensure that it reports all program income properly on its Federal financial reports.

The Unit should develop a process or procedure to ensure that it reports its program income according to Federal regulations. As noted in the finding, the Unit reported the previously unreported program income of $5,734 for FYs 2017 through 2019 and adjusted its costs on its final FFR for FY 2020.

9. Work with the Mississippi Division of Medicaid to ensure the return of the Federal Government's share of all recoveries.

The Unit should work with the DOM to ensure that the Federal share of any penalties, fees, or investigative costs from Medicaid cases is appropriately returned to the Federal government, as it does with Medicaid restitution amounts. Also, the Unit should implement procedures to ensure that the Unit works with the DOM to return the Federal share of the full settlement amount.

Adherence to MFCU performance standards

10. Update its policies and procedures manual to reflect Unit operations and enhance the manual's organization.

The Unit should revise its policies and procedures manual to include current Unit procedures for all Unit operations, including policies and/or procedures for (1) intake of referrals and complaints; (2) supervisory approval to open cases; (3) assignment of cases; (4) periodic supervisory reviews (see also Recommendation 11); and (5) reporting convictions and adverse actions to OIG and the NPDB (see also Recommendation 5). OIG's 2014 report included a similar recommendation. The manual's organization should be enhanced to allow for greater readability and ease of use.

11. Develop written policies and procedures and take other steps to ensure that periodic supervisory reviews are conducted and documented in the case files.

The Unit should develop a written policy(ies) for the frequency of periodic supervisory reviews of case files, for both the investigation and prosecution phase of cases. The Unit should also develop procedures for supervisory review that are clear as to who conducts the supervisory reviews and who is responsible for documenting the reviews in the case management system. The Unit should take steps to ensure that supervisory reviews are conducted and documented, according to the amended procedures. As a step to ensure that Unit supervisors hold periodic supervisory reviews, the Unit could develop and use a system—electronic or otherwise—that reminds supervisors to both conduct and document the reviews. OIG's 2014 report included a similar recommendation regarding the lack of consistent supervisory reviews.

12. Update its training plan to include annual training hours for each professional discipline.

The Unit should revise its training plan to clearly specify the annual number of training hours for each professional discipline and ensure that Unit staff are aware of the training hour requirement for their professional disciplines.

UNIT COMMENTS AND OIG RESPONSE

The Mississippi Unit concurred with 11 of our recommendations and did not concur with 1 recommendation.

The Unit concurred with our first recommendation to examine the Unit's intake process for complaints of patient abuse or neglect and identify improvements. The Unit stated that it had established a new process for reviewing the large number of complaints of patient abuse or neglect received by the Unit and ensuring that those complaints not involving Medicaid are referred to the appropriate office.

The Unit concurred with our second recommendation to take steps to avoid investigative delays and ensure that delays are documented in the case management system. The Unit stated that it has created a new supervisory position to monitor the voluminous number of patient abuse or neglect cases. The Unit stated that it modified its case management system for the purpose of monitoring statute of limitation deadlines. Finally, the Unit stated that it implemented the use of quarterly supervisory reviews in 2020.

The Unit concurred with our third recommendation to develop and implement a plan to increase fraud referrals from the Medicaid agency and other sources. The Unit stated that it had increased its efforts to build partnerships with State and Federal agencies, including OPI, the Medicaid agency program integrity unit. The Unit also stated that it will continue its efforts to hold regular meetings with OPI and managed care organizations, which meetings were interrupted by the pandemic.

The Unit concurred with our fourth recommendation to take steps to improve communication and coordination with OIG investigators and other Federal partners. The Unit stated that, since 2020, it has conducted meetings, both in-person and telephonic, with the USAO. The Unit also stated that it has increased efforts to pursue, when appropriate, joint investigations with OIG investigators and is seeking a Special Assistant United States Attorney designation for a Unit prosecutor.

The Unit concurred with our fifth recommendation to implement processes to ensure that it reports convictions and adverse actions to Federal partners within the appropriate timeframes. The Unit stated that all Unit staff have received training on the procedure for submitting conviction and adverse action information.

The Unit concurred with our sixth recommendation to revise its MOU with the Mississippi Division of Medicaid to reflect current law. The Unit stated that it will modify the MOU to incorporate procedures for receiving referrals from MCOs and will also add a provision to the MOU requiring the parties to review the MOU every 5 years to ensure that it reflects current law and practice.

The Unit concurred with our seventh recommendation to repay Federal matching funds spent on cases that were ineligible for Federal funding. The Unit stated that it will calculate and repay the appropriate Federal funds.

The Unit concurred with our eighth recommendation to develop a procedure to ensure that it reports all program income properly on its Federal financial reports and adjusted its costs to account for previously unreported program income. OIG continues to recommend that the Unit develop a procedure to ensure that future receipts of program income are properly reported.

For the ninth recommendation, that the Unit work with the Mississippi Division of Medicaid to ensure the return of the Federal Government's share of all recoveries, the Unit "acknowledged" the recommendation, but stated that pursuant to *Alabama v. Centers for Medicare & Medicaid Services,* 780 F. Supp. 2d 1219 (M.D. Ala. 2011), it believes that appropriate calculations were made to ensure the return of the Federal Government's share of recoveries. OIG continues to maintain that the Federal Government is entitled to the pro rata share of a State's entire recovery, including penalties, fees, and investigative costs, in accordance with the OIG Policy Transmittal 10-01 and CMS's State Health Official Letter No. 08-004. Those directives require that a State's fraud recoveries, including penalties, fees, and investigative costs, be apportioned between the State and Federal governments on the basis of the applicable FMAP rate. The *Alabama* decision applies to a Federal judicial district that does not include Mississippi, and the CMS policy is supported by other court and administrative decisions.

The Unit concurred with our tenth recommendation to update its policies and procedures manual to reflect Unit operations and enhance the manual's organization. The Unit stated that it is making additions and revisions to its manual.

The Unit concurred with our eleventh recommendation to develop written policies and procedures and take other steps to ensure that periodic supervisory reviews are conducted and documented in the case files. The Unit stated that it will update its manual to reflect the quarterly reviews that have been conducted since 2020.

The Unit concurred with our twelfth recommendation to update its training plan to include annual training hours for each professional discipline. The Unit stated that it will update its manual to specify the training hours for each professional discipline and will track and document annual training requirements for individual staff.

DETAILED METHODOLOGY

Data Collection and Analysis

We collected and analyzed data from the six sources set forth 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. 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

Before the inspection, we reviewed the recertification analysis for FYs 2017 through 2019, which involved examining the Unit's recertification materials, including (1) the annual reports; (2) the Unit director's recertification questionnaires; (3) the Unit's MOU with the State Medicaid agency, Mississippi's DOM; (4) the DOM program integrity director's questionnaires; and (5) the OIG Special Agent in Charge questionnaires. We also reviewed the Unit's policies and procedures manual and the Unit's self-reported case outcomes and referrals included in its annual statistical reports for FYs 2017 through 2019. We examined the recommendations from the 2014 OIG onsite review report and the Unit's implementation of those recommendations.

Review of Unit Financial Documentation

We conducted a limited review of the Unit's control over its fiscal resources. Before the inspection, we analyzed the Unit's response to a questionnaire about internal controls and conducted a desk review of the Unit's financial status reports. We followed up with the Mississippi AGO and Unit officials to clarify issues identified in the questionnaire about internal controls.

Interviews With Key Stakeholders

In March 2020, we interviewed key stakeholders, including officials in the DOM and the U.S. Attorney's office. We also interviewed a manager and a special agent from OIG's Office of Investigations. 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 these interviews to develop subsequent interview questions for Unit management and staff. We also interviewed an official from the MSDH after the inspection.

Interviews With Unit Management and Selected Staff

We conducted structured interviews with the Unit's management and selected staff in August 2020. Of the Unit management, we interviewed the director, the chief investigator, the fraud supervisor, and the Bureau Director II. Of the selected staff, we interviewed one attorney, four investigators, two auditors, and one nurse investigator. In addition, we interviewed the supervisor of the Unit—the Deputy Attorney General of the AGO's Criminal Division. We asked these individuals questions 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; (4) clarification regarding information obtained from other data sources; and (5) the Unit's training and technical assistance needs.

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 2017 through 2019 and include the status of the case; whether the case was criminal, civil, or global; and the dates on which the case was opened and closed, if applicable. The total number of cases was 2,271.

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 Department of Justice and a group of State MFCUs. We excluded 21 global cases, leaving 2,250 case files.

We then selected a simple random sample of 100 cases from the population of 2,250 cases. This sample allowed us to make estimates of the overall percentage of case files with various characteristics with an absolute precision of +/- 10 percent at the 95-percent confidence level. We reviewed the 100 case files for adherence to the relevant performance standards and compliance with statute, regulation, and policy transmittals. During the review of the sampled case files, we consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation.

Review of Unit Submissions to the Office of Inspector General and the National Practitioner Data Bank

We also reviewed all convictions submitted to OIG during the review period so that convicted individuals could be excluded from programs (190) and all adverse actions submitted to the NPDB during the review period (190). 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 2017 through 2019. We also assessed the timeliness of the submissions to OIG and the NPDB.

Review of Unit Operations

Because we conducted the inspection remotely, we were unable to observe the workspace and operations of the Unit's office in Jackson.

APPENDIX A

Unit Referrals by Source for Fiscal Years 2017 Through 2019

	FY 2017		FY 2018		FY 2019		Grand Totals	
Referral Source	**Fraud**	**Abuse or Neglect**	**Fraud**	**Abuse or Neglect**	**Fraud**	**Abuse or Neglect**	**Fraud**	**Abuse or Neglect**
HHS OIG	0		5		7		12	
Law enforcement—other	4		2		3		9	
Licensing board	3		5		2		10	
Managed care organizations	0		0		0		0	
Medicaid agency—PI/SURS[1]	7		2		20		29	
Medicaid agency—other	0		1		0		1	
Private citizen	10		12		10		32	
Provider	9	1,918	15	1,968	8	2,110	32	5,996
Other	7		6		5		18	
Total	**40**	**1,918**	**48**	**1,968**	**55**	**2,110**	**143**	**5,996**
Annual Total	**1,958**		**2,016**		**2,165**		**6,139**	

Source: OIG analysis of Unit Annual Statistical Reports, FYs 2017 Through 2019.

[1] Program Integrity/Surveillance and Utilization Review Subsystem.

APPENDIX B

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

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of All Cases Closed at the Time of Our Review	100	73.0%	63.4%	81.2%
Percentage of All Cases That Had Supervisory Approval To Open	100	98.0%	93.1%	99.8%
Percentage of All Closed Cases That Had Supervisory Approval To Close	73	97.3%	90.6%	99.7%
Percentage of All Cases That Had Significant Unexplained Delays in Investigative Phase	100	18.0%	11.2%	26.8%
Percentage of All Cases Open Longer Than 90 Days	100	83.0%	74.4%	89.6%
Percentage of All Case Files Open Longer Than 90 Days and That Contained at Least One Periodic Supervisory Review	83	85.5%	76.3%	92.2%
Percentage of All Case Files Open Longer Than 90 Days and That Contained Some Periodic Supervisory Review, But Not Quarterly Supervisory Review	71	69.0%	57.1%	79.3%

Source: OIG analysis of Mississippi MFCU case files, 2020.

APPENDIX C

Unit Comments

MEDICAID FRAUD
DIVISION

August 2, 2021

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

Re: *Mississippi Medicaid Fraud Control Unit:*
2020 Inspection for FY 2017-2019, OEI-12-20-00200

Dear Ms. Murrin:

The Mississippi Medicaid Fraud Control Unit is in receipt of your correspondence dated July 2, 2021, enclosing the *Mississippi Medicaid Fraud Control Unit: 2020 Inspection, OEI-12-20-00200.* We thank you and your team for the professionalism and dedication exhibited to improving the Unit during the review period. Working with you and your team was very insightful.

We welcome periodic reviews and the valuable information and findings that allow the Unit to advance and improve. We appreciate the opportunity to respond to the findings reached.

Recommendation 1: *Examine the Unit's intake process for complaints of patient abuse or neglect and identify improvements.*

Response: We concur with the recommendation. The Unit received approximately 5996 complaints of abuse, neglect, and exploitation during the review period under Mississippi's mandatory reporting statute. While the majority of the complaints received originated in a care facility setting, there were some complaints that were determined to have originated in a private home setting after the investigation began. In 2020, with the change in leadership under the new Attorney General,

Lynn Fitch, the Unit increased its review and vetting process in the initial investigation stage to ensure that complaints received involving abuse, neglect, and exploitation occurring in a private home setting, that are not Medicaid related, are referred to the Vulnerable Person's Unit within the Public Integrity Division of the Mississippi Attorney General's Office for investigation. This new review vetting process consists of two staff supervisors and two administrative assistants who work in tandem to ensure eligibility requirements. Cross training among the three administrative assistants was also completed in 2021.

Recommendation 2: Take steps to avoid investigative delays and ensure that delays are documented in the case management system.

Response: We concur with the recommendation. Under the new Attorney General, the Unit has taken additional supervisory oversight steps to ensure proper time tracking of cases is occurring. In 2020, the Unit created the additional supervisory position of Chief Abuse, Neglect, and Exploitation Investigator to specifically monitor and track the voluminous amount of cases to ensure that cases are progressing timely and that the applicable statute of limitations are tracked. The Unit modified the existing case management system to track statute of limitation deadlines with automated alerts. Periodic supervisory reviews were also implemented in 2020 on a quarterly basis.

Recommendation 3: Develop and implement a plan to increase fraud referrals from the Medicaid agency and other sources.

Response: We concur with the recommendation. The Unit has increased its efforts to develop and build partnerships with both State and Federal agencies through continuous and regular communication between the Unit and the DOM's OPI. The 2020 pandemic strained the progress of efforts made holding larger periodic interdisciplinary group meetings for current case discussions and anticipated case referrals.

Historically, the OPI and the Unit conducted monthly "JSUR/S" meetings. These meetings included a data analysis presentation by Medicaid staff of aberrant providers broken down by provider types, procedure codes, etc.... They were scheduled by Medicaid with a calendar invite sent to the Unit staff. These meetings were cancelled by the DOM and never rescheduled. The Unit was also invited to participate in meetings with the OPI and the MCO's to discuss case referrals, but these meetings were cancelled by the DOM and not rescheduled.

a.550 HIGH STREET - 15th FLOOR - ATTN: MFCU - JACKSON, MISSISSIPPI 39201
TELEPHONE (601) 359-4220 - FACSIMILE (601) 359-4214

The Unit will continue to increase its efforts to hold regular meetings on a quarterly basis with the OPI and the MCOs.

Recommendation 4: *Take steps to improve communications and coordinate with OIG investigators and other Federal Partners.*

Response: We concur with the recommendation. Despite the pandemic, since 2020 the Unit has conducted in-person meetings with the U.S. Attorney's Office as well as numerous telephonic meetings. Increased efforts have also been made to pursue, where appropriate, joint investigative cases with OIG investigators. The Unit is in the process of obtaining a USAO SAUSA designation for a Unit prosecutor.

Recommendation 5: *Implement processes to ensure that it reports convictions and adverse actions to Federal partners within the appropriate time frames.*

Response: We concur with the recommendation. Since 2020, under the new Attorney General, all Unit staff, including investigators, prosecutors, and administrative assistants have been retrained in the procedure for submitting disposition documentation to the administrative submission team members within 7 days of court disposition to allow the administrative submission team 23 days to report convictions and adverse actions as required within 30 days. Cross training among the three administrative assistants was also completed in 2021 to ensure all three administrative assistants are capable of submitting convictions and adverse actions to the Federal partners.

Recommendation 6: *Revise its MOU with the Division of Medicaid to reflect current law.*

Response: We concur with the recommendation. The Unit has discussed its current MOU with the DOM regarding referrals of potential fraud from the MCOs and established procedures are incorporated in collateral documents apart from the MOU. The Unit will revise the MOU and incorporate that language.

The Unit will also revise the MOU to reflect an updating provision no less than every 5 years to ensure that the agreement reflects current law and practice.

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TELEPHONE (601) 359-4220 - FACSIMILE (601) 359-4214

Recommendation 7: *Repay Federal matching funds spent on cases that were ineligible for Federal funding.*

Response: We concur with the recommendation. The Unit intends to calculate the appropriate costs and repay the Federal matching funds. The Unit received approximately 5996 complaints of abuse, neglect, and exploitation during the review period under Mississippi's mandatory reporting statute. While the majority of the complaints received originated in a care facility setting, there were some complaints that were determined to have originated in a private home setting after investigation had begun. In 2020 the Unit increased its review and vetting process in the initial investigation stage to ensure that complaints received involving abuse, neglect, and exploitation occurring in a private home setting, that are not Medicaid related, are referred to the Vulnerable Person's Unit within the Public Integrity Division of the Mississippi Attorney General's Office for investigation. This new review vetting process consists of two staff supervisors and two administrative assistants who work in tandem to ensure eligibility requirements. Cross training among the three administrative assistants was also completed in 2021.

Recommendation 8: *Develop a procedure to ensure that it reports all program income properly on its Federal financial reports.*

Response: We concur with the recommendation. The Unit has corrected previously unreported program income of $5,734 for FYs 2017 through 2019 and adjusted its costs on its final FFR for FY 2020.

Recommendation 9: *Work with the Mississippi Division of Medicaid to ensure the return of the Federal Government's share of all recoveries.*

Response: We acknowledge the recommendation, however, pursuant to *Alabama v. Centers for Medicare Medicaid Services*, 780 F.Supp. 2d 1219 (M.D. Ala. 2011), we believe appropriate calculations were made to ensure the return of the Federal Government's share of its rightful recoveries.

Recommendation 10: *Update its policies and procedures manual to reflect Unit operations and enhance the manual's organization.*

Response: We concur with the recommendation. The Unit's Policies and Procedure Manual is currently receiving additional directives, operational updates, and revisions to reflect recent statutory updates, directives of the present administration both as an agency and new divisional management.

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TELEPHONE (601) 359-4220 - FACSIMILE (601) 359-4214

Recommendation 11: *Develop written polices and procedures and take other steps to ensure that periodic supervisory reviews are conducted and documented in the case files.*

Response: We concur with the recommendation. The Unit's Policies and Procedure Manual will include written policies and procedures reflective of the increased periodic supervisory reviews that have been conducted since 2020, under the new Attorney General and Unit leadership, on a quarterly basis and documented in the case files.

Recommendation 12: *Update its training plan to include annual training hours for each professional discipline.*

Response: We concur with the recommendation. The Unit's additions to the Units's Policy and Procedure Manual will address discipline distinction in order to comply with the standards. Individual staff training folders will be implemented to properly track and document annual training requirements.

The Mississippi Attorney General's Office and the Mississippi Medicaid Fraud Control Unit appreciate the opportunity to improve the Unit's effectiveness and efficiency. The insight provided within the report is greatly appreciated and we look forward to our continued partnership.

Sincerely,

Marlin A. Miller
Assistant Attorney General
Medicaid Fraud Control Unit Director

a.550 HIGH STREET - 15th FLOOR - ATTN: MFCU - JACKSON, MISSISSIPPI 39201
TELEPHONE (601) 359-4220 - FACSIMILE (601) 359-4214

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

Susan Burbach of the Medicaid Fraud Policy and Oversight Division served as the team leader for this inspection. Keith Peters of the Medicaid Fraud Policy and Oversight Division also participated in the inspection. Office of Evaluation and Inspections staff who provided support include Kevin Farber and Sara Swisher. OIG staff who provided support include Elizabeth Lohr.

Two agents from the Office of Investigations also participated in the inspection and provided technical assistance to the Unit.

This report was prepared under the direction of Richard Stern, Director of the Medicaid Fraud Policy and Oversight Division.

Contact

To obtain additional information concerning this report, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov. OIG reports and other information can be found on the OIG website at oig.hhs.gov.

Office of Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201

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