

OFFICE OF THE INSPECTOR GENERAL
ANNUAL REPORT

Fiscal Year 2007



**Maryland Department of Health
and Mental Hygiene**

Martin O'Malley, Governor
Anthony G. Brown, Lt. Governor
John M. Colmers, Secretary

Thomas V. Russell, Inspector General

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STATEMENT FROM THE INSPECTOR GENERAL

The Office of the Inspector General (OIG) is pleased to issue our first annual report for the state fiscal year (FY) 2007, which ended June 30, 2007. This report provides an overview of OIG activities and accomplishments, and contains a synopsis of OIG cost avoidance and recoveries.

The OIG is responsible for providing the Secretary of the Department of Health and Mental Hygiene (DHMH) with objective and independent findings, and recommendations to improve program efficiencies and effectiveness. The OIG also investigates potential fraud, waste and abuse against or within Departmental programs.

FY 2007 was a year of transition for the OIG. In April 2006, the Maryland General Assembly passed Senate Bill (SB) 117 that required the Department to consolidate its fraud, waste and abuse efforts under the OIG thereby eliminating overlapping authority. In part, this was accomplished by relocating Medicaid Program Integrity to the OIG. Additionally, the OIG created a task force to review existing law and regulations regarding fraud, waste and abuse. The task force consisted of representatives from the health care provider community, legal counsel, and Departmental staff. Using the administrative authority granted by SB 117, the task force drafted regulations that authorize the OIG to engage in certain activities relating to fraud, waste and abuse in Departmental programs.

In July 2006, the Program Integrity Division was consolidated under the OIG. In May 2007, the OIG underwent an internal reorganization. To better serve the citizens of the State of Maryland and improve programmatic functions, two Assistant Inspectors General and a Program Manager position were formed utilizing existing resources.

Through an interagency work group, the OIG works closely with the Medicaid Fraud Control Unit of the Attorney General's Office and the Department's Medical Care Administration, Office of Health Care Quality, Mental Hygiene Administration, Developmental Disabilities Administration, and Office of the Attorney General. This work group meets bi-weekly to review potential cases and offer expertise in their respective areas to enhance the Department's ability to recover and protect Departmental funds.

Since the OIG cannot accomplish goals in isolation, the OIG conducted numerous presentations to various providers. These presentations stressed the importance of compliance -- encouraging voluntary compliance efforts, and offering assistance to establish internal processes to combat fraud, waste and abuse -- in order to maintain integrity of Departmental programs. We will continue to educate and train providers and contractors to contribute to an increase in cost avoidance and to improve the quality of care.

The OIG will continue to enhance and improve investigations, audits, reviews, and monitoring by investing in its staff and increasing opportunities for their professional development and training. The OIG recently became a member of the National Health Care Anti-Fraud Association and will continue to maintain its membership in the National Association of Inspectors General and the Association of Certified Fraud Examiners to ensure quality standards and principles regarding all OIG functions.

As the OIG begins FY 2008, it is our goal to continue to focus on improved accountability from individuals receiving and providing services on behalf of the Department; to ensure effective management and fiscal controls in the planning and operations of Department programs and services; to increase the number of partnerships with stakeholders; to increase the level of assistance provided to law enforcement agencies in protecting DHMH program resources; and to continue to invest in the training and skill development of DHMH personnel which includes providers, employees, and contractors.

The OIG is committed to its core values of leadership, accountability and integrity in fulfilling its mission and serving the State of Maryland, DHMH, and Maryland citizens.

Thomas V. Russell
Inspector General

ORGANIZATIONAL PROFILE

About the Maryland State Department Of Health and Mental Hygiene

Mission To protect, promote and improve the health and well being of all Maryland citizens in a fiscally responsible way.

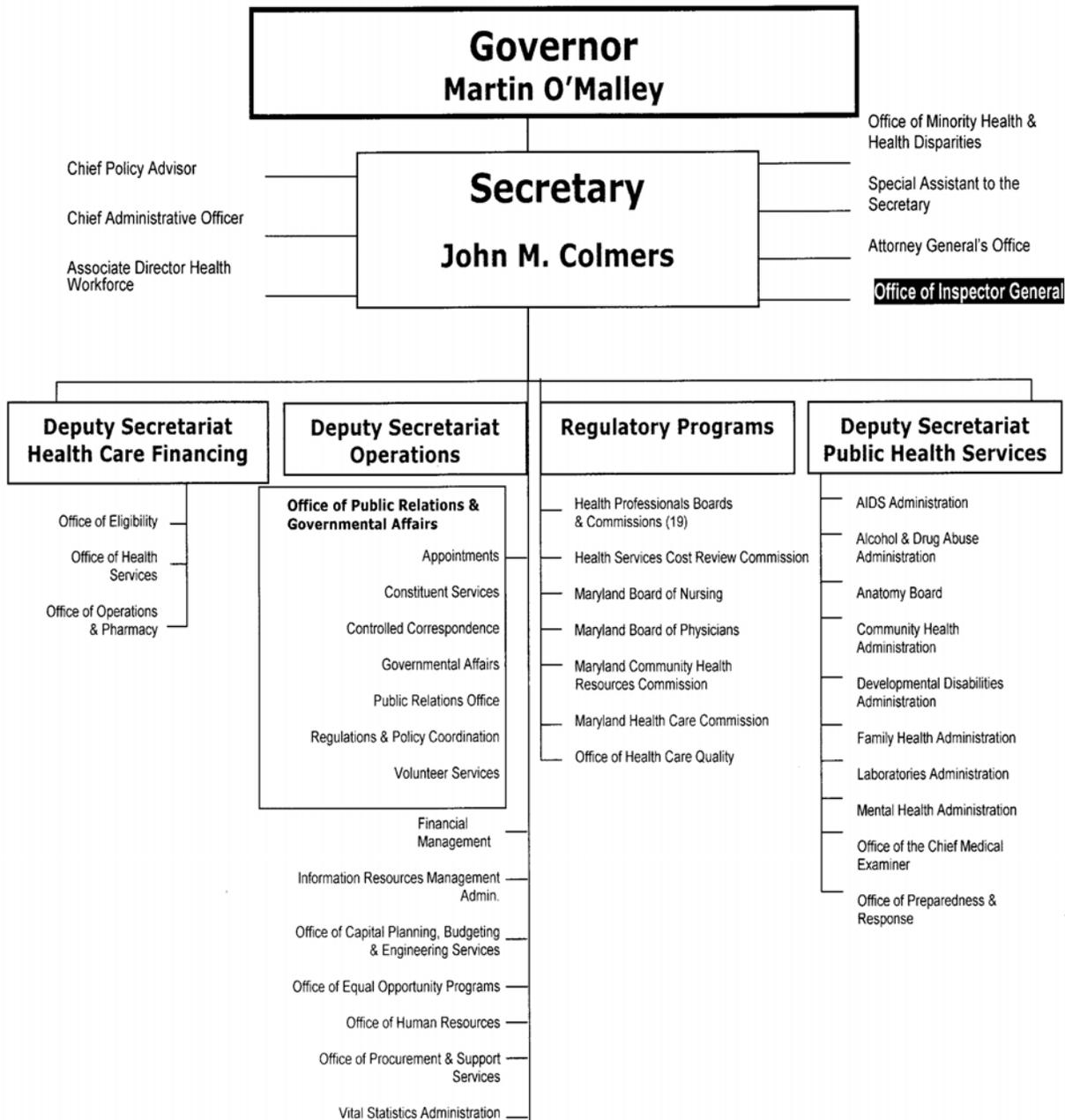
Vision Leading The Way To A Healthy Maryland In The New Millennium.

Principles The principles of the Maryland health care delivery system are to:

- Assure every citizen of Maryland financial and clinical access to health care;
- Provide services at a reasonable cost;
- Maintain the high quality of Maryland's health care system;
- Improve the health status of individuals, emphasis on prevention and early intervention services;
- Assure public accountability through use of reporting criteria such as health status, outcomes, and financial reports;
- Promote sharing of public responsibility costs equitably; and
- Assure long-term financial accountability.

Maryland's health care delivery system consists of public and private hospitals, nursing homes, outpatient clinics, home health care services, hospices, providers (such as physicians, dentists, nurse practitioners, and physician assistants), health educators, other health professionals, and many others. The mission of the Maryland Department of Health and Mental Hygiene touches the life of every citizen of Maryland. The Department is responsible to ensure each Maryland resident can live a life free from the threat of communicable diseases, tainted foods, and dangerous products. The Department also regulates health care providers, facilities, and organizations. In addition, it manages direct services to patients where appropriate. The Department of Health and Mental Hygiene is responsible for assuring that the people of Maryland have appropriate access to high quality health care at a reasonable cost to individuals, employers, and taxpayers. In order to fulfill this responsibility, a number of programs regulate health care providers and community services. Twenty health occupational boards license health care professionals and investigate complaints. In addition, health care facilities and community services are inspected and monitored through the Office of Health Care Quality.

Maryland Department of Health and Mental Hygiene



About The Office Of The Inspector General

| | |
|--------------------|---|
| Mission | To protect the integrity of the DHMH and promote standards that benefit the citizens of Maryland and program beneficiaries. |
| Vision | To be a source of objective, relevant and reliable information in assessing the business practices of DHMH internal and external customers. |
| Core Values | Leadership, Accountability, and Integrity |

Key Products and Services

The primary duties of the OIG are to:

- Perform periodic examinations and follow-up reviews of the accounts, records, procedures, and policies of DHMH administrations, facilities, and Local Health Departments to help safeguard the Department's assets by minimizing various internal control risks, and ascertaining and monitoring corrective actions taken;
- Prevent fraud, waste, and abuse of Departmental funds;
- Ensure the Department and its employees comply with all applicable State and federal law and regulation in its billing practices;
- Ensure that private health information entrusted to the Department is appropriately protected from disclosure;
- Ensure that human subject research funded by the Department is conducted according to State and federal law and regulation; and
- Provide education and training for employees and providers.

Leadership

During FY 2007, the OIG leadership team consisted of:

Thomas V. Russell
Inspector General

Ellwood L. Hall, Jr.
Assistant Inspector General
Division of Audits

Pamela T. Owens, Esq.
Assistant Inspector General
Divisions of Corporate Compliance and Program Integrity

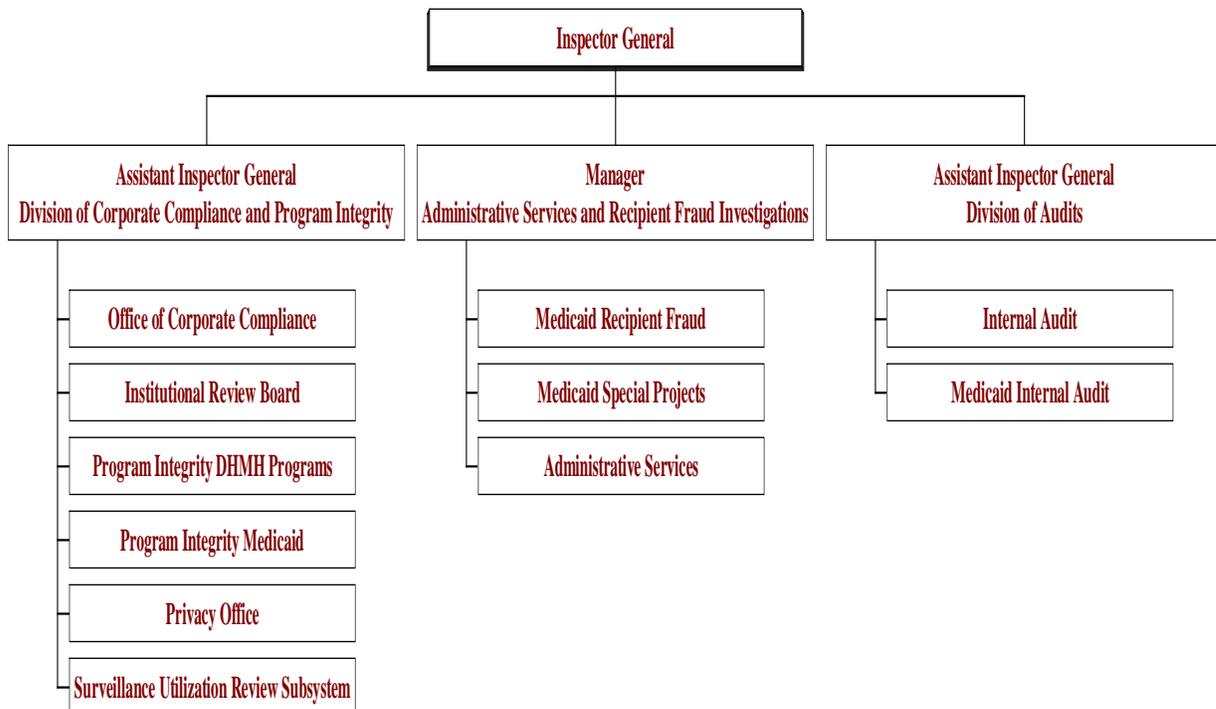
Michael Cuber, C.F.E
Manager
Administrative Services and Recipient Fraud Investigations

Staff Qualifications

During FY 2007, the OIG consisted of 55 professional staff distributed across numerous functional areas represented in the organizational chart illustrated below. As a whole, the OIG staff possesses an extensive level of professional experience in law enforcement, fraud investigation, clinical support, and auditing as well as human subject research. Furthermore, the OIG staff possesses professional credentialing and membership affiliations in a wide array of organizations, as listed below.

- National Association of Certified Fraud Examiners
- Association of Certified Fraud Examiners, Maryland Chapter
- Institute of Internal Auditors
- Certified Public Accountants
- Health Care Compliance Association
- Association of Inspectors General
- Public Responsibility in Research & Medicine

State of Maryland
Department of Health and Mental Hygiene
Office of the Inspector General



Divisions At A Glance

The OIG consists of six major divisions, Audits, Program Integrity, Corporate Compliance/Privacy, Institutional Review Board, Surveillance and Utilization Review, and Administrative Services and Recipient Investigations.

The Audit Division consisted of two units, an Internal Audits Division and a Medicaid Audit Division. Both Divisions perform periodic examinations and follow-up reviews of the accounts, records, procedures, and policies of DHMH administrations, facilities, and Local Health Departments to help safeguard the Department's assets by minimizing various internal control risks, and ascertaining and monitoring corrective actions taken. The Division is also responsible for external audit coordination and coordinating responses to external audit reports. The Division seeks to prepare DHMH units for legislative and federal audits. The Unit accomplishes this by ensuring that DHMH administrations have implemented corrective action that is sufficient to resolve previously cited audit findings, and proactively reviews problem areas to prevent future audit deficiencies. Effective December 2007, the DHMH External Audit Division, which performs audits of human service vendors receiving funding from DHMH Administrations, will come under the OIG and report to the Assistant Inspector General for Audits. This division previously reported to the DHMH Director of Fiscal Services.

The Program Integrity Division is committed to protecting the Department's fiscal resources from fraud, waste, and abuse. During this fiscal year, the Division consisted of two units, *Program Integrity-DHMH Programs* and *Program Integrity-Medicaid*¹. *Program Integrity DHMH Programs* focuses on the activities of providers participating in programs funded through the State. *Program Integrity Medicaid* focuses on the activities of providers participating in the Maryland Medicaid Program.

The Program Integrity Division is composed of auditors, investigators, clinicians, and medical care program specialists. These individuals target areas with a high risk for abuse. To increase its effectiveness, the Program Integrity Division partners with other DHMH Administrations to share information about questionable billing activity. In some cases, the Division conducts joint investigations or may refer certain activities to other regulatory agencies or prosecutorial units.

The Program Integrity Division conducts audits, investigations, and billing reviews of providers who receive payment from DHMH for services provided to Maryland citizens. In general, the Division reviews complaints indicating improper billing practices. Those complaints come from a variety of sources such as DHMH patients and clients, family members of patients and clients, other providers, former employees of a provider, and other State and federal agencies. In addition to reacting to complaints, the Division also receives and reviews information regarding aberrant billing from the Surveillance and Utilization Review System (SURS). The Division also conducts provider outreach and training on issues related to integrity in billing.

¹ In August of 2007, the two Program Integrity units were combined.

The Division of Corporate Compliance is responsible for assuring employees and contractors comply with the Code of Conduct, Corporate Compliance Policy, the Health Insurance Portability and Accountability Act (HIPAA) and other privacy-related laws. It is composed of two units: the Corporate Compliance Unit, and the Privacy Office. In addition to a host of other duties, the Division provides compliance, ethics, and privacy training to employees and contractors.

Compliance Unit

DHMH is committed to being proactive in its efforts to follow the guidelines of the U.S. Department of Health and Human Services, Office of the Inspector General and has therefore established its voluntary Corporate Compliance Program (CCP).

Because DHMH is an entity that submits claims to the federal government for service rendered to recipients enrolled in federally funded health programs, it must maintain effective internal compliance activities under the Federal Sentencing Guidelines. The Division of Corporate Compliance is responsible for ensuring that the Department and its employees comply with pertinent laws and regulations as well as internal policies related to billing practices, and ethical conduct in general. Additionally, the Compliance Unit is responsible for ensuring the Department meets the employee education requirement under the Deficit Reduction Act of 2005.

The Compliance Unit operates a toll-free hotline for employees, contractors, and Maryland citizens to report instances of fraud, waste, abuse, and employee misconduct. Individuals using this hotline may remain anonymous. The Unit conducts investigations into allegations of employee misconduct and assists prosecutorial agencies in prosecuting instances of employee fraud.

Privacy Office

The Privacy Office is responsible for ensuring the Department adheres to State and federal law in its use and disclosure of private health information. The Department is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to designate a Privacy Officer. The individual in this position manages the Privacy Office, as well as, oversees and coordinates a broad range of health information policy, procedures, and program activities for all DHMH business units in compliance to the mandate. This unit provides training on a host of privacy-related issues and assists the covered entities within DHMH in complying with applicable privacy law.

The Institutional Review Board is committed to the protection of human subjects engaged in research. In accordance with federal regulations (45 CFR 46), the Institutional Review Board (IRB) is the unit within DHMH responsible for reviewing research to ensure that the rights, safety, and dignity of human subjects are protected. The IRB was established by the Department in 1977 in response to federal regulations requiring that an organization conducting human subject research with United States Public Health Services funding have that research reviewed and approved by an IRB. Under DHMH policy, the IRB reviews any research protocol involving human subjects: 1) if those subjects are patients or clients of the Department; 2) if the funding for the research project was provided by DHMH; 3) if the investigator is an employee of the Department; or, 4) if the investigator seeks data held by or for the Department. The DHMH IRB reviews approximately 125 new research protocols each year, and as required by federal regulation, conducts continuing reviews of ongoing projects at least once per year. Additionally, the IRB conducts on-site reviews of active research protocols to ensure that approved research is being conducted in the manner in which it was approved.

The Surveillance and Utilization Review Subsystem (SURS) is a subsystem of the Maryland Medicaid Information System. Its function is to develop profiles of health care delivery and utilization patterns of providers. It focuses on finding outlier providers and recipients by using profiling techniques. Profiles are based on user-defined parameters and other guidelines in various categories of service. Program Integrity often develops SURS findings into full billing reviews of a particular provider. However, the SURS Unit also conducts claims analysis and works directly with providers to address findings.

The Division of Administrative Services and Recipient Fraud Investigations is responsible for addressing and facilitating administrative activities on behalf of the OIG with DHMH. Recipient Fraud Investigations Unit is also a component of this unit responsible for responding to referrals submitted by Local Health Departments and Local Department of Social Services and investigating allegations of fraud and abuse by Medicaid recipients of the Maryland Medicaid Program. Furthermore, this unit refers fraud cases to the local States Attorney Offices for prosecutorial review. In addition, this Unit conducts special projects that include functioning as the DHMH point of contact for the resolution of Public Assistance Reporting Information System (PARIS) matches.

HIGHLIGHTS OF FY 2007

Legislative Impact

DEFICIT REDUCTION ACT (DRA) OF 2005

According to the General Accounting Office (GAO), approximately \$300 billion is spent each year to fund the Medicaid program nationally. It is estimated that five percent to eight percent, which translates to \$15 billion to \$24 billion, is lost to fraud and abuse. From 2001 through 2004, the GAO assessed state level Medicaid Integrity efforts and concluded that the funding and staff resources varied. The efforts were considered disproportionately small when weighed against the risk of serious financial loss. Most importantly, the Centers for Medicare and Medicaid Services (CMS) lacked two critical components, (1) the resources required to provide effective oversight, and (2) a strategic plan for its Medicaid fraud and abuse control activities.

With the passage of the Deficit Reduction Act (DRA) of 2005, CMS and the Federal OIG have been put in the forefront of Medicaid fraud and abuse enforcement, that prior was each states' responsibility.

As part of the DRA, Congress mandated creation of the Medicaid Integrity Program (MIP). The Department of Health and Human Services (DHHS) delegated MIP requirements to CMS (traditionally delegated authority over Medicare and Medicaid). CMS hired Medicaid Integrity Contractors to undertake four specific functions, (1) review Medicaid provider actions to determine whether fraud, waste or abuse have occurred; (2) audit Medicaid claims; (3) identify Medicaid overpayments relating to those claims; and (4) educate providers and others regarding payment integrity and quality of care.

Also, the DRA requires the establishment of a Comprehensive Medicaid Integrity Plan for ensuring the integrity of the Medicaid Program and the establishment of a stable funding mechanism for the MIP. Furthermore, the DRA mandates DHHS devote 100 full time employees exclusively to the MIP activities. As part of the five-year plan, the MIP will foster collaboration with the Federal OIG, other federal and state law enforcement, state Medicaid agencies, and the National Association of Medicaid Fraud Control Units.

In response, the DHMH Division of Corporate Compliance instituted a program aimed at meeting the employee education requirement of the DRA. The Division prepared a comprehensive description of the federal False Claims Act and applicable State anti-fraud statutes. This information was included in the Department's Employee Handbook and its Corporate Compliance Policy. An informational component was also added to the new employee orientation program and Local Health Officers and Facilities Managers were instructed on the requirement and the Department's response.

Excerpts from Gary Thompson, "The Other Side of the DRA Coin: The Medicaid Integrity Program and Its Implications for the Health Care Industry," Health Care Fraud Report, Analysis & Perspective, Vol. 11, No. 10, May 9, 2007, pp. 345-346.

MARYLAND SENATE BILL 117 OF 2006

Chapter 70 of the 2006 Maryland Laws, (Senate Bill 117, as amended) - *Department of Health and Mental Hygiene - Office of the Inspector General - Health Program Integrity and Recovery Act* statutorily established the Office of the Inspector General (OIG) within the Department of Health and Mental Hygiene (DHMH or Department).

Chapter 70 codifies the Office of the Inspector General as new Subtitle 5, "Health Program Integrity and Recovery Activities," under Title 2, the organizational title for the Department. The Act gives broad authority to the Inspector General to take necessary steps to recover funds paid to a provider or obtained by a recipient by mistake or through fraud (Health-General § 2-504, Md. Ann. Code). The Act also provides whistleblower protection for employees who report fraud, waste and abuse to the OIG (Health-General § 2-505). In addition, by un-codified language, Chapter 70 requires the Department to:

Establish a task force composed of all interested parties for the purpose of consolidating Departmental authority over fraud, waste, and abuse by reviewing Maryland laws governing the Department, and regulations issued by the Department, to eliminate overlapping and duplicate administrative authority within the Department as a result of establishing the Office of the Inspector General.

DHMH was to report its findings and recommendations to the Senate Finance Committee and the House Health and Government Operations Committee by December 1, 2006. Upon request of the Department, the General Assembly extended this deadline to January 1, 2007.

The OIG convened a task force composed of advocates, representatives from the provider community, and representatives of payer organizations to review existing anti-fraud law and regulation. The group met numerous times throughout the summer of 2006 and examined laws,

regulations and other provisions relied upon by DHMH to combat fraud which demonstrated to be a patchwork of the basic Medicaid Provider Agreement, isolated statutes not structured in the form of modern anti-fraud legislation, and regulations found in various parts of COMAR Title 10. After reviewing the array of existing law and regulation, the task force agreed that a single system for dealing with fraud, waste and abuse of State healthcare dollars at an administrative level was appropriate. DHMH and the OIG explored whether it would be feasible to consolidate its auditing and investigatory procedures under a new COMAR Title 60 covering the Office of the Inspector General. The task force was receptive to this idea and reviewed several preliminary drafts of regulations with that objective in mind. However, after review by the Office of the Attorney General, it was determined that given that certain powers were expressly removed from Senate Bill 117, consolidating legal authority exclusively under one new set of regulations was not possible. Thereafter, the OIG determined that future legislation would be required and planned Departmental legislation for the 2008 session of the Maryland General Assembly.

MARYLAND SENATE BILL 243 OF 2006

To implement the requirements of Senate Bill 243, the Department of Budget and Management, (DBM), has been given the responsibility to monitor the efforts of the Executive Branch's Departmental units to ensure that agencies are effectively resolving audit findings reported by the Office of Legislative Audits, (OLA). To implement this responsibility, DBM has established an audit compliance unit that will work with State agencies to ensure compliance. Senate Bill 243 also requires that any unit that receives five or more repeat audit findings provide to OLA a quarterly status report of corrective actions taken starting nine months from the date of the audit report until the item is cleared by the OLA. In this regard, DBM is also requiring a monthly status report starting the month after the audit report is issued to ensure that the findings have been corrected before reporting results to OLA.

Lastly, under Senate Bill 243, DBM has been requested to evaluate the feasibility of establishing an Inspector General position within the Judiciary and each cabinet-level agency of the Executive Branch for the purpose of conducting internal audits, implementing corrective actions to address audit findings by the OLA and ensuring compliance with applicable laws, rules, and regulations. The DHMH OIG is leading the charge and has already been codified in statute and has already incorporated the Department's internal audit function within the OIG.

Federal Mandate

CMS NATIONAL STANDARDS SURVEY ASSESSMENT

In the initial implementation of the Medicaid Integrity Program (MIP), the Centers for Medicare and Medicaid Services (CMS) hired two contractors, Helix Group, Inc. and Strategic Management System, Inc., to assist in the design and development of audits and support state Medicaid program integrity efforts. In an attempt to identify best practices used by state Medicaid Programs to combat fraud, waste and abuse, CMS requested DHMH participate in the State Program Integrity Assessment Project (SPIA). Maryland was one of nine states requested to participate in the pilot. In January 2007, the CMS contractor, Helix Group met with the management of DHMH OIG Program

Integrity and DHMH Medicaid Management. During the two-day meeting, interviews were held to obtain information on procedures used in conducting Medicaid provider audits and investigations, criteria used in referring cases to Medicaid Fraud Control Unit, initiating recovery actions, provider enrollment, and return on investment for Program Integrity activities.

The results of this assessment were published in the Federal Register in August 2007 for public comment and a final report will be published in December 2007.

PAYMENT ERROR RATE MEASUREMENT (PERM)

The Improper Payments Information Act of 2002 (IPIA), Public Law 107-300, enacted on November 26, 2002, requires the heads of federal agencies to annually review programs under their purview that are susceptible to significant erroneous payments. The objective is to estimate the amount of improper payments, to report those estimates to the Congress, and to submit a report on actions the agency is taking to reduce erroneous expenditures. To implement the requirements of IPIA, CMS developed the Payment Error Rate Measurement (PERM) Initiative. Under PERM, reviews will be conducted in three areas: (1) fee-for-service (FFS), (2) managed care, and (3) program eligibility for both the Medicaid program and State Children's Health Insurance Program (SCHIP).

CMS requires each state Medicaid Program to participate once every three years. Maryland was required to participate in the federal FY 2007 (October 2006 through September 2007) review. A review is conducted of Medicaid payments for accuracy, provider medical records are audited for correct billing and verification that services were performed, and Medicaid and Maryland Children's Health Program records are reviewed for correct eligibility determination.

CMS hired a private contractor to conduct the medical and paid claims reviews. Each state is required to conduct eligibility reviews. CMS mandated the state staff responsible for conducting eligibility or administering the Medicaid eligibility program and state Medicaid Quality Control staff not conduct these reviews.

The Medicaid Chief Operating Officer for DHMH requested the Program Integrity Special Projects Unit of the OIG to conduct the PERM eligibility reviews. In September 2005, the Special Projects Unit participated in the CMS PERM Pilot Project, and therefore, had prior experience conducting such reviews. Each month within FY 2007, the Special Projects Unit selected a random sample of Medicaid and Maryland Children's Health Program cases for review. The projected date for the completion of all PERM review is January 2008.

Excerpts from Centers for Medicare and Medicaid Services, *Fiscal Year 2007 Payment Error Rate Measurement, Verifying Eligibility for Medicaid and SCHIP Benefits*, Version 09/28/06, p. 3.

OIG Consolidation and Reorganization

Prior to July 2006, the Department was performing anti-fraud, waste, and abuse functions in two separate areas, the Office of the Inspector General and the Medicaid Program Integrity Unit. The Office of the Inspector General housed the Division of Internal Audits, the Division of Corporate Compliance, and the State Program Integrity Unit. The Medicaid Program Integrity Unit was located within the Medicaid Office of Planning and Finance. To increase efficiency, eliminate duplication of efforts, improve the Department's fraud, waste, and abuse prevention program, and in response to *Department of Health and Mental Hygiene - Office of the Inspector General - Health Program Integrity and Recovery Act* (Senate Bill 117 of 2006), the Medicaid Program Integrity was relocated to the OIG.

At that time, approximately two-thirds of the Medicaid Program Integrity staff was relocated to the OIG. For approximately nine months, the organizational structure and lines of authority remained the same. However, in May 2007, the OIG reorganized into two major divisions under the leadership of two Assistant Inspectors General (AIG). The AIG responsible for the Division of Audits provides follow-up on all audits conducted by the Office of legislative Audits. As a part of the consolidation, the Medicaid Audit unit, formerly a sub-unit of Medicaid Program Integrity, became part of the Division of Internal Audits. This move provided more independence in reporting and was more in line with auditing guidelines.

The AIG responsible for the Division of Program Integrity and Corporate Compliance manages the Program Integrity-DHMH Programs, Program Integrity-Medicaid, Institutional Review Board, and Corporate Compliance.

OIG ACCOMPLISHMENTS OF FY 2007

Division of Audits Accomplishments

One of the primary functions of the Division of Internal Audits is to coordinate external audits of the Department such as legislative, federal, single state audits, etc. In addition to coordinating and arranging entrance and exit conferences, the Division must also review and approve all audit report responses prior to sign-off by the DHMH Secretary. Unlike most State agencies, DHMH has over 28 audited programs and administrations within the Department to manage and coordinate. Because of this continuous oversight, the Legislative Auditors have a permanent site dedicated for their staff within our Department.

For FY 2007, (see Chart 1) the Legislative auditors completed nine audit reports of DHMH administrations and facilities, one of which was a report on each of the 20 Health Occupations Boards and Commissions. Although more audits were in process, nine were completed and published. These audits rendered over 72 audit findings which breakout into over 144 separate recommendations that must be tracked and reviewed. Findings ranged from not depositing cash timely to missing disaster recovery plans.

In addition to reviewing and approving Legislative Audit Report responses, the Division also coordinated, reviewed and approved audit findings responses for over 13 ongoing or completed federal audits, (see Chart 2). The audits covered topics ranging from “Katrina Relief Programs” to “Medicaid Providers Who Were Delinquent on Federal Taxes”.

Due to the fact that the Department’s multibillion-dollar budget contains a substantial portion of federal dollars, the Department is also subject to a yearly single state audit that assesses the Department’s compliance level with federal laws in its expenditure of the federal dollars received.

Lastly, to follow-up on the corrective actions taken by each administration and facility in resolving its Legislative Audit findings, the Division requires each DHMH unit to submit quarterly status reports of corrective actions taken to resolve its respective audit findings. Chart 3 shows the status of these submissions during FY 2007. Units are not required to submit status reports while they are undergoing a legislative audit, and therefore the completion percentage for that period is marked as not applicable (N/A). One of the goals of the Department’s Managing for Results (MFR) is to reduce the number of repeat audit findings to below 30 percent (see Chart 4). The State average runs from approximately 35 to 45 percent. For the most part, the Department has been successful in reaching its goal of holding repeat findings below 30 percent. For FY 2007, the Department’s average peaked to 42.6 percent in part because of at least four smaller units with only a low number of findings (under four) which were only able to fully implement one finding leaving a 66 percent repeat ratio which skewed the Department’s average.

| CHART 1 MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE LEGISLATIVE AUDITS COMPLETED FOR PERIOD FY 2007 | | | |
|---|----------------------|-----------------------|------------------------------|
| Unit | Report Issued | Total Findings | Total Recommendations |
| Alcohol and Drug Abuse Administration | 12/20/06 | 2 | 6 |
| Clifton T. Perkins Hospital Center | 01/12/07 | 4 | 7 |
| Developmental Disabilities Administration | 05/04/07 | 10 | 19 |
| Laboratories Administration | 10/17/06 | 5 | 8 |
| Medical Care Programs Administration | 07/28/06 | 20 | 40 |
| Professional Health Boards and Commission | 08/23/06 | 12 | 25 |
| Spring Grove Hospital Center | 04/02/07 | 10 | 23 |
| Walter P. Carter Center | 01/01/07 | 3 | 6 |
| Western Maryland Center | 12/22/06 | 6 | 10 |
| Totals | | 72 | 144 |

| CHART 2 MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE LIST OF FEDERAL AUDITS FOR PERIOD FY 2007 |
|---|
| Pending or in Process: |
| Medicare Part D – Calculation of State Phase Down Contribution: OIG |
| Hurricane Katrina Relief Program: OIG |
| Services Provided In Multiple States: OIG |
| Maryland Children’s Health Insurance Program: CMS (Region Three) |
| Medicaid Providers Delinquent on Federal Taxes: GAO |
| Completed: |
| School Based Health Services: OIG |
| Disproportionate Share Hospital (DSH) Payment: CMS (Region Three) |
| Dual Eligible Beneficiaries onto Medicare Part D: GAO |
| Medicaid Beneficiaries Eligible in Two States: OIG |
| Medicaid Drug Expenditures: OIG |
| Contingency Fee Contracts: OIG |
| Administrative Cost Allocation: OIG (#A-03-05-00202) |
| HealthChoice Waiver: CMS (Region Three) #03-FM-2005-MD-01-D |

CHART 3
MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
LEGISLATIVE AUDIT QUARTERLY STATUS REPORT OF COMPLETIONS
FOR PERIOD FY 2007

| Administration/Facility | Period Ending 9/30/2006 | Notes | Period Ending 12/31/2006 | Notes | Period Ending 3/31/2007 | Notes | Period Ending 6/30/2007 | Notes | Number Of Audit Exceptions | Number Of Audit Exceptions Reported Complete |
|--|-------------------------|-------|--------------------------|-------|-------------------------|-------|-------------------------|-------|----------------------------|--|
| AIDS Administration | 75% | | 75% | | N/A | A | N/A | A | 4 | 3 |
| Alcohol and Drug Abuse Administration | N/A | A | 25% | | 50% | | 100% | | 2 | 2 |
| Cigarette Restitution Fund | 75% | | 100% | | 100% | | 100% | | 4 | 4 |
| Clifton T. Perkins Hospital Center | N/A | A | N/A | A | 25% | | 25% | | 4 | 1 |
| Community Health Administration | 100% | | 100% | | 100% | | 100% | | 2 | 2 |
| Deer's Head Hospital Center | 100% | | 100% | | 100% | | 100% | | 2 | 2 |
| Developmental Disabilities Administration | 75% | | N/A | A | N/A | A | N/A | A | 12 | 9 |
| Eastern Shore / Upper Shore | 100% | | 100% | | 100% | | 100% | | 1 | 1 |
| Family Health Administration | 100% | | 100% | | 86% | | 86% | | 7 | 6 |
| Finan & Brandenburg Centers | 100% | | 100% | | 100% | | 100% | | 1 | 1 |
| Health Services Cost Review Commission | 100% | | 100% | | 100% | | 100% | | 1 | 1 |
| Holly Center | 100% | | 100% | | 100% | | 100% | | 1 | 1 |
| Laboratories Administration | N/A | A | N/A | A | 40% | | 40% | | 5 | 2 |
| Maryland Health Care Commission | 100% | | 100% | | 100% | | 100% | | 1 | 1 |
| Medical Care Programs Administration | 50% | | 50% | | N/A | A | N/A | A | 20 | 10 |
| Mental Hygiene Administration | 100% | | 100% | | 100% | | N/A | A | 11 | 11 |
| Office of the Chief Medical Examiner | N/A | B | N/A | B | N/A | B | N/A | B | 0 | N/A |
| Office of the Secretary | 75% | | N/A | A | N/A | A | N/A | A | 20 | 15 |
| Potomac Center | 100% | | 100% | | N/A | A | N/A | A | 1 | 1 |
| RICA – Baltimore | 100% | | 100% | | 100% | | 100% | | 1 | 1 |
| RICA - John L. Gildner | N/A | B | N/A | B | N/A | B | N/A | B | 0 | N/A |
| RICA - Southern Maryland | 0% | | 0% | | 0% | | 50% | | 2 | 1 |
| Rosewood Center | 100% | | 100% | | 100% | | 100% | | 2 | 2 |
| Health Professional Boards & Commission | N/A | A | 33% | | 33% | | 33% | | 12 | 4 |
| Spring Grove Hospital Center | N/A | A | N/A | A | N/A | A | 50% | | 10 | 5 |
| Springfield Hospital Center | 100% | | 100% | | 100% | | 100% | | 5 | 5 |
| Walter P. Carter Center | 75% | | N/A | A | 100% | | 100% | | 3 | 3 |
| Western Maryland Center | 100% | | N/A | A | 50% | | 100% | | 6 | 6 |
| Totals | | | | | | | | | 140 | 98 (70%) |
| <i>A = Undergoing a Legislative Audit - Information based on last quarterly status report prior to audit</i> | | | | | | | | | | |
| <i>B = No Audit Findings</i> | | | | | | | | | | |

| CHART 4 MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE PERCENTAGE OF LEGISLATIVE AUDIT FINDINGS REPEATED FOR PERIOD FY 2007 | | | | | |
|--|---|---|--|---------------------------------|--|
| Unit | Date Legislative Audit Report Issued | Total Findings In Report | Total Prior Findings Repeated | Total Prior Findings | Percentage Of Prior Findings Repeated |
| Alcohol and Drug Abuse Administration | 12/20/06 | 2 | 2 | 3 | 66.7% |
| Clifton T. Perkins Hospital Center | 01/12/07 | 4 | 2 | 4 | 50.0% |
| Developmental Disabilities Administration | 05/04/07 | 10 | 3 | 12 | 25.0% |
| Laboratories Administration | 10/17/06 | 5 | 0 | 3 | 0.0% |
| Medical Care Programs Administration | 07/28/06 | 20 | 8 | 20 | 40.0% |
| Professional Health Boards and Commission | 08/23/06 | 12 | 6 | 9 | 66.7% |
| Spring Grove Hospital Center | 04/02/07 | 10 | 2 | 3 | 66.7% |
| Walter P. Carter Center | 01/08/07 | 3 | 1 | 4 | 25.0% |
| Western Maryland Center | 12/22/06 | 6 | 2 | 3 | 66.7% |
| Totals | | 72 | 26 | 61 | 42.6% |

Division of Corporate Compliance and Program Integrity Accomplishments

The Divisions of Corporate Compliance and Program Integrity receive cases from a variety of sources. Both Divisions maintain a toll-free “hotline” which allows individuals to refer instances of possible fraud, waste, and abuse by employees or providers. Employee misconduct is most often reported by other employees. Reports of provider fraud are often received from recipients, family members of recipients, and other practitioners. Individuals reporting such instances may remain anonymous.

Corporate Compliance Accomplishments

When the Division of Corporate Compliance receives a report of employee fraud, waste, abuse, or misconduct, the Division may refer it directly to the employee’s supervisor or another manager within the employee’s chain of command for review. The Division may also elect to investigate the allegation directly. If the Division elects to review the allegation, it acts only as a fact-finder. The Division issues a report detailing the facts substantiated through the investigation and forwards that report to the employee’s hiring authority. It is the employee’s hiring authority, with the assistance of the DHMH Office of Human Resources, who makes disciplinary decisions. However, in some instances of employee misconduct, the Division is required by Executive Order 01.01.2007.01 to report the conduct to the Criminal Investigative Division of the Office of the Attorney General and to the Office of the Governor.

CHART 5
MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CORPORATE COMPLIANCE CASES
NEWLY OPENED IN FY 2007

| Case Openings By Source | | Case Openings By Complaint Type | | Case Openings By Agency Type | |
|-------------------------|-----------|---------------------------------|-----------|------------------------------|-----------|
| Written | 11 | Misconduct | 18 | Health Care Facility | 11 |
| Telephone | 3 | Fraud | 4 | Administration | 9 |
| Hotline | 3 | Abuse | 1 | Local Health Department | 4 |
| Other | 8 | Other/Not Available | 2 | Board | 1 |
| | | | | Other/Not Available | 0 |
| Total | 25 | Total | 25 | Total | 25 |

CHART 6
MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CORPORATE COMPLIANCE CASES
CASES ACTIVE DURING FY 2007

| Active Cases By Source | | Active Cases By Complaint Type | | Active Cases By Agency Type | |
|------------------------|-----------|--------------------------------|-----------|-----------------------------|-----------|
| Written | 18 | Misconduct | 28 | Administration | 16 |
| Telephone | 6 | Fraud | 12 | Health Care Facility | 16 |
| Hotline | 6 | Abuse | 1 | Local Health Department | 8 |
| Other/Not Available | 15 | Waste | 1 | Board | 2 |
| | | Other/Not Available | 3 | Other/Not Available | 3 |
| Total | 45 | Total | 45 | Total | 45 |

Program Integrity Accomplishments

In addition to the receipt of cases via the hotline, the Division of Program Integrity develops cases through data analysis provided by the SURS Unit. Regardless of the source of the referral, when the Division of Program Integrity receives a report of provider fraud, waste, or abuse, the Division conducts a billing review of the provider. At the conclusion of the review, the Division issues a report to the DHMH program that paid the claims under review. If appropriate, the report recommends to the paying Program that it recover inappropriately paid funds from the provider. However, the Program makes the final determination about whether, and in what amount, funds will be retracted. Additionally, the Program's review may necessitate taking further administrative action against the provider. The Division of Program Integrity also refers certain cases to the Medicaid Fraud Control Unit of the Office of the Attorney General for prosecutorial review.

| CHART 7 MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE PROGRAM INTEGRITY COST AVOIDANCE, RECOVERY AND RETRACTION FINANCIALS FY 2007 COST SAVINGS BY MONTH | |
|--|---------------------|
| Month | Savings |
| July 2006 | \$384,456 |
| August 2006 | 1,247,672 |
| September 2006 | 1,116,379 |
| October 2006 | 220,017 |
| November 2006 | 517,589 |
| December 2006 | 1,991,967 |
| January 2007 | 793,280 |
| February 2007 | 1,769,054 |
| March 2007 | 1,816,564 |
| April 2007 | 1,236,712 |
| May 2007 | 964,811 |
| June 2007 | 5,471,370 |
| Total | \$17,529,871 |

| CHART 8 MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE PROGRAM INTEGRITY – PROVIDER CASES CASES NEWLY OPENED IN FY 2007 | |
|--|------------|
| Case Openings by Opening Reason | |
| Incorrect Billing | 107 |
| Incorrect Procedures Codes | 10 |
| Certification/Credential Problems | 4 |
| Plan of Care/Time Sheets | 4 |
| Up Coding | 3 |
| Other/Not Reported | 37 |
| Total | 165 |

| CHART 9 MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE PROGRAM INTEGRITY – PROVIDER CASES CASES CLOSED IN FY 2007 | |
|--|------------|
| Case Closings by Closing Reason | |
| Case referred to recovery | 47 |
| No fraud determined | 38 |
| Administratively Closed | 33 |
| Unable to substantiate complaint | 8 |
| Case referred to MFCU | 7 |
| Recipient meets Medicaid eligibility | 1 |
| Total | 134 |

MAJOR CORPORATE COMPLIANCE AND PROGRAM INTEGRITY CASES REVIEWED

Caroline County Health Department

In September of 2006, a former employee of the Caroline County Health Department pled guilty to theft in Caroline County Circuit Court for stealing \$35,737.72. This plea was the result of an audit and investigation conducted jointly by the OIG and the Division of External Audits. The investigation revealed the employee diverted cash from the daily deposits received by the health department as a point of service payment and replaced it with a check intercepted from the health department's incoming mail that had not yet been posted to the vendor's account.

Kidney Disease Program

In March of 2007, the OIG received information that the Department's Kidney Disease Program (KDP) might have a fictitious vendor/provider on its rolls. The KDP is a State-funded program that provides services to beneficiaries with end-stage renal disease.

Through interviews, investigation, and data analysis, the OIG determined that \$1,818,912.39 in funds had been diverted from the KDP through a fictitious vendor scheme. An employee of the KDP signed an admission acknowledging her role in the diversion scheme. The Office of the Attorney General (OAG) filed a civil action on behalf of the Department in April 2007. The case has also been referred to the OAG Criminal Investigative Division for prosecutorial review.

Private Duty Nursing Services Agency

The OIG received complaints from several private nursing agencies that another agency was billing the maximum number of units of service allowed by a patient's physician's order regardless of the quantity provided. The OIG conducted a review of the nursing agency's billing and identified numerous instances of over-billing. It also identified instances of missing documentation, billing irregularities for more units than recorded in the nursing notes and on the timesheets, and possible false nursing notes which were referred to the Board of Nursing. These irregularities indicated a lack of internal controls and a lack of adequate quality assurance by the agency. The OIG recommended that the administrative program recover approximately \$212,000. The administrative program sought recovery of the payments. This case was referred to the Medicaid Fraud Control Unit (MFCU) located in the Office of the Attorney General for prosecutorial review.

Autism Waiver Provider

The OIG conducted a billing review of an autism waiver provider to determine whether claims submitted were in accordance with regulation. The review consisted of an examination of the agency's personnel credentials, claims documentation, and a comparison of the claims to the plans of care. The review determined that the agency did not maintain adequate personnel documentation. Generally, the agency failed to adequately provide documentation verifying criminal background checks, employment reference checks, education, credentials, and training. The documentation errors detected were therapeutic integration services that did not meet the minimum four-hour requirement, billed hours rounded up, incorrect billing codes, timesheet irregularities such as date conflicts, billed more hours

than recorded on timesheets, no entries on timesheets, and no technician's name on timesheets. Numerous claims were also billed in excess of the plans of care. The OIG recommended that the program seek recovery for all claims reviewed totaling \$95,996.75. The administrative program sought recovery of the payments and removal of the provider from the program. This case was referred to the MFCU for prosecutorial review.

Older Adults Waiver Provider

The OIG conducted a review of a provider of home support services to older adults under the Older Adult Waiver program. The review consisted of a credential review of the agency's personnel, a review of claims documentation, and a comparison of the claims to the plans of care. The review found that the agency did not maintain adequate personnel files of its staff. Generally, there was no proof of verification of criminal background check, no proof of verification of education, no proof of verification of credentials/degrees/certificates, no proof of verification of the references, and no proof of training. Documentation errors included: missing documentation, partial hours rounded up, billed more hours than recorded on timesheets, no entries on timesheets, billed wrong code, and no technician name on timesheet. Several claims were also billed in excess of the plans of care. The OIG recommended that all of the claims reviewed, totaling \$175,230.56, be recovered. The administrative program sought recovery of the payments and removal of the provider from the program. This case was referred to the MFCU for prosecutorial review.

Administrative Services and Recipient Fraud Investigations Accomplishments

Administrative Services is responsible for addressing and facilitating numerous administrative activities on behalf of the OIG to improve operations while effectively and efficiently managing OIG fiscal resources. On a daily basis, the division interfaces with a variety of internal and external customers in executing personnel actions, procurement and contract management, budget and finance issues, tracking and maintenance of assigned state vehicles, registration of employee trainings, and maintenance of network security access.

Administrative Services Accomplishments

PROCUREMENT, CONTRACTS, AND GRANT AWARDS

Accurint

During FY 2007, the OIG entered into a contract with SEISINT, Inc. to provide the OIG investigators access to a public records database called Accurint. This database service is used to obtain background information on both providers and recipients. Accurint provides information on land ownership, vehicle ownership, estate settlements, criminal records, and professional licenses.

CMS Transitional Grant

With the enactment of the DRA, CMS offered states an opportunity to apply for federal grants to help in identifying ways to reduce Medicaid costs and improve the effectiveness of programs in reducing fraud, waste and abuse. The OIG applied for the CMS Transitional Grant to fund a Fraud Case Management System for Medicaid investigation and reviews. In

February of 2007, CMS awarded a two-year grant to the DHMH OIG to fund a fraud case management system. Immediately upon receiving the grant, the OIG began the request for proposal (RFP) process used to solicit bids and ultimately select a qualified contractor to provide the service as requested.

System Development and Enhancements

During FY 2007, the OIG sought to improve its data collection and reporting capabilities. The consolidation of Medicaid Program Integrity into the OIG presented a new challenge of consolidating four existing data collection and management systems into one. The systems in use were the Recipient Fraud file, two Provider Fraud files, and the Corporate Compliance file. These Microsoft Access databases had been functioning independently. The OIG identified the need to establish a more comprehensive data management system that would allow for improved collection, reporting, and storage capabilities.

Recipient Fraud Investigations Accomplishments

The OIG Recipient Fraud Investigations Unit is charged with the task of conducting investigations into allegations of Medicaid recipient fraud. With the transfer of this unit to the Office of the Inspector General in fiscal year 2007, there were 198 referrals received and 150 cases completed with a cost avoidance and recovery of \$ 1,432,233.

In addition, the Unit delivers outreach training to new workers employed by the Maryland Department of Human Resources, Social Services Administration. Also, Recipient Fraud Investigations has been successful in referring a number of suspected recipient fraud cases to the State's Attorney Offices located throughout the State of Maryland.

| CHART 10 MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE PROGRAM INTEGRITY – RECIPIENT CASES CASES NEWLY OPENED IN FY 2007 | |
|--|------------|
| Case Openings by Allegation | |
| Failed to report current income | 88 |
| Failed to report current family composition | 44 |
| Failed to report current resources | 41 |
| Failed to report current residency status | 16 |
| Failed to provided requested verification | 4 |
| Failed to report change in medical eligibility | 3 |
| Suspicious account activity | 2 |
| Total | 198 |

| CHART 11 MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE PROGRAM INTEGRITY – RECIPIENT CASES CASES CLOSED IN FY 2007 | |
|--|------------|
| Case Closings by Closing Reason | |
| Case referred to Recoveries Division | 81 |
| Referred to appropriate department or agency for resolution | 24 |
| Administratively closed | 16 |
| No fraud determined | 12 |
| Unable to substantiate complaint | 11 |
| Recipient meets Medicaid eligibility criteria | 5 |
| No Loss to the State of Maryland Medical Assistance Program | 1 |
| Total | 150 |

MAJOR RECIPIENT FRAUD INVESTIGATION CASES REVIEWED

Long Term Care Recipients

Case #1: The authorized representative (AR) for a Medical Assistance Long Term Care (LTC) nursing home recipient failed to report that the recipient owned a savings account with a balance of \$81,892.16 which would make them ineligible for Medical Assistance benefits. The AR transferred the assets to herself and her son. The OIG received a referral from the Local Department of Social Services (LDSS) and conducted an investigation into the allegation. The OIG referred the case to the State's Attorney Office for prosecutorial review. The AR was charged with Medicaid fraud, convicted and ordered to make restitution to the State of Maryland through the courts in the amount of \$52,678.75.

Case #2: The AR for a Medical Assistance LTC nursing home recipient failed to report that the recipient owned a home property that was sold for \$265,000.00. The proceeds were transferred to the AR. At the time of application, the AR failed to provide bank account statements, which would have revealed the sale of this property; subsequently, making the recipient ineligible for Medicaid Assistance benefits. The OIG received a referral from the LDSS and conducted an investigation into the allegation. The OIG referred the case to the State's Attorney Office for prosecutorial review. The AR was charged with Medicaid fraud, pled guilty and ordered to make restitution to the State of Maryland through the courts in the amount of \$32,057.67.

Maryland Children's Health Program (MCHP) Recipient

The OIG received a referral from the LDSS to conduct an investigation into the Maryland Children's Health Program (MCHP) eligibility of a recipient. The allegation focused on the applicant's reported household composition and family income at the time of application. The OIG conducted an investigation into the allegation and referred the case to the State's Attorney Office for prosecutorial review. The recipient was charged with Medicaid fraud, pled guilty, sentenced and ordered to make restitution to the State of Maryland through the courts in the amount of \$17,821.96.

Human Resource Development

STAFF PRESENTATIONS

Forming partnerships with our stakeholders and reaching out to the community with information and education is a major focus of the Department and the OIG. During FY 2007, the OIG provided a number of community outreach presentations attended by approximately 350 individuals throughout the State of Maryland. Listed below is a sampling of the groups served.

- Providers of Mental Health Services
- Members of the Health Facilities Administration of Maryland
- Members of the Community Behavioral Health Association
- Providers of Long Term Care Services

CONFERENCES AND TRAININGS

During the FY 2007, the members of the OIG staff attended various conferences and trainings designed to develop and enhance professional skills. Listed below is a sampling of the trainings and conferences attended.

- 17th Annual ACFE Fraud Conference
- Principles of Fraud Examination
- Medicaid Billing for Finance Officers
- Interviewing Techniques for Auditors: Eliciting Information
- Advanced Computer-Aided Fraud Prevention and Detection
- Maryland Chapter of ACFE Annual Fraud Conference
- United Council on Welfare Fraud

In-service Trainings: Following the consolidation of Medicaid Program Integrity under the OIG, it was important to orient the incoming staff to essential elements of the OIG operation. One essential element was the preparation of investigative reports. The OIG utilized a standardized format and style in the drafting OIG investigative reports. The trainings were designed to equip the staff with the skills necessary to produce reports that consistently meet the established requirements of the OIG. During the fiscal year, a total of three trainings were conducted, of which approximately 30 staff members attended.

Certified Fraud Examiners: The Office of the Inspector General is a strong supporter of the Association of Certified Fraud Examiners (ACFE). It is the goal of the OIG to present staff with the opportunity to become Certified Fraud Examiners (CFE). In order to become a Certified Fraud Examiner, a candidate must demonstrate an understanding and possess knowledge in four major areas critical in the fight against fraud. The areas are Fraudulent Financial Transaction, Criminology and Ethic, Legal Elements of Fraud and Fraud Investigation. Persons interested in obtaining certification must pass a test administered by the Association of Certified Fraud Examiners.

Institutional Review Board Conference: Staff of the IRB unit attended a conference co-sponsored by the Federal Office for Human Research Protection. The conference was titled, “Crossing the Line: What is Acceptable Risk?” Attendance at the conference was part of the continuous effort to protect the rights, safety and dignity of participants in human subject research.

Maryland Department of Health and Mental Hygiene
Office of the Inspector General
201 W. Preston Street
Baltimore, Maryland 21201
(410) 767-5784
<http://www.dhmh.state.md.us/oig>