Department of Health and Human Services

Office of Inspector General

Washington Medicaid Fraud Control Unit: 2023 Inspection

Ann Maxwell

Deputy Inspector General for Evaluation and Inspections

June 2024, OEI-09-23-00230

REPORT HIGHLIGHTS

June 2024 | OEI-09-23-00230

Washington Medicaid Fraud Control Unit: 2023 Inspection

Why OIG Did This Review

The Office of Inspector General (OIG) administers the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, annually recertifies each Unit, and oversees the Units' performance in accordance with the requirements of the grant. As part of this oversight, OIG conducts periodic inspections of Units and issues public reports of its findings.

OIG Finding and Observations

- Overall, the Washington MFCU operated in accordance with grant requirements.
- The Unit reported case outcomes of 60 indictments; 28 convictions; 40 civil settlements and judgments; and $63.6 million in recoveries for FYs 2020–2022.
- The Unit cooperated with Federal partners to pursue joint cases.
- The Unit made programmatic recommendations to the State Medicaid agency and provided nonmanagerial staff with extensive training.
- The Unit established a digital forensic laboratory and hired digital forensic investigators to support investigations.
- The Unit did not report all convictions and adverse actions to Federal partners as required and lacked policies and procedures for those processes.

What OIG Recommends

We recommend that the Unit implement new policies and procedures to ensure required reporting of convictions and adverse actions to Federal partners. The Unit concurred with our recommendation.

TABLE OF CONTENTS

BACKGROUND

OBJECTIVE

To examine the performance and operations of the Washington 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]

MFCUs are funded jointly by Federal and State governments. 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) 2022, combined Federal and State expenditures for the MFCUs totaled approximately $343 million, of which approximately $257 million represented Federal funds.[8]

[1] SSA § 1903(q)(3)-(4). 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 2022. The Federal FY 2022 was from October 1, 2021, through September 30, 2022.

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 during 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.[13] OIG reports may also include observations regarding Unit operations and practices, including beneficial practices that may be useful to share with other Units. OIG also provides training and technical assistance to Units, as appropriate, during inspections and reviews.

Washington MFCU

The Washington MFCU (also known as the Medicaid Fraud Control Division) is located within the Washington Office of the Attorney General (AGO) and has offices in Olympia, Seattle, and Spokane. At the end of 2022, the Unit had 55 staff (including the managerial positions in parentheses): 18 investigators (including the Special Agent in Charge), 13 attorneys (including the Unit director and deputy directors for the civil and criminal sections), 13 auditors (including the chief forensic analyst), and 11 other staff (including the grants and operations manager). The Unit had an increase of 15

[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] OIG conducted a previous onsite review of the Washington MFCU in 2016. *Washington State Medicaid Fraud Control Unit: 2016 Onsite Review*, OEI-09-16-00010, September 2016. Accessed at https://oig.hhs.gov/oei/reports/oei-09-16-00010.asp on December 15, 2023.

staff positions in FY 2019, growing to 51 staff from 36 staff in FY 2018.[14] During our review period FYs 2020–2022, the Unit spent $25.7 million (with Washington's share of $6.4 million).

Referrals

During FYs 2020–2022, the Unit reported receiving referrals of potential Medicaid fraud and patient abuse or neglect from a variety of sources. See Appendix A for a list of Unit referrals by source for FYs 2020–2022.

When the Unit receives a referral of suspected fraud, the Unit's intake officer reviews the information and determines whether to send the complaint to Unit management. Unit management will then review the referral to determine whether to (1) open the referral as a case, (2) close the referral, (3) or refer it to another agency. When the Unit receives a referral of patient abuse or neglect, a nurse investigator presents the referral to the Unit management along with their clinical assessment of the potential case. Unit management will then decide whether to open the referral as a case.

Investigations and Prosecutions

Once the Unit opens a case, Unit management assigns the case (or matter) to a team consisting of an attorney; an investigator; a paralegal; and, if needed, an auditor and/or a forensic investigator. In addition, Unit management assigns a nurse to each patient abuse or neglect case. The multidisciplinary team works together to form a plan for the investigation and prosecution of the case, and the team can modify the plan as the case proceeds.[15] In general, the Unit uses a "dual track" process, opening each investigation as a criminal and civil case. The Unit first pursues the investigation as a criminal case, and if appropriate, as a civil case. Investigators participate in periodic supervisory reviews of their caseloads with the Special Agent in Charge.

Once an investigation is complete, the team discusses the case with the MFCU's deputy directors for the criminal or civil sections and Unit director. If the managers determine that the case is ready, the Unit sends to the Washington Attorney General a memo that summarizes the case, requests approval to move forward, and sets forth the charges that should be brought in the case.

Through a memorandum of understanding with the United States Attorney's Office (USAO) for the Eastern District of Washington, a Unit attorney can be designated as a

[14] The State of Washington House Bill (HB) 1109-2019-2020 passed in April 2019 and authorized appropriations for additional staffing and program operations for the Washington MFCU. See pages 24-25 of the HB.

[15] Prior to June 2018 the Washington Legislature had not passed an enabling statute granting Washington MFCU personnel basic law enforcement powers such as issuing search warrants or making arrests. As a result of legislation introduced in SB 6051-2017-2018 (companion Bill HB 2273), Washington passed legislation (effective June 2018) granting MFCU investigators commissioned law enforcement status (see Substitute Senate Bill 6051, e-pages 2-3, and RCW chapter 74.67). The commissioned status is subject to certain requirements, such as those noted at RCW 43.101.200.

Special Assistant United States Attorney (SAUSA).[16] Among other activities, the SAUSA can provide input on charging, investigative, and/or closing decisions.

Washington Medicaid Program

The Washington Medicaid program is administered by the Washington Health Care Authority (HCA) and provides health coverage to enrollees in the program. As of December 2023, total Medicaid enrollment in Washington was almost 1.9 million individuals.[17] And as of FY 2020, Washington's Medicaid expenditures were approximately $14.6 billion.[18] During our review period, five Medicaid managed care organizations (MCOs) operated in the State of Washington. In 2021, 88 percent of Washington Medicaid enrollees received services through these five MCOs.[19]

The State Medicaid Agency's Division of Program Integrity Unit (PIU) is responsible for Medicaid program integrity efforts. The PIU identifies Medicaid fraud through complaints and, when appropriate, refers credible allegations to the MFCU.

Methodology

OIG conducted the inspection of the Washington MFCU in April 2023. Our inspection covered the 3-year period of FYs 2020–2022.

We based our inspection on an analysis of data and information from eight sources: (1) recertification data, case outcome data, and Unit documentation; (2) financial documentation; (3) structured interviews of key stakeholders; (4) structured interviews of Unit management and selected nonmanagerial staff; (5) a survey of Unit nonmanagerial staff; (6) a review of a random sample of case files that were open at any point during the review period; (7) a review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period; and (8) an onsite review of Unit operations. See the detailed methodology on pages 16-18.

In examining the Unit's operations and performance, we applied the published MFCU performance standards, but we did not assess adherence to every performance indicator for every standard.

[16] Memorandum of Understanding between United States Attorney's Office Eastern District of Washington and Washington State Office of the Attorney General, July 20, 2022. See sections I and II(g).

[17] CMS, *August 2023 Medicaid & CHIP Enrollment Data Highlights*. Accessed at Medicaid & CHIP Enrollment Data Highlights | Medicaid on March 27, 2024.

[18] OIG, *MFCU Statistical Data for FY 2020*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2020-statistical-chart.pdf on December 7, 2023.

[19] KFF, *Total Medicaid MCO Enrollment*. Accessed at Total Medicaid MCO Enrollment | KFF on April 8, 2024.

Standards

We conducted this study 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. They are subject to the same internal quality controls as other OIG evaluations, including internal and external peer review.

PERFORMANCE ASSESSMENT

Case Outcomes

The Unit reported 60 indictments; 28 convictions; and 40 civil settlements and judgments for FYs 2020–2022.

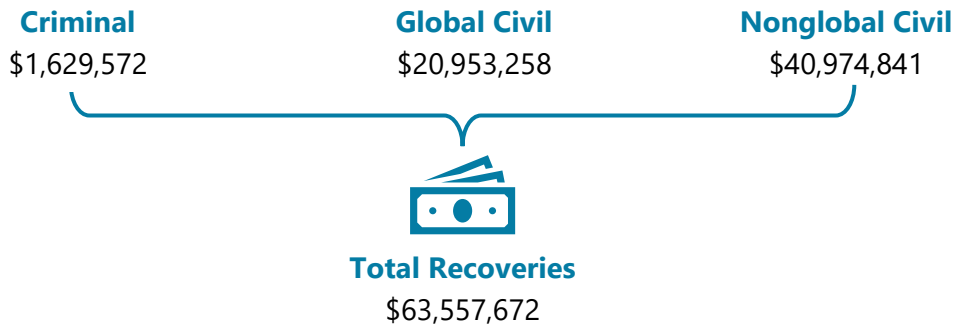
Of the 28 convictions reported by the Unit, 18 involved provider fraud and 10 involved patient abuse or neglect.[20]

60 Indictments

28 Convictions

40 Civil Settlements & Judgments

The Unit reported combined criminal and civil recoveries of $63.6 million for FYs 2020–2022.



Source: OIG analysis of Unit statistical data, FYs 2020–2022.

Notes: "Global" civil recoveries derive from civil settlements or judgments in global cases, which are cases that involve the U.S. Department of Justice and a group of State MFCUs and are facilitated by the National Association of Medicaid Fraud Control Units (NAMFCU). Total recoveries are rounded to the nearest tenth and may not sum exactly due to rounding.

[20] OIG provides information on MFCU operations and outcomes but does not require or otherwise establish specific case outcome thresholds that MFCUs must meet. MFCU investigators and prosecutors should apply professional judgment and discretion in determining what criminal and civil cases to pursue. Of similarly sized MFCUs during the review period, indictments ranged from 14 to 372 with a median of 79; fraud convictions ranged from 23 to 381 with a median of 94; patient abuse or neglect convictions ranged from 1 to 51 with a median of 9; and civil settlements and judgments ranged from 23 to 65 with a median of 53. We defined similarly sized MFCUs as those with staff sizes ranging from 43 to 93 employees in FY 2022. This included 7 MFCUs other than the Washington MFCU. Although comparison across similarly sized MFCUs provides context for the case outcomes of a particular MFCU, many factors other than a MFCU's staff size can affect case outcomes.

In assessing the performance and operations of the Washington MFCU, we 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 MFCU performance standards. We made one finding regarding the Unit's performance and operations, along with one associated recommendation for improvement. We also identified one beneficial practice.

Performance Standard 1: Compliance with Requirements

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

Observation: The Unit was generally in compliance with applicable requirements, with one area of noncompliance.

The area of concern relates to the Unit's reporting of convictions and adverse actions to Federal partners and is addressed under Performance Standard 8 on pages 11-12.

Performance Standard 2: Staffing

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 experienced significant nonmanagerial staff turnover during FYs 2020–2022.

The Unit had up to 54 nonmanagerial staff positions during the 3-year period and experienced the departure of 29 employees during the same period, as shown in Exhibit 1. Further, these positions were vacant on average over 200 days before the Unit hired new staff.[21] Unit management reported that this level of turnover contributed to slowing some case investigations and prosecutions. For example, four of the Unit's nine approved attorney positions had vacancies, thereby delaying some court proceedings, according to Unit management. OIG interviews with nonmanagerial staff and managers suggest that those who departed did so for various reasons, such as to retire, to pursue career advancement opportunities (e.g., Assistant United States Attorney), and for personal reasons. The time and attention focused on hiring, onboarding, and training new staff placed a further strain on the Unit's operations and case progression.

[21] There was turnover of one managerial position during our review period.

Exhibit 1: The Unit experienced turnover of 29 nonmanagerial positions during FYs 2020–2022

Position (nonmanagerial)	Number of vacancies	Average length of vacancies (days)	Highest number of approved positions
Attorney	4	222	9
Investigator	11	206	19
Other staff	10	252	14
Auditors	4	173	12
	Total 29	**Overall Average 220**	**Total 54**

Source: OIG analysis of Unit recertification data, FYs 2020–2022.

Note: In this table, we calculated the total vacancies by counting the number of times during FYs 2020–2022 that a nonmanagerial position became vacant.

Beneficial Practice: The Unit hired digital forensic experts to support investigations.

In May 2019, the Unit established a digital forensic laboratory and thereafter hired three digital forensic investigators. Nonmanagerial staff in the digital forensic laboratory try to work independently from investigative units. They conduct digital investigative activities and provide consultation and factual case testimony on steps such as the identification, examination, and production of electronically stored information. Nonmanagerial staff in the Unit's digital forensics laboratory have also collaborated on investigations with OIG's digital investigative branch.

Performance Standard 3: Policies and Procedures

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

Observation: The Unit did not always close cases in accordance with its policies and procedures.

At the time of our review, 14 percent (12/83) of reviewed case files had notations that the cases were closed, but should have been closed earlier than they were, or were open, but should have been closed. Unit nonmanagerial staff did not close the cases in the case management system as required by the Unit's policies and procedures. As a result, 9 of the 12 cases continued to receive supervisory reviews even after work on those cases had ended. Some of the cases had been closed or inactive for over a year.

Performance Standard 4: Maintaining Adequate Referrals

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

Observation: The Unit took steps to maintain an adequate volume and quality of fraud and patient abuse or neglect referrals.

Consistent with Performance Standard 4, the Unit took steps to encourage fraud referrals from referral sources. The Unit engaged in ongoing outreach efforts and activities with many external partners and reported receiving fraud referrals from a variety of sources. On a monthly basis, Unit managers, analysts, and investigators met with the PIU and other State agencies to discuss the status of specific cases, fraud trends, and potential new referrals, according to the Unit. As a part of regularly scheduled meetings, the Unit sometimes provided training to external partners such as MCOs on the characteristics of a quality referral.

During the review period, the Unit reported receiving 825 fraud referrals and 6,376 patient abuse or neglect referrals. During FYs 2020–2022, the Unit opened 341 fraud cases and 80 patient abuse or neglect cases. See Appendix A for all referral sources and volumes of fraud and patient abuse or neglect referrals.

Performance Standard 5: Maintaining Continuous Case Flow

A Unit takes steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases.

Observation: The COVID-19 public health emergency (COVID-19 PHE) significantly impacted the Unit's operations and case progression; the Unit implemented strategies to mitigate the effects of the PHE on its operations.

In response to the COVID-19 PHE, in March 2020, Washington implemented statewide policies to help contain the spread of the virus. As a result, the Unit's offices were fully or partially closed during much of the COVID-19 PHE, which delayed case flow. For example, early in the PHE investigators could not go onsite to gather evidence and field operations were highly restricted. These restrictions hampered the Unit's ability to develop cases and complete investigations for a time. Further, Unit management reported that criminal and civil court proceedings stopped or substantially slowed because of court closures so they participated in virtual hearings.

The Unit's Special Agent in Charge developed a COVID-19 PHE risk mitigation plan in April 2020; the plan was revised as needed throughout the review period. The plan provided a general framework for conducting investigative activities during the PHE and was tailored to the specific needs of each field operation. The plan included instructions for implementing safety protocols; conducting interviews; collecting and processing evidence; and performing other investigative activities. For example, the plan allowed investigators to conduct interviews outdoors and the Unit offered masks to investigators and interviewees.

The Unit also used virtual platforms to participate in court hearings. The Unit prepared for court hearings by conducting virtual interviews and trial preparation of witnesses and suspects, according to Unit management. The Unit also adapted its search warrant process to obtain evidence remotely and engaged in virtual negotiation presentations and depositions.

Performance Standard 6: Case Mix

A Unit's case mix, as practicable, covers all significant provider types and includes a balance of fraud and, where appropriate, patient abuse and neglect cases.

Observation: The Unit's caseload included both fraud and patient abuse or neglect cases and covered a broad mix of provider types.

Of the cases the Unit had open during our review period, 88 percent (1,278/1,457) were fraud cases and 12 percent (179/1,457) were patient abuse or neglect cases. During this period, the Unit's cases covered 40 different provider types, such as labs, nursing homes, personal care services attendants, and pharmacists.

Performance Standard 7: Maintaining Case Information

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 generally maintained case files in an effective manner, but some practices resulted in inconsistent documentation in the Unit's case tracking system.

At the time of our review, the Unit used an electronic case tracking system to monitor and report case information. Unit staff generally maintained case files in an effective manner; however, while documentation designated some cases as being closed, the Unit did not take the necessary steps to close the cases and the associated case files remained subject to quarterly reviews. Further, the case tracking system contained multiple repositories to store case information, and case information across the repositories was not always consistent. The Unit reported that it purchased a new case tracking system and implemented it in fall 2023. OIG did not review this new case management system because it was implemented after our onsite review.

Performance Standard 8: Cooperation with Federal Authorities on Fraud Cases

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

Observation: The Unit cooperated with Federal partners to pursue joint cases.

The Unit communicated and coordinated on joint health care fraud cases with OIG investigators. Unit management reported meeting monthly with OIG's Special Agent

in Charge to discuss deconfliction and to provide an updated case list. During the review period, the Unit and OIG jointly investigated a total of 29 cases.

The Unit established a strong partnership with the USAO, Eastern District, to jointly investigate and prosecute criminal and civil cases. At the time of the site visit, the Unit had one attorney who worked as a SAUSA within the USAO, Eastern District. The SAUSA collaborated with USAO attorneys on Federal cases that involved or otherwise had a nexus to the State Medicaid program. During the review period, the partnership resulted in 27 individuals being charged, 10 convictions, and about $1.1 million in associated Medicaid recoveries.

In the USAO for the Western District, where over 80 percent of the State's population resides, the Unit had limited collaboration with respect to criminal cases but cooperated on civil cases. Unit management reported that it did not have any joint criminal cases with the USAO, Western District, during the review period. On the other hand, the Unit cooperated with the civil division of the USAO, Western District, jointly investigating 11 civil cases. The Unit is pursuing a stronger partnership on criminal cases with the Western District.

Finding: The Unit did not report all convictions and adverse actions to Federal partners as required and lacked policies and procedures for those processes.

The MFCU did not report all convictions and adverse actions in accordance with Federal requirements. Federal regulations require Units, for the purpose of excluding convicted parties from Federal health care programs, to transmit information on all convictions to OIG within 30 days of sentencing, or "as soon as practicable" if the Unit encountered delays in receiving the necessary information from the court.[22]

We found that the Unit did not report 13 of 28 convictions to OIG as required. In addition, we found that of the 15 convictions that the Unit reported to OIG, 9 convictions were reported more than 30 days after sentencing. Of the nine convictions reported late, four were submitted 31 to 60 days after sentencing; three were submitted between 61 and 90 days after sentencing; and two were submitted more than 90 days after sentencing. Late reporting of convictions to OIG delays the initiation of the program exclusion process, which may result in improper payments to providers by the Medicaid program or other Federal health care programs, as well as possible harm to enrollees.

[22] 42 CFR § 1007.11(g)(3). Also, Performance Standard 8(f) states that Units should transmit information on convictions to OIG within 30 days of sentencing.

The Unit did not report 13 of 28 adverse actions to the NPDB as required.[23] Also, of the 15 adverse actions that the Unit reported to the NPDB, none were reported timely.[24] The Unit submitted one adverse action within 61 to 90 days after the action, and the remaining 14 more than 90 days after the action. The NPDB is intended to restrict physicians, dentists, and other health care practitioners from moving State to State without disclosure or discovery of previous adverse actions.[25] If a Unit fails to report adverse actions to the NPDB, individuals may be able to find new health care employment with an organization that is not aware of the adverse action against them.

Unit management acknowledged that the Unit's policies and procedures did not include these reporting requirements, explaining this was why they did not always report as required. Following the onsite visit, Unit management reported developing policies and procedures to address the conviction and adverse action reporting requirements to Federal partners.

Performance Standard 9: Program Recommendations

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

Observation: The Unit made two programmatic recommendations that the State adopted.

The Unit recommended that the State Medicaid agency review MCO claims to detect whether some health care providers' national provider identifiers (NPIs) were being used to bill for services that were in fact provided by other providers in the same clinic. The State adopted the recommendation and sent out a provider alert clarifying that certified behavior technicians, for example, must be enrolled with Washington's Medicaid program and their NPI must be listed on claims for services provided. The Unit developed this recommendation from its data mining activities.[26]

The Unit also recommended that the State verify that both the prescriber and the pharmacy are enrolled as Medicaid providers when reimbursing for prescription claims. The State adopted this recommendation and modified its system to include a review of provider eligibility. Unit management reported that the recommendation

[23] 45 CFR § 60.5. Examples of final adverse actions include, but are not limited to, health care-related criminal convictions and civil judgments (but not civil settlements), and program exclusions. See SSA § 1128E(a) and (g)(1).

[24] Performance Standard 8(g) states that the Unit should report "qualifying cases to the Healthcare Integrity & Protection Databank [HIPDB], the National Practitioner Data Bank, or successor data bases." The HIPDB and the NPDB merged in 2013; therefore, we reviewed the reporting of adverse actions under NPDB requirements. See 78 Fed. Reg. 20473 (April 5, 2013).

[25] 45 CFR § 60.1. NPDB, *About Us*. Accessed at https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp on April 16, 2024.

[26] Pursuant to 42 CFR § 1007.20, the Unit is approved by OIG to conduct data mining, which allows the Unit to make its own fraud referrals through analysis of Medicaid claims data.

improved the State's ability to detect ineligible providers before issuing payments in error.

Performance Standard 10: Agreement with Medicaid Agency

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

Observation: The Unit's MOU with the State Medicaid agency reflected current practice, policy, and legal requirements.

The MOU between the Unit and the Washington Medicaid agency was signed in November 2019, and it reflects current practices, policies, and legal requirements.

Performance Standard 11: Fiscal Control

A Unit exercises proper fiscal control over its resources.

Observation: We did not identify deficiencies in the Unit's fiscal control of its resources.

From the responses to a detailed fiscal controls questionnaire, we identified no issues related to the Unit's budget process, accounting system, property, or personnel. In our inventory review, we located 30 of the 30 sampled inventory items.

Performance Standard 12: Training

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

Observation: The Unit provided nonmanagerial staff with extensive training.

Unit management made nonmanagerial staff training a priority during its onboarding process and in the continuation of education of all staff. Unit management developed training plans for each staff member; these plans include professional certification, such as nurse licensing and attorney continuing legal education credit hours. Unit nonmanagerial staff reported extensive training opportunities, including widespread access to internal training offered by the Unit or the AGO, and external training offered by entities such as NAMFCU and OIG. Unit management developed cross trainings, which have included participation by local law enforcement, the Drug Enforcement Administration, the Federal Bureau of Investigation, and OIG.

CONCLUSION AND RECOMMENDATION

Overall, the Washington MFCU operated in accordance with grant requirements. The Washington MFCU reported case outcomes of 60 indictments; 28 convictions; 40 civil settlements and judgments; and $63.6 million in recoveries for FYs 2020–2022. We observed that the Unit maintained a strong partnership with OIG and the USAO, Eastern District; made programmatic recommendations to the State Medicaid agency; provided nonmanagerial staff with extensive training; and employed digital forensic experts. However, the Unit did not report all convictions and adverse actions to Federal partners as required and lacked policies and procedures for those processes. Therefore,

We recommend that the Washington MFCU:

Implement new policies and procedures to ensure required reporting of convictions and adverse actions to Federal partners

Unit management acknowledged that the policies and procedures used during the study period did not include these reporting requirements. Following the onsite visit, Unit management reported developing policies and procedures to address the requirement to report convictions and adverse actions to Federal partners. The Unit should fully implement these policies and procedures to ensure that each case meets the requirement to report all convictions to OIG within 30 days of sentencing, or as soon as practicable if the Unit encounters delays in receiving necessary information from the court, and adverse actions to the NPDB within 30 days of the final adverse action date.

UNIT COMMENTS AND OIG RESPONSE

The Washington MFCU concurred with our recommendation to implement new policies and procedures to ensure required reporting of convictions and adverse actions to Federal partners. The Unit reported that it has implemented procedures as part of its Operations Manual following the onsite inspection and revamped its joint case procedures regarding the reporting obligation.

We appreciate the steps the Unit has taken to address the recommendation in the report. We believe that these steps will improve the Unit's adherence to the performance standard and program requirements and will strengthen its operations.

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

DETAILED METHODOLOGY

Data Collection and Analysis

We collected and analyzed data from the eight sources described 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 2020–2022, including (1) the Unit's recertification materials, (2) the Unit director's recertification questionnaires, (3) the Unit's MOU with the State Medicaid agency, (4) the program integrity director's questionnaires, and (5) the OIG Special Agent in Charge questionnaires. We also reviewed the Unit's policies and procedures manuals and the Unit's self-reported case outcomes and referrals included in its annual statistical reports for 2020–2022.

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 reports. We followed up with Unit officials to clarify any issues identified in the questionnaire about internal controls. We also selected a purposive sample of 30 items from the Unit's inventory list of 155 items and verified those items onsite.

Interviews with Key Stakeholders

In March and April 2023, we conducted interviews with key stakeholders, including officials in HCA; five MCOs; OI; and United States Attorney's Offices—Eastern District and Western District. We focused these interviews on the Unit's relationship and interaction with the stakeholders as well as opportunities for improvement.

Onsite Interviews of Unit Management and Selected Nonmanagerial Staff

We conducted structured interviews with the Unit's management and selected nonmanagerial staff in April 2023. Of the Unit's management, we interviewed the director; the Special Agent in Charge; criminal and civil division chiefs; the general counsel; and the chief auditor. In addition, we interviewed the supervisor of the Unit—the Deputy Attorney General of the AGO. The selected Unit nonmanagerial staff were three attorneys, five lead investigators, an auditor, and two other staff. 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.

Survey of Unit Nonmanagerial Staff

In April 2023, we conducted an online survey of 35 Unit nonmanagerial staff members, including investigators, auditors, attorneys, and other staff. Our questions focused on operations of the Unit and investigation and prosecution of MFCU cases.

Onsite Review of Case Files

To craft a sampling frame, we requested that the Unit provide us with a list of cases that were open at any time during FYs 2020–2022 and include the status of each case; whether the case was criminal, civil, nonglobal, or global; and the dates on which the case was opened and closed, if applicable. The total number of cases was 834.

We excluded all global cases from our review of the Unit's case files because global cases are civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a group of State MFCUs. We excluded 390 global cases, leaving 444 nonglobal case files.

We then selected a simple random sample of 86 cases from the population of 271 cases. We removed an additional 3 case files from our sample during our onsite review because they were global cases, leaving 83 case files. We reviewed the 83 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 Unit staff to address any apparent issues with individual case files, such as missing documentation.

Review of Unit Submissions to OIG and the National Practitioner Data Bank

We reviewed all convictions submitted to OIG for program exclusion and all adverse actions submitted to the NPDB during our review period. We reviewed whether the Unit submitted information on all sentenced individuals and entities to OIG for program exclusion and all adverse actions to the NPDB for FYs 2020–2022. We also assessed the timeliness of the submissions to OIG and the NPDB.

Onsite Review of Unit Operations

During the onsite inspection in Olympia, we observed the Unit's operations; offices and meeting spaces; security of data and case files; and location of select equipment.

APPENDICES

Appendix A: Unit Referrals by Source for Fiscal Years 2020–2022

Referral Source	FY 2020		FY 2021		FY2022		3-Year Total		
	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Total
Adult Protective Services	N/A*	2,200	69	1,371	32	242	101	3,813	3,914
Anonymous	7	7	3	3	3	2	13	12	25
HHS-OIG	30	1	30	0	14	2	74	3	77
Licensing Board	4	0	0	0	1	1	5	1	6
Local Prosecutor	0	0	0	0	1	0	1	0	1
Long-Term Care Ombudsman	0	1	0	2	3	4	3	7	10
Managed Care Organizations	15	11	20	1	3	0	38	12	50
Medicaid Agency Other	108	868	55	846	55	559	218	2,273	2,491
Program Integrity Unit	1	0	9	1	7	1	17	2	19
Other	4	46	1	5	2	3	7	54	61
Other Law Enforcement	14	11	6	1	12	4	32	16	48
Private Citizen	84	107	92	23	59	5	235	135	370
Private Health Insurer	1	0	0	0	0	0	1	0	1
Provider	3	12	1	0	0	0	4	12	16
Provider Association	0	3	0	0	1	0	1	3	4
State Agency Other	21	24	34	5	20	4	75	33	108
Subtotal	**292**	**3,291**	**320**	**2,258**	**213**	**827**	**825**	**6,376**	**7,201**
Total	**3,583**		**2,578**		**1,040**		**7,201**		

*Adult Protective Services's FY 2020 fraud referral number includes fraud referrals that should have been screened out for reasons such as lack of jurisdiction. Therefore, we did not include this FY 2020 number because we do not know how many referrals the Unit screened out. The Unit indicated that as of FY 2021, it excluded the referrals that have been screened out for reporting purposes.

Bob Ferguson
ATTORNEY GENERAL OF WASHINGTON
Medicaid Fraud Control Division
PO Box 40114 • Olympia WA 98504-0114 • (360) 586-8888

May 21, 2024

Ann Maxwell
Deputy Inspector General for Evaluation and Inspections
Department of Health and Human Services
Office of Inspector General
Room 5660, Cohen Building,
330 Independence Avenue, SW
Washington, DC 20201

Re: Response to Draft Report OEI 09-23-00230

Dear Deputy Inspector General Maxwell,

The Division concurs with the recommendation that the Division implement new policies and procedures to ensure that convictions and adverse actions are reported to Federal partners within 30 days of sentencing or as soon as practicable as set forth in 42 CFR 1007.11(g)(3). During the inspection, the OIG found delayed reports in cases in which the Division was assisting Federal partners and fellow MFCUs. This was due to the Division's misunderstanding as to which agency was reporting the convictions. In order to ensure accurate and prompt reporting, the Division implemented procedures as part of its Operations Manual following the onsite inspection and revamped its assist procedures regarding the reporting obligation.

Respectfully,

Larissa Payne
Director/Division Chief
Medicaid Fraud Control Division

Enclosures: as

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

Linda Min served as the team leader for this study, and Matt DeFraga served as the lead analyst. Others in the Office of Evaluation and Inspections San Francisco Regional Office who conducted the study include Michelle Goodwin. Medicaid Fraud Policy and Oversight Division staff who participated in the review included Susan Burbach. Office of Evaluation and Inspections headquarters staff who provided support include Rob Gibbons and Sarah Swisher.

We would also like to acknowledge contributions of two special agents from the Office of Investigations, and Sara Bodnar and Lonie Kim from the Office of Counsel to the Inspector General. Sheen Wu, Director of the Oregon MFCU, served as a peer reviewer.

This report was prepared under the direction of Blaine Collins, Regional Inspector General for Evaluation and Inspections in the San Francisco Regional Office, and Michael Henry, Deputy Regional Inspector General, as well as in consultation with 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

ABOUT THE OFFICE OF INSPECTOR GENERAL

Office of Inspector General
https://oig.hhs.gov

The mission of the Office of Inspector General (OIG) is to provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of the people they serve. Established by Public Law No. 95-452, as amended, OIG carries out its mission through audits, investigations, and evaluations conducted by the following operating components:

The Office of Audit Services. OAS provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. The audits examine the performance of HHS programs, funding recipients, and contractors in carrying out their respective responsibilities and provide independent assessments of HHS programs and operations to reduce waste, abuse, and mismanagement.

The Office of Evaluation and Inspections. OEI's national evaluations provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. To promote impact, OEI reports also provide practical recommendations for improving program operations.

The Office of Investigations. OI's criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs and operations often lead to criminal convictions, administrative sanctions, and civil monetary penalties. OI's nationwide network of investigators collaborates with the Department of Justice and other Federal, State, and local law enforcement authorities. OI works with public health entities to minimize adverse patient impacts following enforcement operations. OI also provides security and protection for the Secretary and other senior HHS officials.

The Office of Counsel to the Inspector General. OCIG provides legal advice to OIG on HHS programs and OIG's internal operations. The law office also imposes exclusions and civil monetary penalties, monitors Corporate Integrity Agreements, and represents HHS's interests in False Claims Act cases. In addition, OCIG publishes advisory opinions, compliance program guidance documents, fraud alerts, and other resources regarding compliance considerations, the anti-kickback statute, and other OIG enforcement authorities.