Department of Health and Human Services

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West Virginia Medicaid Fraud Control Unit: 2023 Inspection

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Why OIG Did This Review

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 and observations.

What OIG Found

For the review period FYs 2020-2022, the Unit reported obtaining 37 indictments, 34 convictions, 41 civil settlements, and $75.3 million in recoveries. We observed that the Unit maintained strong working relationships with stakeholders, took steps to ensure continuous case flow, and provided ample training to its staff. We identified several areas in which the Unit should improve its adherence to performance standards or program requirements:

- Some of the Unit's case files were accessible by unauthorized Unit staff.
- Although the Unit's case management system allowed managers to effectively monitor cases, it did not allow for the accurate reporting of Unit performance data to OIG.
- The Unit did not report adverse actions to the National Practitioner Data Bank (NPDB) from 2017 through 2022 and did not consistently report its convictions to OIG for exclusion within the required timeframe.
- Although the Unit reported that it made program recommendations to the State Medicaid agency, it did not adequately monitor the State's response to the Unit's program recommendations.
- The Unit reported retaining certain settlement proceeds rather than working with the Medicaid agency to ensure the appropriate return of the Federal Government's share of those recoveries.

What OIG Recommends

To address the findings, we recommend that the Unit (1) eliminate access to sensitive case material for unauthorized staff; (2) take steps to ensure that its new case management system allows for the accurate reporting of performance data; (3) take steps to report all adverse actions to the NPDB within the required timeframe; (4) take steps to report all convictions to OIG within the required timeframe; (5) implement a method to monitor the State's responses to the Unit's program recommendations; and (6) work with the Bureau of Medicaid Services to ensure the return of the Federal Government's share of all recoveries. The Unit concurred with five of our recommendations and did not concur with one recommendation.

TABLE OF CONTENTS

BACKGROUND

OBJECTIVE

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

Medicaid Fraud Control Units

MFCUs investigate (1) Medicaid provider fraud and (2) patient abuse or neglect 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 enrollees 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 begins on October 1 and ends on September 30 of the following year.

OIG Grant Administration and Oversight of MFCUs

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

West Virginia MFCU

The West Virginia MFCU is located within the State Attorney General's Office (AGO) in Charleston. Prior to FY 2020, the MFCU was located in the West Virginia Department of Health and Human Resources' (DHHR's) Office of Inspector General. In 2019, the West Virginia legislature passed a bill to move the MFCU from DHHR to the AGO.[13] On October 1, 2019, the MFCU transferred to the AGO.

At the time of our onsite inspection in August 2023, the Unit had 22 staff—3 attorneys (including the Unit director and deputy director), 9 investigators (including 2 investigation supervisors), 3 auditors (including the chief auditor), 4 fraud analysts, a nurse analyst, a paralegal, and a case coordinator. Each investigation supervisor supervised a team of investigators, and the chief auditor supervised the auditors and

[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 under "Policy Guidance."

[13] West Virginia Senate Bill 318, March 7, 2019.

three of the four fraud analysts. These supervisors and a senior fraud analyst reported to the Unit's deputy director. During our review period of FYs 2020–2022, the Unit spent approximately $5.1 million, with a State share of approximately $1.27 million.

Referrals

During FYs 2020–2022, the Unit reported receiving Medicaid provider fraud referrals from several sources, including the State Medicaid agency's program integrity unit, managed care organizations (MCOs), and private citizens. The Unit may also receive referrals of patient abuse or neglect from the West Virginia Office of Health Facility Licensure and Certification (OHFLAC) and adult protective services.[14] See Appendix A for a list of Unit referrals by source for FYs 2020–2022.

The investigation supervisors and an attorney (the "intake team") evaluate referrals at the weekly complaint review meeting. During that meeting, the intake team determines whether to (1) open the referral as an active case, (2) pursue the referral as a "preliminary inquiry," (3) forward the referral to another agency with the jurisdiction to pursue it, or (4) close the referral without further action.

The Unit may also generate internal referrals from its own casework or analysis, or through data mining.[15] The Unit's data mining program (run by the senior fraud analyst) generates potential fraud cases through analysis of Medicaid claims data. When a data mining algorithm identifies billing outliers, the senior fraud analyst evaluates the results to determine whether potential fraud cases exist.

Investigations and Prosecutions

The Unit uses a collaborative team approach to investigate cases. Once the Unit opens a case, Unit management assigns an investigator, an attorney, and an auditor or fraud analyst to the investigation team.[16] The Unit may also assign the nurse analyst to a team if medical review of a case is needed. Upon assignment, the investigation team meets to formulize a strategy for the investigation. The investigation supervisors oversee all investigations through periodic supervisory reviews of the Unit's case files and periodic meetings with the team. Upon completion of the investigation, the investigation team meets with Unit management to determine whether to proceed with a criminal or civil prosecution or to close the case if there is insufficient evidence to support prosecution.

[14] OHFLAC is the State survey and certification agency, responsible for investigating maltreatment complaints in West Virginia health care facilities.

[15] Pursuant to 42 CFR § 1007.20, the Unit is approved by OIG to conduct data mining. Data mining is defined as "the practice of electronically sorting Medicaid or other relevant data, including, but not limited to, the use of statistical models and intelligent technologies to uncover patterns and relationships within that data to identify aberrant utilization, billing, or other practices that are potentially fraudulent." 42 CFR § 1007.1.

[16] A fraud analyst conducts analysis of Medicaid claims data and other information relevant to the case.

Although the Unit may investigate Medicaid fraud and patient abuse or neglect cases throughout the State, it does not have Statewide jurisdiction to prosecute those cases, but rather must refer cases to other prosecutorial authorities, such as a county attorney or the U.S. Attorney's Office (USAO). Some West Virginia county attorneys regularly authorize Unit attorneys to prosecute cases in their counties, while other county attorneys prosecute the cases themselves, with Unit staff strictly performing a supporting role. West Virginia does not have a State False Claims Act.

West Virginia Medicaid Program

The West Virginia DHHR's Bureau for Medicaid Services (BMS) administers the State Medicaid program. As of December 2023, the program served approximately 500,000 enrollees.[17] Approximately 87 percent of West Virginia's Medicaid enrollees received services through three MCOs.[18] In FY 2022, West Virginia's Medicaid expenditures were approximately $5.4 billion.[19]

BMS's Office of Program Integrity (OPI) is responsible for Medicaid program integrity efforts. OPI investigates Medicaid potential fraud complaints, including those received from the MCOs, and, when appropriate, refers credible allegations of fraud to the MFCU.

Methodology

OIG conducted an onsite inspection of the West Virginia MFCU in August 2023. Our inspection covered the 3-year period of FYs 2020–2022. We based our inspection on an analysis of data and information from 7 sources: (1) Unit documentation, including a review of recommendations from OIG's 2013 onsite review report and the Unit's implementation of those recommendations; (2) financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with the Unit management and other selected staff; (5) a review of a random sample of 84 case files from the Unit's 386 nonglobal case files that were open at any point during the review period; (6) a review of all convictions submitted to OIG for program exclusion and any adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period; and (7) an onsite review of Unit operations. See the Detailed Methodology on page 21.

[17] CMS, *April 2023 Medicaid & CHIP Enrollment Data Highlights*. Accessed at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html on April 4, 2024.

[18] BMS, *Mountain Health Trust (Managed Care)*. Accessed at https://dhhr.wv.gov/bms/Members/Managed%20Care/Pages/default.aspx on August 28, 2023.

[19] MFCU Statistical Chart for FY 2022. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2022-statistical-chart.pdf on February 29, 2024.

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.

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, but they are subject to the same internal quality controls as are other OIG evaluations, including internal and external peer review.

PERFORMANCE ASSESSMENT

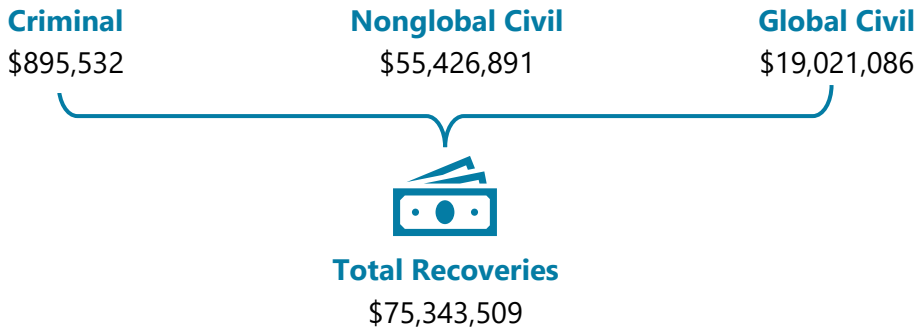
In examining the performance and operations of the West Virginia Unit, we identified the Unit's reported case outcomes; made six findings along with several observations regarding the Unit's performance and operations; and made six recommendations for improvement.

Case Outcomes

The Unit reported 37 indictments, 34 convictions, and 41 civil settlements for FYs 2020–2022.

Of the 34 convictions, 26 involved provider fraud and 8 involved patient abuse or neglect.[20]

The Unit reported total recoveries of more than $75.3 million for FYs 2020–2022.



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

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

Performance Standard 1: Compliance with Requirements

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

Observation: According to the information we reviewed, the West Virginia Unit did not comply with three applicable regulations governing MFCUs.

First, we found that the Unit did not comply with regulations regarding the reporting of case information to the Federal government: The Unit did not report adverse actions to the National Practitioner Data Bank (NPDB) and did not consistently report convictions to OIG for purposes of program exclusion within the required timeframe. We present these two findings under Performance Standard 8. We also identified a concern regarding the security of Unit case files, as explained in the finding below.

Finding: Some of the Unit's case files were accessible by unauthorized Unit staff.

MFCU regulations state that a Unit will guard the privacy rights of all beneficiaries and other individuals whose data are under the Unit's control and will provide adequate safeguards to protect sensitive information and data under the Unit's control.[21] During our case file review, we found that the Unit's case management system did not allow for special designations for sensitive case material, nor did it have the functionality to limit access to that material to specific individuals in the Unit.[22] At the time of our inspection, the Unit was transitioning to a new case management system; AGO management stated that the new system would be able to identify and limit access to sensitive case materials.

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 staff turnover during the review period, which Unit management reported had an impact on investigations.

We found that a total of 18 staff, including 9 investigators, 2 investigation supervisors, the chief investigator, and 2 staff attorneys, left the Unit from FY 2020 to the time of our onsite review.[23] Three investigators and one investigation supervisor left the Unit within 9 months. Unit management reported that the investigator turnover significantly impacted the Unit because of the need to reassign cases to other investigators, who then had to learn about the cases. The investigators also had to manage increased caseloads (the Unit reported that caseloads ranged between 15 to 28 cases per investigator; Unit management indicated that their target was a maximum of 15 cases). However, OIG's review of the Unit's case files did not identify

[21] 42 CFR § 1007.11(f).

[22] No AGO staff outside the MFCU had access to the Unit's case management system with the exception of one AGO staff member who acted as a liaison between the Unit and the AGO.

[23] The Unit was approved for 25 positions during our review period.

significant delays in the investigation phase of cases. According to Unit management and other staff, most of the investigators left for higher-paying jobs in the private sector (for example, a job with an MCO's special investigations unit). The Unit did not report difficulty with hiring staff to replace those staff who left.

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 maintained a policies and procedures manual but did not consistently adhere to two procedures.

Consistent with the Performance Standard, the Unit maintained a policies and procedures manual for its operations and took steps to ensure that Unit staff were familiar with Unit policies and procedures and that staff could access the manual electronically on the Unit's shared drive. However, we found two instances in which the Unit did not consistently adhere to policies and procedures related to required reporting of case information to the NPDB and OIG. These procedures also lacked timeframes for reporting. We address these observations where we discuss the related findings under Performance Standard 8.

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 and patient abuse or neglect referrals from key referral sources during the review period. To encourage fraud referrals, the Unit reported, it had regular meetings with BMS-OPI and with each of the MCOs that operate in the State. During the monthly meeting with OPI, OPI representatives share prospective cases with the Unit and the Unit provides status updates on cases in progress. The Unit also participates in separate monthly meetings with each MCO special investigations unit (SIU) and OPI, during which the MCO discusses cases it has opened as well as potential referrals from the SIUs. The feedback provided by the Unit on these potential referrals during these meetings in part determines whether the SIU forwards a matter to the Unit as a referral.

In addition to these regular meetings, the Unit and the OPI director reported, the two agencies engage in an annual cross-training event. During these training events, Unit staff educate OPI staff on topics such as actions OPI can take to contribute to successful MFCU prosecutions and the adequacy of the volume and quality of OPI referrals. OPI provides technical training to Unit staff on topics such as new BMS technologies and particular aspects of the Medicaid program. The OPI director

reported that the open lines of communication have led to a collaborative working relationship with the Unit.

To increase awareness of the Unit's mission among external entities who may make referrals, the Unit appointed a senior investigator as the "outreach coordinator." The outreach coordinator gave presentations to various external entities around the State that refer fraud and patient abuse and neglect cases to the Unit, such as BMS; OHFLAC; community organizations throughout the State; health care provider groups; aging and disability advocate groups; nursing homes; and sober homes.

During the review period, the Unit reported that it received 529 fraud referrals, of which 38 came from OPI and 8 came directly from MCOs.[24] Of the 46 referrals from OPI and MCOs, the Unit opened 32 as cases. The Unit also received 1,517 patient abuse or neglect referrals during the review period, primarily from OHFLAC, and opened 74 as cases. See Appendix A for all sources of referrals involving fraud and patient abuse or neglect during FYs 2020–2022.

Observation: The Unit generated 19 new cases through its data mining activities during the review period.

The Unit's internal data mining program was another source of fraud referrals during the review period. The Unit has been approved to engage in data mining since 2017. To conduct data mining, the Unit partners with OPI not only to deconflict its data mining activities but also to share the data mining tools provided by OPI's contractor. Specifically, OPI contracts with a company for the provision of data mining software tools and, per the memorandum of understanding (MOU) between the parties, OPI makes the tools and ongoing training available to the MFCU senior fraud analyst, who conducts the Unit's data mining queries. As a result of the Unit's data mining activities during the review period, the Unit reported a significant number of new cases, opening eight cases in FY 2020, five cases in FY 2021, and six cases in FY 2022. The Unit had between 26 and 29 ongoing cases generated from data mining each year during the review period.[25] The Unit reported cumulative recoveries of $229,969 during the review period from cases generated from data mining.

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 Unit took steps to maintain a continuous case flow.

We found that, consistent with Performance Standard 5, the Unit took steps to maintain a continuous flow for its active cases and completed most cases in a timely

[24] The MCOs have been directed by OPI to send referrals to OPI, and then if warranted, OPI sends these referrals to the MFCU. Thus, the Unit received few referrals directly from the MCOs.

[25] The Unit worked a number of cases during our review period that were opened in years prior to our review period.

manner. Our review of case files found that, consistent with Performance Standard 5(b), Unit supervisors approved the opening and closing of all cases and generally conducted periodic case file review according to the timeframe prescribed by the Unit's policies and procedures. Further, we observed that the Unit's investigations were facilitated by a collaboration of subject experts, in which investigators were supported by both a fraud analyst and a nurse analyst, as appropriate for a case.

Finally, to improve the timeliness of its investigations, the Unit obtained evidence in appropriate cases from certain witnesses and suspects using "Requests for Information" ("RFIs"), rather than using a subpoena. Specifically, the Unit used the RFIs to obtain information from enrolled providers on the basis of the provider's obligation contained in the Medicaid enrollment agreement to provide pertinent information to the MFCU in a timely manner.[26]

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 cases both of fraud and of patient abuse or neglect, covering a broad mix of provider types.

Of the 468 cases that were open during FYs 2020–2022, 81 percent (381 cases) involved provider fraud and 19 percent (87 cases) involved patient abuse or neglect. During this period, the Unit's cases covered 37 different provider types, including personal care services attendants; nurses; nursing facilities; and mental health and substance abuse treatment centers.

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.

Finding: Although the Unit's case management system allowed managers to effectively monitor cases, it did not allow for the accurate reporting of Unit performance data to OIG.

Performance Standards 7(e) and 7(f) state that the Unit should have an information management system that manages and tracks case information from initiation to resolution and that allows for the monitoring and reporting of case information. We found that the Unit had an electronic case management system that effectively tracked case progression. Unit managers reported that the system allowed them to run reports, track the Unit's caseload, and monitor the status of cases. However, the case management system did not allow for the accurate reporting of the Unit's annual

[26] The enrollment agreements stipulated that a provider must respond to an RFI within 30 days or be in violation of that agreement.

statistical reporting data to OIG.[27] As a result, the Unit reported inaccurate performance data and had to submit significantly amended annual statistical reports to OIG for FYs 2020–2022.

Unit staff explained that the Unit's case management system could not be adjusted to accommodate the changes to OIG's reporting requirements.[28] As a result, once the Unit moved to the AGO at the start of FY 2020, the Unit began to maintain separate spreadsheets to track case data and certain cases had to be manually tracked.[29] Unit staff explained that a new case management system that would be able to accurately produce performance data was to be implemented. Subsequent to our inspection, the Unit implemented a new case management system in April 2024.

A prior onsite review of the West Virginia MFCU found similar conditions. OIG's 2013 onsite review of the MFCU found the Unit had an inadequate case management tracking system, reported inaccurate recovery data in quarterly statistical reports to OIG (replaced in FY 2015 with annual statistical reporting), and created parallel spreadsheets to compensate for the case management system's inadequacies. In response to the related recommendation, the Unit implemented the current case management system (which we found was still insufficient for reporting).[30]

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 maintained cooperative working relationships with Federal law enforcement partners, including OIG and the U.S. Attorney's Offices.

The Unit consistently cooperated with OIG's Office of Investigations (OI), jointly investigating a total of 23 cases during the review period. Unit and OI staff communicated regularly to share updates and deconflict cases. Unit investigators and OI agents also frequently communicated about investigative activities and coordinated field operations to be conducted jointly.

In addition, the Unit maintained a positive working relationship with the USAOs in the Northern and Southern Districts. USAO staff reported a cooperative working relationship with the Unit's senior fraud analyst, who regularly communicated with USAO staff in both Districts on potential referrals and joint cases. The senior fraud analyst also frequently provided data analysis and interview support for joint cases. In addition, the USAO in the Northern District and the Unit were in the process of

[27] MFCU regulations require the Unit to submit a statistical report for each Federal fiscal year. 42 CFR § 1007.17(a)(2).

[28] OIG's reporting requirements changed in FY 2015 and FY 2023.

[29] The Unit had carried over its case management system from DHHR when it moved to the AGO.

[30] *West Virginia State Medicaid Fraud Control Unit: 2013 Onsite Review* (OEI-07-13-00080) October 4, 2013.

designating the Unit director as a Special Assistant U.S. Attorney (SAUSA). The Unit also participated in the Northern District's health care task force, known as the Mountaineer Task Force; attended meetings of the Appalachian Regional Prescription Opioid (ARPO) Strike Force; provided data on ARPO-related matters to Federal partners; and reported attending subject interviews for some ARPO cases.

Finding: The Unit was not registered with the NPDB and did not report its adverse actions from 2017 through 2022.

Federal regulations require that any adverse actions resulting from investigations or prosecutions of health care providers be reported to the NPDB within 30 days of the final adverse action.[31, 32] However, the Unit was not registered with the NPDB during the 3-year review period and, therefore, did not report any adverse actions to the NPDB. According to NPDB records, the Unit had not reported any adverse actions since approximately 2017.

The Unit's policies and procedures manual addressed procedures for submitting adverse actions to the NDPB, but the Unit did not follow those procedures. The written procedures stated that the investigator provides court records to the staff attorney, and the staff attorney gathers all the court documents and other pertinent information and then provides a package to the paralegal, requesting submission to the NPDB. However, the procedures lacked specificity regarding the required timeframe for submitting the adverse action to the NPDB. See the related observation under Performance Standard 3.

Unit staff stated that there was a misunderstanding about which Unit staff were assigned responsibility to report adverse actions, despite the Unit having written procedures that delineated the responsibility. Also, the Unit reported that the case management system may have been sending reminders about NPDB submissions to individuals not responsible for submissions.

Once OIG notified the Unit in May 2023 that it was not registered with the NPDB and had not been submitting adverse actions to it, the Unit registered with the NPDB and began submitting adverse actions, including all convictions from the review period of FY 2020 though FY 2022. As of February 2024, the Unit reported it had also submitted adverse actions resulting from cases prior to FY 2020.

At the time of our inspection, the Unit reported that it had developed new practices for the submission process. The Unit assigned responsibility for gathering court documents and submitting adverse actions to the NPDB to the Unit's paralegal. The Unit also reported adding automated task reminders in its case management system

[31] 45 CFR § 60.5. Examples of adverse actions include, but are not limited to, health care-related criminal convictions and civil judgments (but not civil settlements), and program exclusions. In addition, Performance Standard 8(g) specifies that the Unit should report qualifying cases to the NPDB.

[32] The NPDB is intended to restrict the ability of physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice and adverse actions. For general information about the NPDB, see https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp#:~:text=The%20National%20Practitioner%20Data%20Bank,practitioners%2C%20providers%2C%20and%20suppliers.

for the paralegal to handle submissions to the NPDB. The Unit's policies and procedures manual had not been updated to reflect these new practices.

Finding: The Unit did not consistently report its convictions to OIG for exclusion within the required timeframe.

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.[33] During the review period, the Unit did not submit 32 percent of its convictions (11 of 34) to OIG within the 30-day timeframe.[34] According to Unit staff and OIG analysis, the late submissions were primarily the result of internal control issues, and occasionally also the result of delays in receiving the necessary documents from the courts.

The Unit had written policies and procedures on preparing to submit convictions to OIG, but the procedures were not consistently followed and did not specify timeframes for preparing the submissions and submitting them. The Unit's written procedures directed investigators to provide court records to the staff attorney, and the staff attorney to gather the court documents and provide a package to the paralegal for submission to OIG. However, this procedure in many cases was not followed by Unit staff, and this led to delays in submissions. Further, the procedures did not specifically address that the submissions were to be made within 30 days of sentencing or as soon as the Unit received the necessary court documents if there were delays in receiving them (see the related observation under Performance Standard 3).

At the time of our inspection, the Unit director and other staff reported that the Unit had taken steps to improve its reporting of convictions to OIG. The Unit provided training for staff on the exclusions process. The Unit reported, at the time of our review, that its paralegal had begun to receive automated task reminders to help ensure that the Unit makes timely submissions to OIG. The Unit also reported that the Unit's case closure checklist now cannot be closed until the exclusions (and NPDB) information has been submitted.

OIG's 2013 onsite review also found that the Unit did not consistently report convictions to OIG within the required timeframe, finding that "in 10 of 20 instances, the Unit sent the referral more than 30 days after sentencing." The Unit director at the time of the review attributed those delays in reporting to county "prosecutors not reporting back to the Unit regarding the disposition of cases."[35] The director did not attribute delays in reporting to OIG to internal control issues.

[33] 42 CFR § 1007.11(g). Also, Performance Standard 8(f) states that Units should transmit convictions to OIG within 30 days of sentencing.

[34] Of the 11 submissions made after the 30-day timeframe, the Unit submitted 4 convictions within 31-60 days of sentencing, 4 within 61-90 days of sentencing, and 3 over 90 days after sentencing.

[35] *West Virginia State Medicaid Fraud Control Unit: 2013 Onsite Review* (OEI-07-13-00080) October 4, 2013.

Performance Standard 9: Program Recommendations

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

Finding: Although the Unit reported that it made program recommendations to the State Medicaid agency, it did not adequately monitor the State's response to those recommendations.

Performance Standard 9(b) states that the Unit should make program recommendations, when warranted, to the State government and should monitor State actions in response to those recommendations. The Unit reported that it made four program recommendations to BMS during the review period. However, the Unit did not monitor the State response to those recommendations and could not locate paperwork associated with the recommendations, including the official written recommendations to BMS. The Unit director explained that three of the four recommendations were made by the previous director, but the Unit could not locate information regarding those recommendations or their status. The director reported making one of the four recommendations during his tenure as director in 2022, but he was unable to locate documentation related to that recommendation. The director recalled discussing this recommendation with the OPI director in telephone calls and during a monthly OPI meeting, and his recollection was that action had not been taken by BMS to address the recommendation.

Observation: The Unit drafted a statutory recommendation to the State legislature during our review period.

Performance Standard 9(a) states that the Unit, when warranted, should make statutory recommendations to the State legislature to improve the operations of the Unit, including amendments to the enforcement provisions of the State code. The Unit drafted a statutory recommendation to the State legislature that would facilitate charging patient abuse or neglect defendants with a felony, as opposed to a misdemeanor, in certain circumstances. According to the Unit, West Virginia's statute that addresses the abuse and neglect of incapacitated adults contains language addressing intent ("maliciously") that makes it difficult to prosecute providers for an abuse or neglect felony.[36] The Unit's recommendation would remove this language (which, according to the Unit, is not present in the State's child abuse and neglect statute) and therefore improve the MFCU's ability to protect the State's vulnerable citizens. A bill to this effect was introduced in the State legislature in February 2024.[37]

[36] WV Code § 61-2-29 and 61-2-29a.

[37] S.B. 821, 2024 Reg. Sess. (W. Va. 2024).

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 BMS was amended and executed in June 2023 and reflected current practice, policy, and legal requirements.

Performance Standard 11: Fiscal Control

A Unit exercises proper fiscal control over Unit resources.

Observation: From our limited review, we identified no significant deficiencies in the Unit's fiscal control of its resources.

From the Unit's responses to a detailed fiscal controls questionnaire and from follow-up with fiscal staff and Unit officials, we identified no significant issues related to the Unit's budget process, accounting system, cash management, procurement, property, or personnel. In our inventory review, we located 30 of the 30 sampled inventory items.

Finding: The Unit reported retaining certain settlement proceeds rather than working with the State Medicaid agency to ensure the appropriate return of the Federal Government's share of those recoveries.

Per Section 1903(d) of the SSA and Centers for Medicare & Medicaid Services (CMS) policy, amounts recovered by a State through a State false claims action or other State action must be refunded at the Federal Medical Assistance Percentage (FMAP) rate.[38, 39] The State Medicaid agency is responsible for returning the Federal share of those recoveries to the Federal Government. The Unit reported submitting all settlement proceeds identified as Medicaid restitution (the overpayment amount) to BMS, as required. However, contrary to the CMS requirements, the Unit retained additional civil settlement recoveries, including the full amounts of penalties, fees, or investigative costs. These additional funds were directly deposited into a special fund for purposes of funding the State match requirement for the MFCU, rather than these

[38] CMS State Health Official (SHO) Letter No. 08-004. Accessed at https://www.medicaid.gov/federal-policy-guidance/downloads/SHO08004.pdf on July 2, 2024.

[39] Also see OIG State Fraud Policy Transmittal No. 10-01, Program Income, which references the CMS policy statement outlined in SHO Letter No. 08-004. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/policy_transmittals/2010-1%20State%20Fraud%20Policy%20Transmittal%20Number%2010-01%20Program%20Income%203-22-2010.pdf on November 9, 2023.

amounts being returned to BMS for calculation of the FMAP and return of funds to the Federal government.[40]

Performance Standard 12: Training

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

Observation: The Unit maintained training plans for its staff and staff had access to ample training.

Performance Standards 12(a) and 12(b) state that the Unit should maintain a training plan for each professional discipline and that the Unit should ensure that professional staff comply with their training plans and maintain records of this compliance. We found that the Unit maintained a training plan that included annual training hours for professional staff and that staff generally met or exceeded those requirements. Professional staff attended training that aided in the Unit's mission, including training provided by the National Association of Medicaid Fraud Control Units. Unit staff reported that they had plentiful training opportunities, and that Unit management was supportive of staff attending outside trainings identified by staff, as appropriate.

Observation: A senior investigator served as the Unit's training coordinator and developed a training checklist for newly hired staff.

The Unit appointed one of its senior investigators as a "training coordinator" who was responsible for onboarding new staff. The training coordinator developed a training checklist for newly hired staff to ensure that those staff received all the training necessary to understand the Unit's operations. An example of the onboarding training is that newly hired investigators shadowed experienced investigators during investigations.

[40] The funds were deposited into the Medicaid Fraud Control Unit Special Revenue Fund.

CONCLUSION AND RECOMMENDATIONS

The West Virginia MFCU reported case outcomes of 37 indictments, 34 convictions, 41 civil settlements, and approximately $75.3 million in recoveries for FYs 2020–2022. From the information we reviewed, we observed that the Unit maintained strong working relationships with stakeholders, took steps to ensure continuous case flow, and provided ample training to its staff. However, we identified six areas in which the Unit should improve its adherence to performance standards or program requirements.

First, we found that some of the Unit's case files were accessible by unauthorized Unit staff. Second, we found that the Unit's case file management system did not allow for the accurate reporting of Unit performance data to OIG. Third, we found that the Unit was not registered with the NPDB and did not report adverse actions during our review period. Fourth, we found that the Unit did not consistently report convictions to OIG for the purpose of program exclusion in a timely manner. Fifth, we found that the Unit did not adequately monitor the State's response to program recommendations made by the Unit. Finally, we found that the Unit improperly retained certain settlement funds.

To address the findings identified in this report,

We recommend that the West Virginia Unit:

Eliminate access to sensitive case material for unauthorized staff

At the time of our inspection, we found that the Unit's case management system did not allow for special designations for sensitive case material, nor did it have the functionality to limit access to that material to specific individuals in the Unit. In April 2024, the Unit reported that it implemented a new case management system. In accordance with appropriate State and Federal requirements, the Unit should develop policies and procedures for the new system to ensure that sensitive case material is labeled and that access to that case material is restricted to authorized Unit staff.

Take steps to ensure that its new case management system allows for the accurate reporting of performance data

At the time of our inspection, we found that the Unit's case management system did not allow for the accurate reporting of Unit performance data to OIG. In April 2024, the Unit reported that it implemented a new case management system. The Unit should ensure that the new system can manage and track case information from initiation to resolution of the case, and if necessary, work with developers to tailor the

system to meet all the Unit's tracking and reporting needs. The Unit should also confirm that the performance data generated by the new system and submitted to OIG are accurate.

Take steps to report adverse actions to the NPDB within the required timeframe

We found that the Unit was not registered with the NPDB and did not report adverse actions during our review period. Although the Unit registered with the NPDB and submitted its convictions from the review period and for current convictions, additional action is needed to ensure required reporting. The Unit should also update its policies and procedures to formalize the Unit's updated practices and to include timeframes for reporting to the NPDB. The Unit should also develop and implement quality assurance methods to ensure that staff adhere to the procedures for making timely submissions. With its transition to the new case management system, the Unit should continue its use of automated reminders to alert the appropriate staff who are assigned responsibility for submitting information to the NPDB.

Take steps to report all convictions to OIG within the required timeframe

The Unit did not consistently report its convictions to OIG for exclusion within the required timeframe. Unit management reported taking action to make improvements to this process, but additional steps are needed to ensure reporting of all convictions to OIG within 30 days of sentencing, or as soon as practicable if the Unit encounters delays in receiving the necessary information from the courts. The Unit should update its policies and procedures to formalize the Unit's updated practices and to include internal timeframes to ensure timely reporting. The Unit should also develop and implement quality assurance methods to ensure that staff adhere to the procedures.

Implement a method to monitor the State's responses to the Unit's program recommendations

We found that the Unit did not adequately monitor the State's response to program recommendations made by the Unit. The Unit should implement a method to track its program recommendations. Tracking could include archiving documentation related to program recommendations, including State responses the Unit receives in writing or verbally.

Work with the Bureau of Medicaid Services to ensure the return of the Federal Government's share of all recoveries

We found that the Unit returned Medicaid restitution (overpayment) amounts to BMS but improperly retained certain settlement funds. Per Section 1903(d) of the SSA and CMS policy, the Unit should work with BMS to return the Federal share of all recoveries—including additional damages, penalties, fees, or investigative costs. Also, the Unit should update its policies and procedures to ensure that it will return all settlement recoveries to BMS on future settlements.

UNIT COMMENTS AND OIG RESPONSE

The West Virginia Unit concurred with five of our recommendations and did not concur with one recommendation.

The Unit concurred with our recommendation to eliminate access to sensitive case material for unauthorized staff. The Unit reported it implemented a new case management system that allows for special designations for sensitive case materials and possesses the functionality to limit access to those materials to authorized Unit staff.

The Unit concurred with our recommendation to take steps to ensure that its new case management system allows for the accurate reporting of performance data. The Unit reported that the new case management system and implementation of quality assurance procedures enables the Unit to produce accurate performance data.

The Unit concurred with our recommendation to take steps to report adverse actions to the NPDB within the required timeframe. The Unit reported amending its policies and procedures manual to provide greater clarity on the processes that Unit staff must follow in submitting information to the NDPB. The Unit also reported creating quality assurance procedures to ensure that staff adhere to the processes.

The Unit concurred with our recommendation to take steps to report all convictions to OIG within the required timeframe. The Unit reported amending its policies and procedures manual to provide greater clarity on the processes that Unit staff must follow in submitting information to OIG. The Unit also reported creating quality assurance procedures to ensure that staff adhere to the processes.

The Unit concurred with our recommendation to implement a method to monitor the State's responses to the Unit's program recommendations. The Unit reported updating its policies and procedures manual to ensure that it adequately monitors the State's response. Specifically, the Unit reported requiring that its recommendations to the State be put in writing and archived in folders on the Unit's shared drive. The Unit also reported creating a a spreadsheet to track follow-up communications with the State and saving it in a folder on the Unit's shared drive.

The Unit did not concur with our recommendation to work with the Bureau of Medicaid Services to ensure the return of the Federal Government's share of all recoveries. The Unit disagreed that "additional recoveries" beyond restitution constitute "overpayments" of which the Federal Government is entitled to receive a proportionate share at the FMAP rate. The Unit based its nonconcurrence, in part, on the decision issued in *Alabama v. Centers for Medicare & Medicaid Services*, 780 F. Supp. 2d 1219 (M.D. Ala. 2011), *aff'd* 674 F.3d 1241 (11th Cir. 2012).

However, as discussed in the finding and associated recommendation, the Federal Government is entitled to the pro rata share of a State's entire recovery, including

penalties, fees, and investigative costs, in accordance with Section 1903(d) of the Social Security Act, as applied by CMS's State Health Official Letter No. 08-004, and referenced in OIG Policy Transmittal 10-01. The *Alabama* decision vacated the State Health Official Letter on procedural grounds but did not contain any holding interpreting Section 1903(d) to the contrary. Further, the decision is not binding in West Virginia. We therefore continue to recommend that the Unit work with the Bureau of Medicaid Services to ensure the return of the Federal Government's share of all recoveries and amend its policies and procedures to align with Federal requirements governing amounts recovered by a State through a State false claims action or other State action.

We appreciate the steps the Unit has taken to address the recommendations in the report. We believe that these steps will improve the Unit's adherence to the performance standards 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 seven sources described below to examine the performance and operations of the Unit, as well as to identify any opportunities for improvement and instances in which the Unit did not adhere to the MFCU 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 onsite inspection, we reviewed the recertification materials for FYs 2020–2022, including (1) the Unit's recertification questionnaires, (2) the Unit's MOU with BMS, (3) the BMS-OPI program integrity unit questionnaires, and (4) the OIG Special Agent in Charge questionnaires. We also reviewed the Unit's policies and procedures manual and the Unit's self-reported case outcomes and referrals included in its annual statistical reports for FYs 2020–2022. Additionally, we examined the recommendations from the 2013 OIG onsite review report and the Unit's implementation of those recommendations.

Review of Unit Financial Documentation

We conducted a limited review of the Unit's control over its fiscal resources. Before the onsite inspection, we analyzed the Unit's responses to a questionnaire about internal controls and conducted a desk review of the Unit's quarterly financial reports. We followed up with the West Virginia Office of the Attorney General to clarify issues identified in the questionnaire about internal controls. We also selected a purposive sample of 30 items from the Unit's inventory list of 449 items maintained by the Unit and verified those items onsite.

Interviews with Key Stakeholders

In July and August 2023, we interviewed key stakeholders, including officials in BMS-OPI; an MCO's Special Investigations Unit; OHFLAC; OI; and the U.S. Attorney's Office in the Northern and Southern Districts of West Virginia. We focused these interviews on the Unit's relationship and interaction with the stakeholders, as well as opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for the Unit.

Onsite Interviews with Unit Management and Other Selected Staff

We conducted structured interviews with Unit management and other selected staff in August 2023. Of the Unit's management, we interviewed the director, the deputy director, two investigation supervisors, the chief auditor, and the recently retired chief investigator. The selected Unit staff were three investigators, the staff attorney, the senior fraud analyst, and the paralegal. In addition, we interviewed the Unit director's supervisor, the Chief Deputy Attorney General. 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.

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, or global; and the dates on which the case was opened and closed, if applicable. The total number of cases was 468.

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 82 global cases, leaving 386 case files.

We then selected a simple random sample of 84 cases from the population of 386 cases. We reviewed the 84 case files for adherence to the relevant performance standards and compliance with statutes, regulations, and policy transmittals. During our review of the sampled case files, we consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation.

Review of Unit Submissions to OIG and the NPDB

We also reviewed all 35 convictions submitted to OIG for program exclusion during our review period. We reviewed whether the Unit submitted information on all sentenced individuals and entities to OIG for program exclusion for FYs 2020–2022. We also assessed the timeliness of the submissions to OIG. The Unit did not submit any adverse actions to the NPDB during our review period.

Onsite Review of Unit Operations

During the onsite inspection, we observed the workspace and operations of the Unit's office in Charleston. We observed the Unit's offices and meeting spaces; security of data and case files; location of select equipment; and general functioning of the Unit.

APPENDIX

Appendix A: Unit Referrals by Source for FYs 2020–2022

Referral Source	FY 2020		FY 2021		FY 2022		3-Year Total		
	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Total
Adult Protective Services	3	13	3	21	5	13	11	47	58
HHS-OIG	11	0	6	1	13	3	30	4	34
Law Enforcement—Other	12	1	9	0	10	0	31	1	32
Licensing Board	1	0	0	0	0	0	1	0	1
Local Prosecutor	2	0	0	0	1	0	3	0	3
Long-Term Care Ombudsman	0	1	0	0	0	1	0	2	2
Managed Care Organizations	2	0	0	0	6	0	8	0	8
Medicaid Agency—Other	0	0	0	0	2	0	2	0	2
Medicaid Agency—PI/SURS	7	0	21	0	10	4	38	4	42
Private Citizen	65	21	101	34	126	31	292	86	378
Provider	7	6	8	8	6	1	21	15	36
Provider Association	1	0	3	0	0	0	4	0	4
State Agency—Other	0	5	0	5	2	11	2	21	23
State Survey and Certification Agency	2	27	6	353	11	950	19	1,330	1,349
Other	31	1	15	0	21	6	67	7	74
Subtotal	**144**	**75**	**172**	**422**	**213**	**1,020**	**529**	**1,517**	**2,046**
Total	**219**		**594**		**1,233**		**2,046**		

Source: OIG Analysis of Unit Annual Statistical Reports for FYs 2020–2022.

Appendix B: Unit Comments

Following this page are the official comments from the West Virginia MFCU.

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Patrick Morrisey
Attorney General

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Director

June 13, 2024

U.S. Department of Health & Human Services
Office of the Inspector General
Office of Evaluation and Inspections
Attention: Ann Maxwell, Deputy Inspector General
330 Independence Avenue, SW
Washington, DC 20201

RE: Response to Draft WVMFCU Inspection Report

Dear Ms. Maxwell,

We are in receipt of the draft WVMFCU inspection report (#OEI-09-23-00390) reflecting your team's observations from its onsite inspection in August 2023. As we discussed during our exit conference on April 25, 2024, we concur with the first five of the report's six recommendations.

Recommendation 1: Eliminate access to sensitive case material for unauthorized staff.

Regarding the report's recommendation under Performance Standard 1, the Unit is pleased to report that it began using its new case management system (eProsecutor) on April 9, 2024. As we indicated in our prior discussions, the new system both allows for special designations for sensitive case materials and possesses the functionality to limit access to those materials only to those specific individuals in the Unit who are authorized to view them. Should any staff member who is not authorized to view such sensitive materials attempt to do so, eProsecutor will prevent them from doing so.

Recommendation 2: Take steps to ensure that its new case management system allows for the accurate reporting of performance data.

Likewise, regarding the report's recommendation under Performance Standard 7, the Unit believes its switch to eProsecutor combined with its implementation of new Quality Assurance Methods will allow it to produce accurate performance data in its Annual Statistical Reports (ASRs) moving forward. As noted in the report, the Unit was using its former Justware case management system when it moved from the West Virginia Department of Health and Human Resources (DHHR) to

the Attorney General's Office (AGO), and the AGO took the action needed to eliminate the issues cited in the draft report by purchasing eProsecutor as a replacement for Justware.

Recommendation 3: Take steps to report adverse actions to the NPDB within the required timeframe.

Regarding the report's first recommendation under Performance Standard 8, the Unit acknowledges that it was not registered with the NPDB when it was moved from DHHR to the AGO on October 1, 2019, and that it did not re-register until May 19, 2023 after learning of its oversight. The Unit's Policies and Procedures Manual was drafted to assure its compliance with the Performance Standards that were promulgated by HHS-OIG in 77 FR 32645 on June 1, 2012. As we previously discussed, although Performance Standard 8(F) clearly instructed MFCUs to transmit all pertinent information regarding MFCU convictions to OIG "within 30 days of sentencing" for program exclusion purposes, no such deadline was established in Performance Standard 8(G) regarding the submission of "qualifying cases" to the NPDB.

Upon learning of this oversight, the MFCU immediately began submitting information to the NPDB for qualifying cases it had successfully resolved in FY2020, FY2021, and FY2022 after it transitioned from DHHR to the AGO, and it has continued doing so on a timely basis during FY2023 and FY2024. Moreover, beginning on January 10, 2024, the Unit also started submitting information to the NPDB for qualifying cases it had successfully resolved ***before*** it moved from DHHR to the AGO, including cases that were resolved in FY2017, FY2018, and FY2019. As of April 25, 2024, the MFCU had completed that process, ensuring that all such qualifying cases for those three older fiscal years have also been submitted to the NPDB. Lastly, the MFCU has amended its Policies and Procedures Manual to provide greater clarification regarding the processes that Unit staff must follow in submitting information both to OIG for exclusion purposes and to the NPDB, and it has created and implemented new Quality Assurance Methods to ensure that staff adhere to those procedures.

Recommendation 4: Take steps to report all convictions to OIG within the required timeframe.

Regarding the report's second recommendation under Performance Standard 8, the Unit acknowledges that although it has improved the consistency of its timely submission of information to OIG for exclusion purposes since moving to the AGO from DHHR, instances have still occurred when the Unit failed to do so within thirty days of sentencing. An analysis of the Unit's submissions to OIG reveals that its performance has improved since it transitioned to the AGO, and that its overall submission rate is comparable to the submission rates for all MFCUs published by OIG.[1]

[1] *The Office of Inspector General Exclusion Program* (10/22/2021), Slide 22, available at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/mfcu-exclusions.pdf (last visited May 2, 2024).

MFCU PERFORMANCE UNDER AGO

DAYS ELAPSED	FY 2020	%	FY 2021	%	FY 2022	%	FY 2023	%	TOTAL	%
Less than 31 days	3	42.86%	12	76.92%	12	92.31%	9	90.00%	29	69.05%
From 31 to 60 days	1	14.29%	1	15.38%	0	0.00%	0	0.00%	4	9.52%
From 61 to 90 days	1	14.29%	0	0.00%	1	7.69%	0	0.00%	4	9.52%
Greater than 90 days	2	28.57%	1	7.69%	0	0.00%	1	10.00%	5	11.90%
Grand Total	7		14		13		10		42	

MFCU PERFORMANCE UNDER DHHR

DAYS ELAPSED	FY 2016	%	FY 2017	%	FY 2018	%	FY 2019	%	TOTAL	%
Less than 31 days	8	72.73%	4	80.00%	4	57.14%	0	0.00%	16	64.00%
From 31 to 60 days	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
From 61 to 90 days	1	9.09%	0	0.00%	3	42.86%	0	0.00%	4	16.00%
Greater than 90 days	2	18.18%	1	20.00%	0	0.00%	2	100.00%	5	20.00%
Grand Total	11		5		7		2		25	

HHS-OIG STATISTICS FOR ALL MFCUs (FY 2018 - FY2021)

ALL MFCUs	2018	%	2019	%	2020	%	2021	
Less than 31 days	686	71%	1117	70%	681	70%	534	83%
From 31 to 60 days	164	17%	208	13%	132	8%	47	7%
From 61 to 90 days	40	4%	60	4%	61	4%	15	2%
Greater than 90 days	71	7%	222	14%	99	6%	45	7%
Grand Total	961		1607		973		641	

As noted above in connection with the draft report's recommendation that the MFCU take steps to ensure it reports adverse actions to the NPDS within the required timeframe, the MFCU has amended its Policies and Procedures Manual to provide greater clarification regarding the processes that Unit staff must follow in submitting information both to OIG for exclusion purposes and to the NPDB, and it has created and implemented new Quality Assurance Methods to ensure that staff adhere to those procedures.

Recommendation 5: Implement a method to monitor the State's responses to the Unit's program recommendations.

Regarding the draft report's recommendation under Performance Standard 9, the Unit has amended its Policies and Procedures Manual to provide increased structure surrounding its communication of program recommendations to the Legislature, BMS, and other State agencies, as well as the

processes Unit staff must follow to ensure it adequately monitors those entities' responses to its recommendations. Moving forward, all program recommendations that the Unit makes to the Legislature, BMS, and other State agencies are being reduced to writing and saved in separate subfolders in the PROGRAM RECOMMENDATIONS folder on the Unit's G: drive for future reference. The Unit also has created a spreadsheet to track follow-up communications with the Legislature, BMS, and other State agencies related to its program recommendations, including separate tabs for each recommendation, which will be saved in the PROGRAM RECOMMENDATIONS folder on the Unit's G: drive to be updated on an ongoing basis.

Recommendation 6: Work with the Bureau for Medical Services (BMS) to ensure the return of the Federal Government's share of all recoveries.

The Unit notes the draft report's recommendation related to Performance Standard 11 but disagrees that its treatment of "additional recoveries" yielded from civil Medicaid fraud proceedings arising under West Virginia Code §9-7-6 that are above and beyond the amount of restitution payable to the Medicaid program constitutes "overpayments" to which the Federal Government is entitled to receive a proportionate share at the Federal Medical Assistance Percentage (FMAP) rate.

The Unit understands that the Centers for Medicare & Medicaid Services (CMS) has taken the position that State Health Official (SHO) Letter 08-004 remains in effect and requires the States to tender payment to the federal government for not only its proportionate share of the Medicaid restitution recovered in the MFCU's investigations, but also a proportionate share of the "additional recoveries" recovered over and above the "single loss." However, the Unit respectfully disagrees with that position, based in part on the decision issued in *Alabama v. Centers for Medicare & Medicaid Services*, 780 F.Supp.2d 1219 (M.D. Ala. 2011).

Although CMS timely appealed the District Court's decision to the Eleventh Circuit, the agency later filed a motion to dismiss its appeal voluntarily, which the Eleventh Circuit granted. In its subsequent decision in Alabama's cross-appeal, the Eleventh Circuit explained that because "the district court vacated the SHO letter, there is no longer any authoritative CMS rule, guideline, or statement embodying the policies that Alabama opposes" – including CMS's policy on extending the proportionate share rule to "additional recoveries." *Alabama v. Centers for Medicare & Medicaid Services*, 674 F.3d 1241, 1245 (11th Cir. 2012). To the best of the Unit's knowledge, no court has upheld CMS's position in the SHO Letter, and no other legal authority obligates the States to pay the federal government a proportionate share of the "additional recoveries" yielded from civil Medicaid fraud cases brought under State analogs of the federal False Claims Act.

Additionally, as we discussed during the Exit Conference, the Federal Government and the State of West Virginia reached a civil settlement agreement with CRC Health, LLC (CRC), a subsidiary of Acadia Healthcare Company, Inc. in MFCU Case #16-8 on or about May 9, 2019 – before the Unit transitioned from DHHR to the AGO – whereby CRC agreed to pay a total of $17,000,000 to resolve allegations the company submitted and received payment from the State's Medicaid program for $8,500,000 in fraudulent claims. While the Federal Government paid West Virginia its proportionate share of the Medicaid restitution amount ($2,181,100, representing 25.66% of the restitution paid by CRC), it did not pay West Virginia its proportionate share of the $8,500,000 in

"additional recoveries" that CRC paid above and beyond the restitution amount, choosing instead to keep all of those "additional recoveries" for itself.

Thank you for the opportunity to respond to the draft inspection report, and feel free to contact me if you have any questions or need any additional information from us.

Best regards,

John C. Blair
Deputy Attorney General
Office of the West Virginia Attorney General
Director, Medicaid Fraud Control Unit

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

Susan Burbach, Acting Director of the Medicaid Fraud Policy and Oversight Division, served as the team leader for this study, and Matt DeFraga of the Office of Evaluation and Inspections served as the lead analyst. Others in the Medicaid Fraud Policy and Oversight Division who conducted the study include Jordan Swoyer. Office of Evaluation and Inspections headquarters staff who provided support include Robert Gibbons and Sarah Swisher.

We would also like to acknowledge contributions of two special agents from the Office of Investigations. Finally, a MFCU director from another MFCU served as 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, then 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.

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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.