Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

WASHINGTON STATE MEDICAID FRAUD CONTROL UNIT: 2016 ONSITE REVIEW

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WHY WE DID THIS STUDY

The Office of Inspector General (OIG) oversees all State Medicaid Fraud Control Units (MFCUs or Units). As part of this oversight, OIG conducts periodic reviews of all Units and prepares public reports based on these reviews. These reviews assess the Units' adherence to the 12 MFCU performance standards and compliance with applicable Federal statutes and regulations.

HOW WE DID THIS STUDY

We conducted an onsite review of the Washington Unit in January 2016. We analyzed data from seven sources: (1) a review of any documentation related to the Unit's policies and procedures, operations, staffing, and caseload, (2) a review of financial documentation for FYs 2013-2015; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management and selected staff; (6) an onsite review of a sample of case files associated with cases that were open at any point during FYs 2013-2015; and (7) an onsite review of Unit operations.

WHAT WE FOUND

During FYs 2013-2015, the Unit generated 39 convictions, 46 civil judgments and settlements, and total recoveries of more than $48 million. Our review of the Unit found that it was generally in compliance with applicable laws, regulations, and policy transmittals, and that it exercised proper fiscal control of its resources. However, we identified two aspects of Unit operations that should be improved. The Unit did not fully secure some case files, and the Unit's case management system posed challenges to locating and retrieving case information. We noted two practices that the Unit reported were beneficial to its operations: (1) the Unit took steps to ensure it received fraud referrals from managed care organizations, and (2) the Unit made programmatic recommendations to State agencies on its case closing forms and tracked these recommendations in a database.

WHAT WE RECOMMEND

We recommend that the Washington Unit: 1) take steps to ensure that all case files are fully secured, and 2) revise its case file management policies and procedures to enable Unit staff to more efficiently locate and retrieve case information. The Unit concurred with both recommendations.

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OBJECTIVE

To conduct an onsite review of the Washington State Medicaid Fraud Control Unit (MFCU or Unit).

BACKGROUND

The mission of MFCUs is to investigate and prosecute Medicaid provider fraud and patient abuse or neglect under State law.[1] The SSA requires each State to operate a MFCU, unless the Secretary of Health and Human Services (HHS) determines that operation of a Unit would not be cost-effective because minimal Medicaid fraud exists in a particular State and the State has other adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.[2] Currently, 49 States and the District of Columbia (States) have MFCUs.[3]

Each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.[4] Unit staff review referrals of potential fraud and patient abuse or neglect to determine their potential for criminal prosecution and/or civil action. In fiscal year (FY) 2015, the 50 Units collectively reported 1,553 convictions, 795 civil settlements or judgments, and approximately $745 million in recoveries.[5, 6]

Units must meet a number of requirements established by the SSA and Federal regulations. For example, each Unit must:

- be a single, identifiable entity of State government, distinct from the single State Medicaid agency;[7]

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[1] Social Security Act (SSA) § 1903(q). Regulations at 42 CFR § 1007.11(b)(1) add that the Unit's responsibilities may include reviewing complaints of misappropriation of patients' private funds in residential health care facilities.

[2] SSA § 1902(a)(61).

[3] North Dakota and the territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands have not established Units.

[4] SSA § 1903(q)(6); 42 CFR §1007.13.

[5] Office of Inspector General (OIG), *MFCU Statistical Data for Fiscal Year 2015*, Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm on April 19, 2016.

[6] All FY references in this report are based on the Federal FY (October 1 through September 30).

[7] SSA § 1903(q)(2); 42 CFR §§ 1007.5 and 1007.9(a).

- develop a formal agreement, such as a memorandum of understanding, which describes the Unit's relationship with the State Medicaid agency;[8] and
- have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority.[9]

MFCU Funding

Each MFCU is funded jointly by its State and the Federal government. Federal funding for the MFCUs is provided as part of the Federal Medicaid appropriation, but it is administered by OIG.[10] Each Unit receives Federal financial participation equivalent to 75 percent of its total expenditures, with State funds contributing the remaining 25 percent.[11] In FY 2015, combined Federal and State expenditures for the Units totaled $251 million, $188 million of which represented Federal funds.[12]

Oversight of the MFCU Program

The Secretary of HHS delegated to OIG the authority to administer the MFCU grant program.[13] To receive Federal reimbursement, each Unit must submit an initial application to OIG for approval and be recertified each year thereafter.

In annually recertifying the Units, OIG evaluates MFCU compliance with Federal requirements and adherence to performance standards. The Federal requirements for the Units are contained in the SSA, regulations, and policy guidance.[14] In addition, OIG has published 12 performance standards that it uses to assess whether a Unit is effectively performing its responsibilities.[15] The standards address topics such as staffing, maintaining adequate referrals, and cooperation with Federal authorities. Appendix A contains the performance standards.

OIG also performs periodic onsite reviews of the Units, such as this review of the Washington MFCU. During these onsite reviews, OIG evaluates

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[8] 42 CFR § 1007.9(d).

[9] SSA § 1903(q)(1).

[10] SSA § 1903(a)(6)(B).

[11] Ibid.

[12] OIG, *MFCU Statistical Data for Fiscal Year 2015*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm on April 19, 2016.

[13] The SSA authorizes the Secretary of HHS to award grants to the Units. SSA § 1903(a)(6)(B). The Secretary delegated this authority to the OIG.

[14] On occasion, OIG issues policy transmittals to provide guidance and instructions to MFCUs.

[15] 77 Fed. Reg. 32645 (June 1, 2012).

Units' compliance with laws, regulations, and policies, as well as adherence to the 12 performance standards. OIG also makes observations about best practices, provides recommendations to the Units, and monitors the implementation of the recommendations. These evaluations differ from other OIG evaluations as they support OIG's direct administration of the MFCU grant program. These evaluations are subject to the same internal quality controls as other OIG evaluations, including internal peer review.

Additional oversight includes the collection and dissemination of data about MFCU operations and the provision of training and technical assistance.

Washington MFCU

The Washington Unit's headquarters office is located in Olympia; the Unit also has a regional office in Spokane. The Unit is an autonomous entity within the State's Office of the Attorney General, and it has the authority to investigate and prosecute cases of Medicaid fraud and cases of patient abuse or neglect.[16] Unit management reported that Unit investigators do not have the law enforcement authority to serve search warrants, arrest suspects, or carry firearms. At the time of our review, the Unit's management was composed of a director, a chief investigator, a chief civil attorney, and a chief criminal attorney.

The Unit receives referrals of provider fraud and patient abuse and neglect primarily from the Washington State Department of Social and Health Services. The Unit also receives referrals from other sources, including Washington's State Medicaid Agency, which is known as the Health Care Authority (HCA). The Unit's intake unit conducts a preliminary assessment of all referrals to determine whether the allegation has the potential for a full investigation and is within the Unit's grant authority. Management and other staff then discuss referrals that appear to have investigation potential and that are within the Unit's grant authority at bi-weekly case intake meetings to determine whether to open a case.

The Unit may open a case and pursue it through criminal investigation and prosecution and/or civil action, and then close it upon resolution.

Previous Review

In 2010, OIG issued a report regarding its onsite review of the Washington Unit. The review found that the Unit was in full compliance with all applicable Federal rules and regulations that govern the grant and the 12 performance standards.

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[16] For the purposes of this report, the misappropriation or theft of residential health care facility patients' private funds is included in the category of patient abuse and neglect.

METHODOLOGY

We conducted an onsite review in January 2016. We based our review on analysis of data from seven sources: (1) a review of policies, procedures, and documentation related to the Unit's operations, staffing, and caseload; (2) a review of financial documentation for FYs 2013 through 2015; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) an onsite review of files for cases that were open in FYs 2013 through 2015; and (7) onsite observation of Unit operations. Appendix B provides details of our methodology.

Standards

These reviews are conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

From FY 2013 through FY 2015, the Unit reported 39 convictions, 46 civil judgments and settlements, and recoveries of more than $48 million

During FYs 2013-2015, the Unit reported 39 convictions and 46 civil judgments and settlements. These outcomes were relatively consistent over the 3-year period (see Table 1).

Table 1: Washington MFCU Convictions and Civil Judgments and Settlements, FYs 2013 through 2015

Case Outcomes	FY 2013	FY 2014	FY 2015	3-Year Total
Convictions	11	13	15	39
Civil Judgments and Settlements	16	17	13	46

Source: OIG review of MFCU self-reported quarterly statistical reports and other data, 2016.

During this period, the Unit reported total criminal and civil recoveries of more than $48 million (see Table 2).[17] Of the $48 million in total recoveries, $43 million were from "global" cases, which are civil False Claims Act (FCA) cases that are litigated in Federal courts by the U.S. Department of Justice and involve a group of State MFCUs.[18, 19] Of the $5 million in recoveries from non-global cases, $4 million was from civil cases and $1 million was from criminal cases.

The Unit's civil recoveries increased significantly each year, from $169,000 in FY 2013, to $645,000 in FY 2014, to $3.7 million in FY 2015. According to Unit management, the enactment of a State FCA in FY 2012 was the primary reason for the increase in civil recoveries.[20] A State funding appropriation passed in conjunction with the State FCA provided the Unit with financial resources to hire approximately 14 full-time employees, who now comprise the Unit's civil team.

[17] Figures in this paragraph and Table 2 are rounded.

[18] The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases on behalf of the States.

[19] Global cases accounted for 265 of the Unit's 858 cases over the 3-year period.

[20] The Unit testified in support of the Washington State FCA and provided input on the related bill's language. The Washington State FCA provides for increased fraud penalties, authorizes the MFCU to recoup costs spent on civil actions, and provides protection for whistleblowers. Revised Code of Washington, Title 74, Chapter 74.66.

Table 2: Washington MFCU Reported Recoveries and Total Expenditures, by Year, FYs 2013 through 2015

Recovery Types	FY 2013	FY 2014	FY 2015	3-Year Total
Criminal Recoveries	$300,246	$272,920	$160,593	$733,759
Global Civil Recoveries	$16,200,726	$24,750,805	$2,151,942	$43,103,473
Nonglobal Civil Recoveries	$169,262	$644,518	$3,664,430	$4,478,210
Total Civil and Criminal Recoveries	**$16,670,234**	**$25,668,243**	**$5,976,965**	**$48,315,442**
Total Expenditures	$3,596,829	$3,905,815	$4,136,216	$11,638,860

Source: OIG review of MFCU self-reported quarterly statistical reports and other data, 2016.

During FYs 2013-2015, the Unit received a total of 6,716 referrals—1,184 referrals of provider fraud and 5,532 referrals of patient abuse and neglect.[21] During the same time, the Unit opened 360 cases—337 cases of provider fraud and 23 cases of patient abuse and neglect.[22] Unit management explained that it opens relatively few patient abuse and neglect cases because the majority of these referrals concern allegations that do not rise to the level of criminal misconduct. In addition, Unit management explained that other State agencies investigate most of the cases that do rise to this level. The Unit closed 733 cases during the same time—370 cases of provider fraud and 363 cases of patient abuse and neglect.[23, 24] The Unit closed 343 (of the 363) patient abuse and neglect cases in FY 2013, compared to 12 in FY 2014 and 8 in FY 2015. Unit management reported that the FY 2013 closures involved cases that were opened for "monitoring" purposes, whereby the Unit monitored patient abuse and neglect cases being worked by other entities, such as local law enforcement. Because the Unit was not actively investigating "monitoring cases," and no longer engaged in such monitoring, the Unit director decided to stop tracking them in the Unit case management system. This resulted in the large number of case closures in FY 2013.[25]

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[21] The Unit received a relatively high number of patient abuse and neglect referrals because the Department of Social and Health Services sends the Unit a copy of all patient abuse and neglect referrals, pursuant to State mandatory reporting requirements. For additional information on Unit referrals, see Appendix D.

[22] The averages in this paragraph are rounded.

[23] Closures include multiple cases opened before FY 2013.

[24] For additional information on the Unit's opened and closed investigations, including a breakdown by case type and provider category, see Appendix C.

[25] The practice of monitoring cases was implemented by a previous director.

The Unit did not fully secure some case files or the personally identifiable information associated with those case files

During the onsite review, OIG observed that some Unit case files labeled with personally identifiable information (PII) were visible and not secured from access by non-Unit individuals. Specifically, we observed that several boxes labeled with PII were located in an open area, and that cabinets containing case files were unlocked, with the keys in the locks. According to Federal regulations, a Unit must "safeguard the privacy rights of all individuals and will provide safeguards to prevent the misuse of information" under the Unit's control.[26] This includes securing case files containing potentially sensitive PII about witnesses, victims, suspects, and informants. In addition, the Unit's policies and procedures manual requires that all case files containing PII be secured by Unit staff "at the end of their work day, or during periods when they will be leaving their work station unattended."[27] Although Unit staff use a card access system to enter the general office space and visitors are required to sign in, the Unit allowed some non-Unit individuals to have unsupervised access to the office for various reasons (e.g., cleaning, and information technology services).

The Unit's case management system posed challenges to locating and retrieving case information

As we conducted case file reviews, we observed three conditions that inhibited the effectiveness of the Unit's case management system: (1) limited policies and procedures for using the case management system, (2) inconsistent document storage practices across repositories within the system, and (3) inconsistent naming conventions for files stored within the system.[28] In addition to our observations, some Unit staff reported difficulties finding certain information on specific cases when using the system and that the system was not user-friendly. According to Performance Standard 7, Units should maintain their "case files in an

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[26] 42 CFR § 1007.11(f); *OIG State Fraud Transmittal 99-02, Public Disclosure Requests and Safeguarding of Privacy Rights* (December 22, 1999).

[27] *WA Medicaid Fraud Control Unit Operations Manual*, § 2.06.

[28] The Unit stores its case file information and supporting documents in four separate repositories: (1) paper case files, (2) an electronic case tracking system, (3) a shared electronic hard drive, and (4) case file folders in Microsoft Outlook. These four repositories collectively comprise the Unit's case management system. Civil case information is not stored in paper case files, but it is stored in the other three repositories.

effective manner and [develop] a case management system that allows efficient access to case information and other performance data."

The Unit's case management policies and procedures provided limited direction for ensuring that Unit staff maintained case files in an effective manner. For example, the policies did not specify in which of the four repositories certain types of case information should be stored. In addition, policies did not contain naming conventions for criminal case file information stored on the shared electronic hard drive. Finally, policies did not specify how to organize or label pertinent emails within Microsoft Outlook folders specific to individual cases.

The combination of a multiple-repository case management system and limitations in policies and procedures resulted in the inconsistent storage of Unit case file information. Consequently, documentation of periodic supervisory reviews of specific cases could be located in one, some, or all of the repositories.

In addition, although each case had a unique identification number in the electronic case tracking system that could be used to track case information across all four repositories, the Unit did not always use this identification number to label or track case information. In some instances, instead of using the identification number to label and track case information on the shared electronic hard drive, the Unit used the name or initials of the entity under investigation. This practice made it difficult to readily cross-reference case information between repositories. Additionally, although each case had its own Microsoft Outlook folder, we noted that the folders often contained a large number of emails that were not clearly labeled to identify case information contained in the emails.

The Unit exercised proper fiscal control of its resources

Consistent with Performance Standard 11, the Unit exercised proper fiscal control of its resources related to accounting, budgeting, personnel, procurement, and equipment. This performance standard states that a Unit should promptly submit financial reports to OIG, maintain an accurate equipment inventory and personnel activity records, apply generally accepted accounting principles, and employ a financial system that complies with Federal financial management system standards.

Other observations

During our onsite review, Unit management reported that two practices were particularly beneficial to its operations: (1) the Unit took steps to

ensure that managed care organizations (MCOs) refer fraud allegations to the Unit, and (2) the Unit consistently made and monitored programmatic recommendations to State agencies and the State legislature.

The Unit took steps to ensure that MCOs refer fraud allegations to the Unit

The Unit took several steps to ensure that MCOs and HCA refer credible managed care fraud allegations to the Unit.[29] The Unit reported that, as a result of these steps, MCO fraud referrals to the Unit increased from 4 in FYs 2013-14 to 12 in FY 2015. In 2014, Unit management worked with HCA to incorporate language into State contracts with MCOs that requires MCOs to send the Unit a copy of all fraud referrals sent to HCA. In addition, the Unit and HCA incorporated language into their most recent memorandum of understanding that requires HCA to refer all fraud allegations within MCOs to the Unit. Finally, Unit management and HCA stakeholders hosted a 2015 training symposium for program integrity staff from all MCOs operating in Washington.

The Unit made programmatic recommendations to State agencies on its case closing forms and tracked these recommendations in a database

At the conclusion of every criminal case, the Unit provided a case closing report to the referring State agency that, when appropriate, included programmatic recommendations based on an analysis of the circumstances underlying the fraud.[30] After making the recommendation to a State agency, Unit staff noted and tracked the recommendation in a database, which maintains a summary of each recommendation, the intended recipient(s), and any responses received.[31] For example, according to database records, the Unit made and monitored more than 20 recommendations to external agencies in FY 2015.

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[29] The Unit's actions relate to Performance Standard 4(a), which states that a Unit should take steps to ensure that MCOs refer all suspected Medicaid provider fraud cases to the Unit.

[30] This practice relates to Performance Standard 9(b), which states that a Unit should make regulatory or administrative recommendations, when warranted and appropriate, "regarding program integrity issues to the State Medicaid agency and to other agencies responsible for Medicaid operations or funding."

[31] This practice relates to Performance Standard 9(b), which states that a Unit should monitor actions taken by the State legislature and the State Medicaid agency in response to Unit recommendations.

CONCLUSION AND RECOMMENDATIONS

During FYs 2013-2015, the Unit generated 39 convictions, 46 civil judgments and settlements, and total recoveries of more than $48 million. Our review found that the Unit was generally in compliance with applicable laws, regulations, and policy, and that it exercised proper fiscal control of its resources. However, in two areas of its operations, the Unit did not comply with Federal laws and regulations and/or adhere to performance standards. Specifically, the Unit did not fully secure some of its case files, and the Unit's case management system posed challenges to locating and retrieving case information.

We recommend that the Washington Unit:

Take steps to ensure that all case files are secure

The Unit should take appropriate steps to ensure that Unit staff use the safeguards contained in the Unit's policies and procedures manual to secure all case files and PII associated with those case files.

Revise its case file management policies and procedures to enable Unit staff to more efficiently locate and retrieve case information

The Unit should revise its case file management policies and procedures to make the storage and retrieval of case information more efficient. As part of this effort, the Unit should specify the storage location of all criminal and civil case file information and adopt a case file naming convention to uniquely identify case information stored in the four case information repositories.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Unit concurred with both report recommendations.

The Unit concurred with our recommendation to take steps to ensure all case files are fully secured. The Unit reported that it implemented procedures to secure all paper files containing PII. Specifically, the Unit modified its policies and procedures to mandate that staff lock cabinets that have files containing PII. The Unit also noted that it provided keys to select administrative staff who will be responsible for maintaining security of the files. The Unit further explained that it is moving to eliminate all paper case files, which will lessen storage security challenges. The Unit anticipates that these measures will be fully implemented by October 1, 2016.

The Unit concurred with our recommendation to revise its case file management policies and procedures to enable Unit staff to more efficiently locate and retrieve case information. The Unit noted that it is working with the Attorney General's Office Information Services Division staff to adapt the Unit's case file management system to allow for easier access to case information. The Unit explained that it will update its case management policies and procedures to standardize case file naming conventions and locations of electronic documents. The Unit anticipates that these measures will be fully implemented by June 15, 2017.

The full text of the Unit's comments is provided in Appendix E.

APPENDIX A

2012 Performance Standards[32]

1. A UNIT CONFORMS WITH ALL APPLICABLE STATUTES, REGULATIONS, AND POLICY DIRECTIVES, INCLUDING:
A. Section 1903(q) of the Social Security Act, containing the basic requirements for operation of a MFCU;
B. Regulations for operation of a MFCU contained in 42 CFR part 1007;
C. Grant administration requirements at 45 CFR part 92 and Federal cost principles at 2 CFR part 225;
D. OIG policy transmittals as maintained on the OIG Web site; and
E. Terms and conditions of the notice of the grant award.
2. A UNIT MAINTAINS REASONABLE STAFF LEVELS AND OFFICE LOCATIONS IN RELATION TO THE STATE'S MEDICAID PROGRAM EXPENDITURES AND IN ACCORDANCE WITH STAFFING ALLOCATIONS APPROVED IN ITS BUDGET.
A. The Unit employs the number of staff that is included in the Unit's budget estimate as approved by OIG.
B. The Unit employs a total number of professional staff that is commensurate with the State's total Medicaid program expenditures and that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
C. The Unit employs an appropriate mix and number of attorneys, auditors, investigators, and other professional staff that is both commensurate with the State's total Medicaid program expenditures and that allows the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
D. The Unit employs a number of support staff in relation to its overall size that allows the Unit to operate effectively.
E. To the extent that a Unit maintains multiple office locations, such locations are distributed throughout the State, and are adequately staffed, commensurate with the volume of case referrals and workload for each location.
3. A UNIT ESTABLISHES WRITTEN POLICIES AND PROCEDURES FOR ITS OPERATIONS AND ENSURES THAT STAFF ARE FAMILIAR WITH, AND ADHERE TO, POLICIES AND PROCEDURES.
A. The Unit has written guidelines or manuals that contain current policies and procedures, consistent with these performance standards, for the investigation and (for those Units with prosecutorial authority) prosecution of Medicaid fraud and patient abuse and neglect.
B. The Unit adheres to current policies and procedures in its operations.
C. Procedures include a process for referring cases, when appropriate, to Federal and State agencies. Referrals to State agencies, including the State Medicaid agency, should identify whether further investigation or other administrative action is warranted, such as the collection of overpayments or suspension of payments.
D. Written guidelines and manuals are readily available to all Unit staff, either online or in hard copy.
E. Policies and procedures address training standards for Unit employees.
4. A UNIT TAKES STEPS TO MAINTAIN AN ADEQUATE VOLUME AND QUALITY OF REFERRALS FROM THE STATE MEDICAID AGENCY AND OTHER SOURCES.
A. The Unit takes steps, such as the development of operational protocols, to ensure that the State Medicaid agency, managed care organizations, and other agencies refer to the Unit all suspected provider fraud cases. Consistent with 42 CFR 1007.9(g), the Unit provides timely written notice to the State Medicaid agency when referred cases are accepted or declined for investigation.

[32] 77 Fed. Reg. 32645, June 1, 2012.

B. The Unit provides periodic feedback to the State Medicaid agency and other referral sources on the adequacy of both the volume and quality of its referrals.
C. The Unit provides timely information to the State Medicaid or other agency when the Medicaid or other agency requests information on the status of MFCU investigations, including when the Medicaid agency requests quarterly certification pursuant to 42 CFR 455.23(d)(3)(ii).
D. For those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases, the Unit takes steps, such as the development of operational protocols, to ensure that pertinent agencies refer such cases to the Unit, consistent with patient confidentiality and consent. Pertinent agencies vary by State but may include licensing and certification agencies, the State Long Term Care Ombudsman, and adult protective services offices.
E. The Unit provides timely information, when requested, to those agencies identified in (D) above regarding the status of referrals.
F. The Unit takes steps, through public outreach or other means, to encourage the public to refer cases to the Unit.
5. A UNIT TAKES STEPS TO MAINTAIN A CONTINUOUS CASE FLOW AND TO COMPLETE CASES IN AN APPROPRIATE TIMEFRAME BASED ON THE COMPLEXITY OF THE CASES.
A. Each stage of an investigation and prosecution is completed in an appropriate timeframe.
B. Supervisors approve the opening and closing of all investigations and review the progress of cases and take action as necessary to ensure that each stage of an investigation and prosecution is completed in an appropriate timeframe.
C. Delays to investigations and prosecutions are limited to situations imposed by resource constraints or other exigencies.
6. A UNIT'S CASE MIX, AS PRACTICABLE, COVERS ALL SIGNIFICANT PROVIDER TYPES AND INCLUDES A BALANCE OF FRAUD AND, WHERE APPROPRIATE, PATIENT ABUSE AND NEGLECT CASES.
A. The Unit seeks to have a mix of cases from all significant provider types in the State.
B. For those States that rely substantially on managed care entities for the provision of Medicaid services, the Unit includes a commensurate number of managed care cases in its mix of cases.
D. As part of its case mix, the Unit maintains a balance of fraud and patient abuse and neglect cases for those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases.
C. The Unit seeks to allocate resources among provider types based on levels of Medicaid expenditures or other risk factors. Special Unit initiatives may focus on specific provider types.
E. As part of its case mix, the Unit seeks to maintain, consistent with its legal authorities, a balance of criminal and civil fraud cases.
7. A UNIT MAINTAINS CASE FILES IN AN EFFECTIVE MANNER AND DEVELOPS A CASE MANAGEMENT SYSTEM THAT ALLOWS EFFICIENT ACCESS TO CASE INFORMATION AND OTHER PERFORMANCE DATA.
A. Reviews by supervisors are conducted periodically, consistent with MFCU policies and procedures, and are noted in the case file.
B. Case files include all relevant facts and information and justify the opening and closing of the cases.
C. Significant documents, such as charging documents and settlement agreements, are included in the file.
D. Interview summaries are written promptly, as defined by the Unit's policies and procedures.
E. The Unit has an information management system that manages and tracks case information from initiation to resolution.
F. The Unit has an information management system that allows for the monitoring and reporting of case information, including the following:
1. The number of cases opened and closed and the reason that cases are closed.

2. The length of time taken to determine whether to open a case referred by the State Medicaid agency or other referring source.
3. The number, age, and types of cases in the Unit's inventory/docket
4. The number of referrals received by the Unit and the number of referrals by the Unit to other agencies.
5. The number of cases criminally prosecuted by the Unit or referred to others for prosecution, the number of individuals or entities charged, and the number of pending prosecutions.
6. The number of criminal convictions and the number of civil judgments.
7. The dollar amount of overpayments identified.
8. The dollar amount of fines, penalties, and restitution ordered in a criminal case and the dollar amount of recoveries and the types of relief obtained through civil judgments or prefiling settlements.
8. A UNIT COOPERATES WITH OIG AND OTHER FEDERAL AGENCIES IN THE INVESTIGATION AND PROSECUTION OF MEDICAID AND OTHER HEALTH CARE FRAUD.
A. The Unit communicates on a regular basis with OIG and other Federal agencies investigating or prosecuting health care fraud in the State.
B. The Unit cooperates and, as appropriate, coordinates with OIG's Office of Investigations and other Federal agencies on cases being pursued jointly, cases involving the same suspects or allegations, and cases that have been referred to the Unit by OIG or another Federal agency.
C. The Unit makes available, to the extent authorized by law and upon request by Federal investigators and prosecutors, all information in its possession concerning provider fraud or fraud in the administration of the Medicaid program.
D. For cases that require the granting of "extended jurisdiction" to investigate Medicare or other Federal health care fraud, the Unit seeks permission from OIG or other relevant agencies under procedures as set by those agencies.
E. For cases that have civil fraud potential, the Unit investigates and prosecutes such cases under State authority or refers such cases to OIG or the U.S. Department of Justice.
F. The Unit transmits to OIG, for purposes of program exclusions under section 1128 of the Social Security Act, all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders.
G. The Unit reports qualifying cases to the Healthcare Integrity & Protection Databank, the National Practitioner Data Bank, or successor data bases.
9. A UNIT MAKES STATUTORY OR PROGRAMMATIC RECOMMENDATIONS, WHEN WARRANTED, TO THE STATE GOVERNMENT.
A. The Unit, when warranted and appropriate, makes statutory recommendations to the State legislature to improve the operation of the Unit, including amendments to the enforcement provisions of the State code.
B. The Unit, when warranted and appropriate, makes other regulatory or administrative recommendations regarding program integrity issues to the State Medicaid agency and to other agencies responsible for Medicaid operations or funding. The Unit monitors actions taken by the State legislature and the State Medicaid or other agencies in response to recommendations.
10. A UNIT PERIODICALLY REVIEWS ITS MEMORANDUM OF UNDERSTANDING (MOU) WITH THE STATE MEDICAID AGENCY TO ENSURE THAT IT REFLECTS CURRENT PRACTICE, POLICY, AND LEGAL REQUIREMENTS.
A. The MFCU documents that it has reviewed the MOU at least every 5 years, and has renegotiated the MOU as necessary, to ensure that it reflects current practice, policy, and legal requirements.
B. The MOU meets current Federal legal requirements as contained in law or regulation, including 42 CFR § 455.21, "Cooperation with State Medicaid fraud control units," and 42 CFR § 455.23, "Suspension of payments in cases of fraud."
C. The MOU is consistent with current Federal and State policy, including any policies issued by OIG or the Centers for Medicare & Medicaid Services (CMS).
D. Consistent with Performance Standard 4, the MOU establishes a process to ensure the receipt of an adequate volume and quality of referrals to the Unit from the State Medicaid agency.

E. The MOU incorporates by reference the *CMS Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit*.
11. A UNIT EXERCISES PROPER FISCAL CONTROL OVER UNIT RESOURCES.
A. The Unit promptly submits to OIG its preliminary budget estimates, proposed budget, and Federal financial expenditure reports.
B. The Unit maintains an equipment inventory that is updated regularly to reflect all property under the Unit's control.
C. The Unit maintains an effective time and attendance system and personnel activity records.
D. The Unit applies generally accepted accounting principles in its control of Unit funding.
E. The Unit employs a financial system in compliance with the standards for financial management systems contained in 45 CFR 92.20.
12. A UNIT CONDUCTS TRAINING THAT AIDS IN THE MISSION OF THE UNIT.
A. The Unit maintains a training plan for each professional discipline that includes an annual minimum number of training hours and that is at least as stringent as required for professional certification.
B. The Unit ensures that professional staff comply with their training plans and maintain records of their staff's compliance.
C. Professional certifications are maintained for all staff, including those that fulfill continuing education requirements.
D. The Unit participates in MFCU-related training, including training offered by OIG and other MFCUs, as such training is available and as funding permits.
E. The Unit participates in cross-training with the fraud detection staff of the State Medicaid agency. As part of such training, Unit staff provide training on the elements of successful fraud referrals and receive training on the role and responsibilities of the State Medicaid agency.

APPENDIX B

Detailed Methodology

Data collected from the seven sources below were used to describe the caseload and assess the performance of the Washington MFCU.

Data Collection

Review of Unit Documentation. Prior to the onsite visit, we analyzed information regarding the Unit's investigation of Medicaid cases, including information about the number of referrals the Unit received, the number of investigations the Unit opened and closed, the outcomes of those investigations, and the Unit's case mix. We also collected and analyzed information about the number of cases that the Unit referred for prosecution and the outcomes of those prosecutions.

We gathered this information from several sources, including the Unit's quarterly statistical reports, its annual reports, its recertification questionnaire, its policy and procedures manuals, and its memorandum of understanding with the State Medicaid agency. We requested any additional data or clarification from the Unit as necessary.

Review of Financial Documentation. To evaluate internal control of fiscal resources, we reviewed policies and procedures related to the Unit's budgeting, accounting systems, cash management, procurement, property, and staffing. We reviewed records in the Payment Management System (PMS)[33] and revenue accounts to determine the accuracy of the Federal Financial Reports (FFRs) for FYs 2013 through 2015. We also obtained the Unit's claimed grant expenditures from its FFRs and the supporting schedules. From the supporting schedules, we requested and reviewed supporting documentation for the selected items. We noted any instances of noncompliance with applicable regulations.

We selected three purposive samples to assess the Unit's internal control of fiscal resources. The three samples included the following:

1. To assess the Unit's expenditures, we selected a purposive sample of 26 items from 4,133 accounting records. We selected routine and nonroutine transactions representing a variety of budget categories and payment amounts.

[33] The PMS is a grant payment system operated and maintained by the Department of Health and Human Services, Program Support Center, Division of Payment Management. The PMS provides disbursement, grant monitoring, reporting, and case management services to awarding agencies and grant recipients, such as MFCUs.

2. To assess inventory, we selected and verified a purposive sample of 10 items from the current inventory list of 81 items. To ensure a variety in our inventory sample, we included items that were portable, high value, or unusual in nature (e.g., vehicles, communication equipment).

3. To assess employee time and effort, we selected purposive samples of 5 of 36 Unit employees who were paid during the review period. We then requested and reviewed documentation (e.g., time card records) to support the employee's time and effort in the selected pay period.

Interviews with Key Stakeholders. In December 2015 and January 2016, we interviewed eight individual stakeholders from five agencies who were familiar with MFCU operations. Specifically, we interviewed one program integrity manager from HCA; three Assistant U.S. Attorneys; the Corrections Division chief for the Washington Attorney General's Office;[34] two managers from the Department of Social and Health Services; and one OIG Assistant Special Agent in Charge for the State of Washington. We focused these interviews on the Unit's relationship and interaction with OIG and other Federal and State authorities, and we identified opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management.

Survey of Unit Staff. In December 2015, we conducted an online survey of all 30 nonmanagerial staff within each professional discipline (i.e., investigators, auditors, and attorneys) as well as support staff. The response rate was 100 percent. Our questions focused on Unit operations, opportunities for improvement, and practices that contributed to the effectiveness and efficiency of Unit operations and/or performance. The survey also sought information about the Unit's compliance with applicable laws and regulations.

Onsite Interviews with Unit Management. We conducted structured interviews with the MFCU's director, chief investigator, chief criminal attorney, and chief civil attorney in January 2016. We asked these individuals to provide information related to (1) the Unit's 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, and (4) clarification regarding information obtained from other data sources.

[34] The division chief supervises the MFCU director.

Onsite Review of Case Files. We requested that the Unit provide us with a list of cases that were open at any point during FYs 2013-2015. We requested data on the 858 open cases that included, but was not limited to, the current status of the case; whether the case was criminal, civil, or global; and the date on which the case was opened. 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 exclude those cases from our review of a Unit's case files. Therefore, we excluded 265 cases that were categorized as "global" from the list of cases. The remaining number of case files was 593.

We then selected a simple random sample of 100 cases from the population of 593 cases. We determined that 98 of these 100 sampled cases were open longer than 90 days, and 65 were open longer than 1 year. We reviewed the 98 sampled case files that were open for at least 90 days to determine whether documentation for required supervisory reviews was present. Additionally, we reviewed the 65 of those sampled case files that were open for at least a year to determine whether there were investigation or prosecution delays of 1 year or more that were not explained in the case files. Because our case file review generated no findings, we do not report estimates of the number of case files for these subpopulations, nor do we report point estimates and their 95-percent confidence intervals.

From the initial sample of 100 case files, we selected a further simple random sample of 50 files for a qualitative review of selected issues, such as case development. While onsite, we consulted with MFCU staff to address any apparent issues with individual case files, such as missing documentation. We did not estimate any population or subpopulation proportions from this additional sample of 50 case files.

Onsite Review of Unit Operations. During our January 2016 onsite visit, we reviewed the Unit's workspace and operations. Specifically, we visited the Unit headquarters in the State capital. While onsite, we observed the Unit's offices and meeting spaces, security of data and case files, location of select equipment, and the general functioning of the Unit.

Data Analysis

We analyzed data to identify any opportunities for improvement and any instances in which the Unit did not fully meet the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.[35]

[35] All relevant regulations, statutes, and policy transmittals are a*vailable online at* http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu.

APPENDIX C

Investigations Opened and Closed by the Washington MFCU, by Case Type, FYs 2013 through 2015

Case Type	FY 2013	FY 2014	FY 2015	3-Year Total	Annual Average*
Opened	107	119	134	**360**	120
Patient Abuse and Neglect	8	9	6	**23**	8
Provider Fraud	99	110	128	**337**	112
Closed	511	100	122	**733**	244
Patient Abuse and Neglect	343	12	8	**363**	121
Provider Fraud	168	88	114	**370**	123

Source: OIG analysis of Unit Quarterly and Annual Statistical Reports, 2016.

*Averages in this column are rounded.

APPENDIX D

Unit Referrals by Referral Source for FYs 2013 Through 2015

	FY 2013		FY 2014		FY 2015		
Referral Source	**Fraud**	**Abuse & Neglect[1]**	**Fraud**	**Abuse & Neglect**	**Fraud**	**Abuse & Neglect**	**Total**
Medicaid agency – other	148	949	257	2,596	107	1,903	**5,960**
Private citizens	85	2	139	6	106	8	**346**
Other	6	3	48	10	15	2	**84**
Other State agencies	24	1	47	5	5	0	**82**
Adult protective services	10	2	16	35	12	3	**78**
Office of Inspector General	3	0	13	1	35	0	**52**
State Medicaid agency	3	0	20	0	14	0	**37**
Law enforcement	2	1	10	3	14	1	**31**
Managed Care Organizations	3	0	1	0	12	0	**16**
Providers	4	0	8	1	1	0	**14**
Provider associations	0	0	1	0	4	0	**5**
Private health insurer	1	0	2	0	1	0	**4**
Anonymous[3]	N/A	N/A	N/A	N/A	4	0	**4**
Prosecutors	0	0	1	0	1	0	**2**
MFCU hotline[2]	0	0	1	0	N/A	N/A	**1**
Total	289	958	564	2,657	331	1,917	**6,716**
Annual Total	**1,247**		**3,221**		**2,248**		

Source: OIG analysis of Unit Quarterly and Annual Statistical Reports, 2016.

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

[2] The referral source "MFCU hotline" was not a category reported on the FY 2015 Annual Statistical Report.

[3] The referral source "Anonymous" was not a category reported on the FY 2013 and FY 2014 Quarterly Statistical Reports.

APPENDIX E

Unit Comments

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Medicaid Fraud Control Unit
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August 22, 2016

Ms. Suzanne Murrin
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RE: Washington State Medicaid Fraud Control Unit
2016 Onsite Review, OEI-09-16-00010

Dear Deputy Inspector General Murrin:

This letter provides comments on and responses to the Washington State Medicaid Fraud Control Unit 2016 OIG Onsite Review, OEI-09-16-00010 draft report of July 27, 2016. Thank you for affording our office the opportunity to provide input.

We are very pleased that the report concluded that, "[the Unit] was generally in compliance with applicable laws, regulations, and policy transmittals, and that it exercised proper fiscal control of its resources." We also appreciate the report's recognition of, "two practices that…were beneficial to [the Unit's] operations: (1) the Unit took steps to ensure it received fraud referrals from managed care organizations, and (2) the Unit made programmatic recommendations to State agencies on its case closing forms and tracked these recommendations in a database.

The Unit concurs with the two recommendations for improvement in the report and, as noted below, we are moving ahead with actions to adopt the recommendations. The Unit's specific responses are as follows:

Recommendation #1: That the Washington Unit take steps to ensure all case files are fully secured. *The Unit should take appropriate steps to ensure that Unit staff use the safeguards contained in the Unit's policies and procedures manual to secure all case files and PII associated with those case files.*

Unit Comment: We concur with the recommendation that the Unit *should take steps to ensure that all case files are secure.* The Unit, in compliance with the Attorney General's Office (AGO) mandates to ensure protection of confidential information, has had strict security measures in place, such as written AGO and Unit policies and procedures on protecting Personal Identifying Information (PII) and Personal Health Information (PHI); a secured locked Unit facility and required encryption of interoffice transfer protocols, etc. In alignment with the recommendation, the Unit has implemented procedures to secure all hard copy files containing PII and PHI consistent with Unit policy and federal regulations. The Unit has modified the policy and procedures manual to mandate locking all file cabinets that have hard copy files that contain PII and PHI. The Unit has also provided keys to select administrative staff responsible for maintaining the security of the files in the cabinet. The Unit will be eliminating paper files for **criminal** investigations and, like the civil section has done since its inception in 2012, migrate to all-electronic files. This will reduce or eliminate reliance on paper files and mitigate secure storage challenges for hard copy files going forward. These measures have already been initiated. We anticipate that they will be fully implemented by October 1, 2016.

Recommendation #2: That the Washington Unit revise its case file management policies and procedures to enable Unit staff to more efficiently locate and retrieve case information. *The Unit should revise its case file management policies and procedures to make the storage and retrieval of case information more efficient. As part of this effort, the Unit should specify the storage location of all criminal and civil case file information and adopt a case file naming convention to uniquely identify case information stored in the four case information repositories.*

Unit Comment: We concur with the recommendation that the Unit *revise its case file management policies and procedures to enable Unit staff to more efficiently locate and retrieve case information.* The Unit will maintain case files in an effective manner and adapt our case management system to allow efficient access to case information and performance data. Our Information Services Division will be rolling out an updated version of Law Manager (our case management/tracking system) in late 2016 or early 2017. While the Unit has had in place Unit specific business rules for Law Manager, it will work with AGO Information Services Division (ISD) staff to adapt the updated system for easier and more integrated access to case information and to standardize the location of case information across our case file repositories. The Unit will update the current policies and procedures manual for using the case management system. The Unit will eliminate paper investigative files for criminal investigations and, like its civil section, maintain records only on the Unit's electronic hard drive, Outlook and in Law Manager. The Unit will also provide direction and expectations to staff regarding file, folder and document naming conventions and storage locations for criminal and civil cases to facilitate ease of locating and storing specific electronic documents. The expectations will be clear and enacted promptly for all future cases. These measures have already been initiated. We anticipate that they will be fully implemented by June 15, 2017.

I would like to express my deep appreciation for the professionalism and objectivity of the onsite review team. Thank you again for the opportunity to comment on the recommendations of the draft report.

Sincerely,

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DDW/de

cc: Timothy Lang, Chief, Corrections Division

ACKNOWLEDGMENTS

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; and in consultation with Richard Stern, Director of the Medicaid Fraud Policy and Oversight Division.

Matthew DeFraga, of the San Francisco regional office, served as the project leader for the study. Other Office of Evaluation and Inspections staff who conducted the review include Rosemary Rawlins. Other Medicaid Fraud Policy and Oversight Division staff who participated in the review include Susan Burbach. Office of Investigations staff also participated in the review. Office of Audit Services staff who conducted a financial review include Stacy DeWeber and Jen St. Mary. Other central office staff who contributed to this review include Kevin Farber, Joanne Legomsky, and Lonie Kim.

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