

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**WEST VIRGINIA STATE
MEDICAID FRAUD CONTROL
UNIT: 2013 ONSITE REVIEW**



**Stuart Wright
Deputy Inspector General for
Evaluation and Inspections**

**October 2013
OEI-07-13-00080**

**EXECUTIVE SUMMARY: WEST VIRGINIA STATE MEDICAID FRAUD
CONTROL UNIT: 2013 ONSITE REVIEW
OEI-07-13-00080**

WHY WE DID THIS STUDY

The Office of Inspector General (OIG) oversees all Medicaid Fraud Control Units (MFCU or Unit) with respect to Federal grant compliance. As part of this oversight, OIG reviews all Units. These reviews assess Unit performance in accordance with the 12 MFCU performance standards and monitor Unit compliance with Federal grant requirements.

HOW WE DID THIS STUDY

We based our review on an analysis of data from seven sources: (1) a review of policies and procedures, and documentation on the Unit's operations, staffing, and caseload; (2) a review of financial documentation; (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 case files; and (7) an onsite review of Unit operations.

WHAT WE FOUND

For Federal fiscal years 2010 through 2012, the Unit reported combined civil and criminal recoveries of nearly \$46 million and 20 convictions. Our review identified instances in which the Unit did not fully meet Federal regulations or performance standards, and we also identified opportunities for improvement. For example, the time from the Unit's receipt of a referral to the opening of a case exceeded the 60-day investigative timeframe in 70 percent of cases, and case activities and reviews were not adequately documented. Additionally, in 10 of 20 instances, the Unit sent an exclusion referral more than 30 days after sentencing, which could allow convicted individuals to inappropriately bill and be paid by Medicaid and other Federal healthcare programs. The Unit did not provide OIG and other Federal agencies with timely information concerning significant actions in cases. The Unit also had an inadequate case management tracking system, reported inaccurate recovery data in Quarterly Statistical Reports, and did not have complete inventory logs. However, the Unit has made improvements to its operating processes over the past year.

WHAT WE RECOMMEND

Based on these findings, the Unit should work to ensure compliance with each of the 12 performance standards. For example, the Unit should (1) make certain that cases are opened within 60 days of the receipt of referral; (2) investigative activity is adequately documented; (3) individuals are referred for the purpose of program exclusion to OIG within the appropriate timeframe; (4) share cases lists with OIG as agreed; (5) develop an adequate case management tracking system; (6) submit accurate Quarterly Statistical Reports; and (7) ensure inventory logs are complete. The West Virginia Unit concurred with all eight of our recommendations.

TABLE OF CONTENTS

Objective	1
Background	1
Methodology	4
Findings.....	8
For FYs 2010 through 2012, the West Virginia Unit reported combined civil and criminal recoveries of nearly \$46 million and 20 criminal convictions	8
The time from receipt of referral to the opening of the case exceeded 60 days for 70 percent of cases; two cases were open for an extended period and lacked documentation of case progression	9
Case files lacked documentation of supervisory approval for key stages of investigations and periodic reviews	10
The Unit made all required referrals to OIG for program exclusions; however, in 10 of 20 instances, the Unit sent the referral more than 30 days after sentencing	10
The Unit did not provide OIG and other Federal agencies with timely information concerning significant actions in cases pursued by the Unit	11
The Unit's case management and tracking system was inadequate	11
The Unit reported inaccurate recovery data.....	12
The Unit's inventory logs did not include all property purchased by the Unit.....	12
Other observations: Unit improvements, managed care referrals, and wireless technology	13
Conclusion and Recommendations	15
Unit Comments and Office of Inspector General Response	17
Appendixes	19
A: 1994 Performance Standards	19
B: 2012 Revised Performance Standards.....	23
C: Population and Sample Distribution of Case Files Open Any Time During Fiscal Years 2010 Through 2012	30

D: Investigations Opened and Closed By Provider Category for Fiscal Years 2010 Through 2012	31
E: Point Estimates and 95-Percent Confidence Intervals Based on Our Reviews of Case Files	33
F: Medicaid Fraud Control Unit Referrals by Provider Category for Fiscal Years 2010 Through 2012	34
G: Unit Comments	35
Acknowledgments	42

OBJECTIVE

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

BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under State law.¹ Under the Medicaid statute, each State must maintain a certified Unit, unless the Secretary of Health and Human Services determines that operation of a Unit would not be cost effective because (1) minimal Medicaid fraud exists in that State; and (2) 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 created such Units.³ In Federal fiscal year (FY)⁴ 2012, combined Federal and State grant expenditures for the Units totaled \$217.3 million, and Units employed 1,901 individuals.

To carry out its duties and responsibilities in an effective and efficient manner, each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.⁵ Unit staff review complaints provided by the State Medicaid agency and other sources and determine the potential for criminal prosecution. In FY 2012, the 50 Units obtained 1,337 convictions and 823 civil settlements or judgments.⁶ That year, the Units reported recoveries of more than \$2.9 billion.⁷

The Unit must be in an office of the State Attorney General's office, another State government office with statewide prosecutorial authority, or operate under a formal arrangement with the State Attorney General's office.⁸ Units are required to have either Statewide authority to prosecute

¹ Social Security Act (SSA) § 1903(q)(3).

² SSA §§ 1902(a)(61). 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.

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

⁵ SSA § 1903(q)(6) and 42 CFR § 1007.13.

⁶ OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/> on March 7, 2013.

⁷ Ibid.

⁸ 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at <http://oig.hhs.gov> on March 7, 2013.

cases or formal procedures to refer suspected criminal violations to an office with such authority.⁹ In 44 States, the Units are located within offices of State Attorneys General; in the remaining 6 States, including West Virginia, the Units are located in other State agencies.¹⁰ Generally, Units outside of the offices of State Attorneys General must refer cases to other offices with prosecutorial authority.

Each Unit must be a single identifiable entity of State government, distinct from the State Medicaid agency, and each Unit must develop a formal agreement—i.e., a Memorandum of Understanding (MOU)—that describes the Unit’s relationship with that agency.¹¹

Oversight of the MFCU Program

The Secretary of Health and Human Services delegated to OIG the authority to both annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs in operating certified Units.¹² All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.¹³ To receive Federal reimbursement, each Unit must submit an initial application to OIG.¹⁴ OIG reviews the application and notifies the Unit if the application is approved and the Unit is certified. Approval and certification are for a 1-year period; the Unit must be recertified each year thereafter.¹⁵

Under the Medicaid statute, States must operate Units that effectively carry out their statutory functions and meet program requirements.¹⁶ OIG developed and issued 12 performance standards to further define the criteria it applies in assessing whether a Unit is effectively carrying out statutory functions and meeting program requirements.¹⁷ Examples of

⁹ SSA § 1903(q)(1).

¹⁰ The Units share responsibility for protecting the integrity of the Medicaid program with the section of the State Medicaid agency that functions as the Program Integrity Unit. Some States also employ a Medicaid Inspector General who conducts and coordinates the State agency’s activities to combat fraud, waste, and abuse in this area.

¹¹ SSA § 1903(q)(2); 42 CFR §§ 1007.5 and 42 CFR § 1007.9(d).

¹² The portion of funds reimbursed to States by the Federal Government for its share of expenditures for the Federal Medicaid program, including the MFCUs, is called Federal Financial Participation (FFP).

¹³ SSA §§ 1903(a)(6)(B).

¹⁴ 42 CFR § 1007.15(a).

¹⁵ 42 CFR § 1007.15(b) and (c).

¹⁶ SSA § 1902(a)(61).

¹⁷ 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at <http://oig.hhs.gov> on November 22, 2011. Note that the Office of Inspector General (OIG) published revised performance standards on June 1, 2012. (See 77 Fed. Reg. 32645.) The standards referred to in this report are those from 1994, which were in effect at the time of our review. We apply the 2012 performance standards in the report recommendations, where appropriate.

criteria include maintaining an adequate caseload through referrals from several sources, maintaining an annual training plan for all professional disciplines, and establishing policy and procedure manuals to reflect the Unit's operations. See Appendix A for a complete list of the 1994 performance standards used for this review and Appendix B for a complete list of the 2012 performance standards.

West Virginia State MFCU

The West Virginia Unit is located within the Department of Health and Human Resources, Office of Inspector General. The Unit is authorized to investigate and refer for prosecution cases of Medicaid fraud and of patient abuse and neglect. The Unit does not have its own prosecutorial authority. Abuse and neglect prosecutions are handled by each of the individual county prosecuting attorneys. According to West Virginia State law, Medicaid fraud cases may be prosecuted in the circuit court of Kanawha County, where the State capital of Charleston is located; the county in which the defendant conducts business; the county in which the offense was committed; or other venues provided by State law.^{18, 19} At the time of our review, the Unit's 16 employees were located in Charleston. For FY 2012, the West Virginia Unit was authorized \$1,455,192 in Federal funds and expended a total of \$1,043,589 in combined Federal and State funds. Total Medicaid expenditures in West Virginia increased from \$2.7 billion in FY 2010 to \$2.9 billion in FY 2012.

The Unit receives referrals of fraud, abuse, or neglect from the State Medicaid agency, State Survey and Certification agency, contractors, telephone calls to the Unit's Tip Line, and a fraud reporting form located on the Unit's Web site.²⁰ For FYs 2010 through 2012, the Unit received an average of 245 referrals each year.

The Unit office assistant routes the referrals to the supervisory investigators. The supervisors review the referrals and returns them to the office assistant with a notation to take one of the following actions: (1) enter the case into the online case-tracking system and assign it to an investigator; (2) if the case is not going to be assigned immediately, enter the case into the online case-tracking system and return it to the submitting

¹⁸ See West Virginia Code § 9-7-5A.

¹⁹ The Unit's decision as to where to refer a case for prosecution depends on multiple factors: the prosecutor's expertise and his or her working relationship with the Unit, notoriety of the defendant(s) in the community, the number of cases in which the defendant is currently a party, current resources and case loads of prosecutors, complexity of the case, and the availability of witnesses. Additionally, if a case of abuse, neglect, or financial exploitation contains elements of Medicaid fraud, the Unit pursues the entire matter in the county in which the conduct occurred.

²⁰ Accessed at <https://www.wvdhhr.org/oig/mfcu/secRepFrd/> on April 15, 2013.

supervisor; (3) enter the case into the online case-tracking system and close it for lack of jurisdiction; or (4) enter the case, close it, and refer the case to the appropriate agency.

West Virginia's Medicaid population is served primarily through managed care organizations (MCOs). West Virginia's Medicaid managed care program, Mountain Health Trust, contracts with and pays MCOs a monthly capitated rate for beneficiaries enrolled in each MCO.²¹ Each MCO contracts with and pays medical providers to provide services to those beneficiaries. West Virginia contracts with three MCOs: Coventry Health Care of West Virginia, The Health Plan of the Upper Ohio, and Unicare.²² Approximately 236,067 members were enrolled in West Virginia MCOs as of FY 2012, constituting about 55 percent of West Virginia's Medicaid enrollees.²³

Previous Review

In 2007, OIG conducted an onsite review of the West Virginia Unit and found that (1) the Unit did not submit Quarterly Statistical Reports (QSRs) on a timely basis, (2) the information contained in QSRs was inaccurate and required frequent revisions; (3) the Unit did not have an automated, computerized case tracking and management system; and (4) the Unit did not note the final disposition of cases in case files.

In the Unit director's response to the 2007 onsite review, he responded to OIG that future quarterly reports would be accurate and submitted on a timely basis. OIG recommended that the Unit (1) install a computerized case management and tracking system and (2) include a closing memorandum in case files to notate the final disposition of an investigation.

METHODOLOGY

Our review covered the 3-year period of FYs 2010 through 2012. We based our review on an analysis of data from seven sources: (1) a review of policies and procedures and of documentation of the Unit's operations, staffing, and caseload for FYs 2010 through 2012; (2) a review of financial documentation for FYs 2010 through 2012; (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 case files

²¹ West Virginia Bureau for Medical Services, *Mountain Health Trust (Managed Care)*, accessed at <http://www.dhhr.wv.gov> on February 23, 2013.

²² After the close of FY 2011, beneficiaries in West Virginia's Berkeley, Hampshire, Jefferson, Mineral, and Morgan counties were required to enroll in an MCO, causing the number of MCO enrollees to increase from 170,000 in FY 2011 to 236,000 in FY 2012.

²³ Accessed at <http://www.medicaid.gov> on February 23, 2013.

that were open at any time in FYs 2010 through 2012; and (7) an onsite review of Unit operations. We conducted our fieldwork in February 2013.

Although interview and survey respondents occasionally provided information that fell outside of our 3-year review period, we used this information to further explain the results of our analyses covering FYs 2010 through 2012. As relevant, we also included observations we made while onsite in February 2013.

We analyzed data from all seven sources to describe the caseload and assess the performance of the Unit. We also analyzed the 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, and policy transmittals.²⁴ In addition, we noted practices that appeared to be beneficial to the Unit. We based these observations on statements from Unit staff, data analysis, and our own judgment. We did not independently verify the effectiveness of these practices, but included the information because it may be useful to other Units in their operations.

Data Collection and Analysis

Review of Unit Documentation. Prior to the onsite visit, we analyzed information from several sources regarding the Unit's investigation and referral for prosecution of Medicaid cases. Specifically, we collected and analyzed 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 QSRs, annual reports, recertification questionnaire, policy and procedures manuals, MOU with the State Medicaid agency, and the 2007 report on OIG's onsite review. Additionally, we confirmed with the Unit director that the information we had was current as of February 2013 and, as necessary, requested any additional data or clarification.

Review of Fiscal Control. We reviewed the Unit's control over its fiscal resources to identify any internal control issues or other issues involving use of resources. Prior to the onsite review, we reviewed the Unit's financial policies and procedures; its response to an internal control questionnaire; and documents (such as financial status reports) related to MFCU grants. During the onsite review, we reviewed a sample of the

²⁴ All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov>.

Unit's purchase and travel transactions. In addition, we reviewed vehicle records, the equipment inventory, and a sample of time and effort records.

Interviews with key stakeholders. In December 2012, we interviewed key stakeholders, such as officials in the United States Attorneys' Offices, the West Virginia Department of Health and Human Resources and its Office of Inspector General, and other agencies that interacted with the Unit (i.e., the State Ombudsman, the Office of Health Facility Licensure and Certification, and the Insurance Commissioner). 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 2012, we administered an electronic survey of all nonmanagerial Unit 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 operations of the Unit, 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 Unit's management in February 2013. We interviewed the Unit director, the Deputy Director (who also served as the Unit's lead attorney), and the two supervisory investigators. We asked these individuals to provide additional information to better illustrate the Unit's operations, identify opportunities for improvement, identify practices that contributed to the effectiveness and efficiency of Unit operations and/or performance, and clarify information obtained from other data sources. Finally, we discussed with Unit management the status of their actions with respect to recommendations from the 2007 report; we describe these actions in the findings section of this report.

Onsite review of case files and other documentation. We selected a simple random sample of 100 case files from the 198 cases that were open at some point during FYs 2010 through 2012. We reviewed all sampled case files for documentation of supervisory reviews for the opening and closing (as appropriate) of cases, as well as to see whether supervisors conducted periodic case file reviews. From these 100 case files, we selected a further random sample of 50 files for a more in-depth review of selected issues, such as the timeliness of investigations and case development. We projected the results of our case file reviews to the population of Unit

cases. See Appendix C for the distribution of case files from the population and sample.

Onsite Review of Unit Operations. During our February 2013 site visit, we reviewed the Unit's workspace and operations. Specifically, we visited the Unit headquarters in the State Capital; we did not visit Unit staff who worked remotely in Department of Health and Human Resources offices. 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.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

For FYs 2010 through 2012, the West Virginia Unit reported combined civil and criminal recoveries of nearly \$46 million and 20 criminal convictions

The Unit reported total combined criminal and civil recoveries of nearly \$46 million for FYs 2010 through 2012. Recoveries decreased from \$18 million in FY 2010 to \$11 million in FY 2012 as a result of reduced recoveries through global settlements in 2012.²⁵ Although overall recoveries were less in 2012, the Unit obtained a greater percentage of recoveries from State investigations than in the 2 years prior. In FY 2010, approximately 15 percent of total recoveries were attributable to non-“global” cases; however, in FY 2012, that figure increased to 37 percent. Refer to Table 1 for details regarding criminal and civil recoveries.

Table 1: West Virginia MFCU Criminal and Civil Recoveries, FYs 2010–2012.

Type of Recovery	FY 2010	FY 2011	FY 2012	Total Recoveries
Criminal Recoveries	\$1,074,058	\$256,964	\$3,490	\$1,334,512
Global Recoveries	\$15,635,038	\$14,438,712	\$7,058,873	\$37,132,623
Non-Global Civil Recoveries	\$1,721,104	\$1,352,301	\$4,186,740	\$7,260,145
Total Recoveries	\$18,430,200	\$16,047,977	\$11,249,103	\$45,727,280

Source: OIG review of Unit self-reported QSR and other data, FYs 2010–2012.

During the review period, the Unit closed 120 investigations with 21 individuals charged, obtained 20 criminal convictions, and obtained

²⁵ “Global” cases are civil false-claims actions involving the U.S. Department of Justice and other State MFCUs. The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases.

2 dismissals.²⁶ See Appendix D for details on investigations opened and closed by provider category for FYs 2010 through 2012.

The time from receipt of referral to the opening of the case exceeded 60 days for 70 percent of cases; two cases were open for an extended period and lacked documentation of case progression

According to Performance Standard 6(a), each stage of an investigation and prosecution should be completed in an appropriate timeframe. The Unit's policy requires that no more than 60 days elapse between the receipt of a referral and the opening of a case (i.e., the preliminary investigation period). Our review revealed that 70 percent of referrals remained in the preliminary investigation status beyond the 60-day timeframe. The median time from receipt of referral to opening the case was 91 days. Some referrals were received by the Unit but not opened as cases for several months, during which time Unit staff conducted no apparent investigative activity. In other instances, the Unit conducted investigative activity; however, this activity was conducted after 60 days from receipt of referrals. See Appendix E for information regarding the time from receipt of referral to the opening of cases. Later, when those cases were documented in the case-tracking system as having been opened, we could find only limited documentation in the case opening memorandum accounting for investigative activity that had occurred while the case was in a preliminary investigation status (i.e., the period between receipt of referral and opening of the case). Three cases were open for an extended period without any documented investigative progress; one case was left open for 210 days and the other two cases for over 240 days. We could find no evidence in the case files to support those delays.

Case files lacked documentation of supervisory approval for key stages of investigations and periodic reviews

According to Performance Standards 6(b) and (c), Unit supervisors must approve the opening and closing of investigations and conduct periodic supervisory reviews that are documented in the case files. Twenty percent of the Unit's case files did not contain evidence to support supervisory

²⁶ According to Unit staff, the number of people charged in a given time period will not equal the sum of convictions, acquittals, and dismissals for that same period. Some of the 20 individuals convicted during the review period were charged prior to the review period—for example, one suspect was charged in September 2009, prior to the review period, but was convicted in December 2009. Additionally, some of the individuals charged during the review period had not had their cases fully adjudicated by the end of the review period.

approval of opening the case, and 27 percent of cases lacked supervisory approval of closing the case. The Unit did not file case documents in a consistent order, and did not place forms and documents in the case file with any consistency. Additionally, the Unit did not document contact between Unit staff and other Federal agencies. However, all sampled cases opened after April 2011 noted supervisory approval of the case opening; all sampled cases closed after August 2011 noted supervisory approval of the case closing. The Unit indicated that it had developed a case review form to ensure that each stage of an investigation and prosecution is completed in the appropriate timeframe.

Unit policy required that abuse and neglect cases receive monthly supervisory review and that fraud cases receive a supervisory review at the end of each quarter. Seventy-three percent of abuse and neglect cases were missing periodic supervisory reviews and 34 percent of fraud cases were missing periodic supervisory reviews. In total, 56 percent of cases were missing periodic supervisory reviews.²⁷ See Appendix E for information regarding missing opening, closing, and periodic review documentation.

The Unit did not document its participation in National Association of Medicaid Fraud Control Units Global cases. Unit staff did not document actions taken by the Unit to assist or participate in global cases. Also, it did not appear that the Unit had a system in place to account for the final signed settlement agreements for global cases. These documents are essential should the Unit ever wish to pursue further legal action (e.g., defendant defaults on agreement).

The Unit made all required referrals to OIG for program exclusions; however, in 10 of 20 instances, the Unit sent the referral more than 30 days after sentencing

According to Performance Standard 8(d), for purpose of program exclusions under section 1128 of the Social Security Act, the Unit must transmit to OIG the reports of convictions and copies of Judgment and Sentence or other acceptable documentation within 30 days or other reasonable time period. The Unit reported 20 convictions in the 3-year period, and made all required referrals to the OIG. However, in 10 of 20 cases, the Unit sent the referral to OIG for exclusion more than 30 days after sentencing. The amount of days between the sentencing and referral

²⁷ For the purposes of this report, supervisory approval to open and close a case does not constitute a case file review. Periodic supervisory review indicates that a supervisor reviewed a case more than once between the opening and closing of the case.

in these cases ranged from 38 to 385 days. During our onsite interview, the Unit director attributed this delay to the Unit's lack of prosecution authority and prosecutors not reporting back to the Unit regarding the disposition of cases. As a result, the Unit inquires with county prosecutors as to when defendants are sentenced but does not always receive a response. The Unit plans to employ a paralegal to make regular inquiries in the future.

The Unit did not provide OIG and other Federal agencies with timely information concerning significant actions in cases pursued by the Unit

According to revised Performance Standard 8(b), a unit should cooperate and, as appropriate, coordinate with OIG's Office of Investigations (OI) 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. OIG and other Federal agencies reported that the Unit has not routinely shared information about targets of investigations in a timely manner unless the agencies specifically request such information. In June 2012, the Unit director met with the Special Agent in Charge for OI's Region 3 to discuss shared cases and general information about how the offices can best work together to maximize resources. The Unit director stated that the two offices have developed a plan to share caseload lists. In May 2013, the Unit began informing OIG of the cases that the Unit is pursuing, so as to avoid potential conflicts.

In the past, the Unit as well as the Northern and Southern Assistant United States Attorneys (AUSAs) jointly worked on the detection, development, and prosecution of Medicaid cases from the opening of the cases until their final dispositions, and the Unit provided six recent Department of Justice press releases giving credit to the Unit in several investigations. However, both the Northern and Southern Offices of United States Attorneys reported that they are no longer involved in the Unit's investigations or prosecutions. Although the AUSAs in these offices receive the information they request from the Unit, they report that investigations are "no longer a collaborative effort."

The Unit's case management and tracking system was inadequate

According to Performance Standard 3(b), a unit should have an adequate, computerized case management and tracking system in place. However, Unit staff reported that their computerized case management and tracking system regularly lost data and merged case file information from unrelated cases. The Unit created parallel spreadsheets to compensate for

the system's inadequacies. One respondent to the staff survey reported: "The case-tracking system is a huge hindrance; it is old, slow and doesn't work half the time." Another staff member reported that the case-tracking system is not always accessible and that logging in is difficult. The Unit has selected a new case management system that should be operational in the summer of 2014. The problems that our 2007 onsite review found with the case management and tracking system remain unresolved.

The Unit reported inaccurate recovery data

According to Performance Standard 7, a unit should have a process for monitoring the outcome of cases, including the amount of fines and restitution ordered as well as the amount of civil recoveries. In December 2006, representatives of OIG conducted a conference call with the Unit director, the chief investigator, and an administrative services assistant to educate them on preparing the QSRs and ensuring that the reports were correct. The individual serving as the Unit director at that time stated that the Unit would work diligently to ensure that all future QSRs would be accurate and submitted to OIG on a timely basis.

During the course of our review, we identified numerous errors in the recovery statistics reported by the Unit. For example, we identified a \$500,000 discrepancy for FY 2010 after reviewing the Unit's QSR and the data we collected directly from the Unit at the outset of our review. The QSR reflected that total criminal case outcomes for FY 2010 totaled \$529,000; however, after our inquiries, the Unit revised the total to indicate that total criminal case outcomes for FY 2010 totaled nearly \$1.1 million. Additionally, the Unit's QSR showed that total criminal recoveries for FY 2011 were \$33,367; however, the Unit later provided information indicating that the total criminal recoveries for FY 2011 were \$257,000. These errors required the Unit to revise QSRs for FYs 2010, 2011, and 2012.

The Unit had to develop multiple spreadsheets in an attempt to adequately capture all recovery data because the current case-tracking system was inadequate.

The problems that our 2007 onsite review found with the reporting of inaccurate recovery data remain unresolved.

The Unit's inventory logs did not include all property purchased by the Unit

According to the 2012 version of Performance Standard 11(b), a unit should maintain an equipment inventory that is updated regularly to reflect all property under the Unit's control. To determine compliance with

applicable laws and regulations, as well as to determine the need for additional internal controls, we performed a limited review of financial documents from the Unit and of the Unit's equipment inventory and purchase records. During our onsite review, we observed that the following items were not included in the inventory report: a customized office chair, two printers, a paper shredder, and an identification card system. Additionally, we identified an equipment storage room that housed various other property purchased by the Unit, and the items located in this room were not included in the inventory logs. However, the items we selected for review were included in the appropriate log.

Units must take appropriate measures to ensure that they are able to maintain effective control and accountability for property purchased. According to Unit staff, physical inventories of property occur annually. The Unit's logistics manager told us that although physical inventories were conducted during his tenure, the results of those inventories were not reconciled with equipment records. However, inventory is reconciled to a system maintained by the Department of Health and Human Resources. The logistics manager stated that he had "no projected timeframe" as to when this task will be completed.

Other observations: Unit improvements, managed care referrals, and wireless technology

Unit improvements

During 2012, the Unit made many improvements to its operating processes. In September 2012, two individuals in the Unit passed examinations to become certified fraud examiners so as to assist the Unit with analyzing fraud cases. Another individual obtained certification as a Certified Coding Professional. Unit investigators performed outreach at nursing homes, such as distributing brochures and Unit contact information.

In January 2011, the State Medicaid agency began using a Medicaid Fraud Referral Form developed to streamline the referral of cases from the State Medicaid agency to the Unit.²⁸ The Unit modified this form to include all information necessary for the Unit to proceed with an investigation after receiving the initial referral. Additionally, Unit staff reported that the Unit

²⁸ Accessed at <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/WVfy13.pdf> on April 16, 2013. According to CMS, West Virginia's Medicaid Fraud Referral Form incorporates all of the criteria in CMS' September 2008 guidance document *Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit*. The guidance was adopted in Federal regulations at 42 CFR 455.436 effective March 25, 2011.

has increased its interaction and improved its communication with the State Medicaid agency. For example, Unit staff met with the State Medicaid Agency staff each month to discuss referrals.

Managed care referrals

According to the 2012 version of Performance Standard 4(a), the Unit should take 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 cases of suspected provider fraud. In West Virginia, 55 percent of Medicaid enrollees receive their health care services through MCOs.²⁹ However, in FYs 2010 through 2012, QSRs reflected that the Unit opened only one MCO case during our review period. The Unit director reported that as MCO enrollment grows, the Unit has begun meeting with MCO administrators to obtain referrals.³⁰ See Appendix F for information on referrals by provider category.

Wireless technology

Unit management reported that it is unable to obtain wireless technology for investigative staff. The Unit investigates cases Statewide, and staff may be on the road for days at a time but still have a need to stay in touch with the office, their colleagues, and other law enforcement personnel. Unit management reported that there have been instances in which the lack of availability of information in the field has been detrimental to Unit investigators. These instances include an inability to scan documentary evidence, communicate through email or text messaging (e.g., while executing a search warrant or during other activities at a suspect's location), and access applications (e.g., flashlight, notepad, camera, audio/video, calculator, GPS, Emergency Alert System, and a translator in the event the investigators have to interview someone who does not speak English).

²⁹ Medicaid.gov, *West Virginia Medicaid Statistics*, accessed at <http://www.medicaid.gov/> on February 20, 2013.

³⁰ After the close of FY 2011, beneficiaries in West Virginia's Berkeley, Hampshire, Jefferson, Mineral, and Morgan counties were required to enroll in an MCO, causing the number of MCO enrollees to increase from 170,000 in FY 2011 to 236,000 in FY 2012.

CONCLUSION AND RECOMMENDATIONS

For FYs 2010 through 2012, the Unit reported combined civil and criminal recoveries of nearly \$46 million. During the review period, the Unit closed 120 investigations with 21 individuals charged, obtained 20 criminal convictions, and obtained 2 dismissals. In January 2011, the Unit adopted a standardized referral form that helps to ensure that all pertinent information is now included in referrals. Other agencies have reported that in the past year, the Unit's interactions and communication with them have markedly improved.

However, our review identified instances in which the Unit did not fully meet performance standards and identified opportunities for improvement. Specifically, in 70 percent of cases, the time from the Unit's receipt of a referral to the opening of the case exceeded the 60-day investigative timeframe established by the Unit. Fifty-six percent of case files lacked evidence of supervisory review and approval for key stages of investigations. The Unit made all required referrals to OIG for program exclusion, but in 10 of 20 instances, the Unit sent the referral more than 30 days after sentencing.

Although 55 percent of West Virginia's Medicaid enrollees are enrolled in managed care, the Unit received no managed-care referrals during our review period. Additionally, the Unit did not provide OIG with timely information concerning significant actions in cases pursued by the Unit, and both the Northern and Southern Offices of United States Attorneys reported that they are no longer included in the Unit's investigations or prosecutions. The Unit's staff reported that the case management and tracking system is inadequate. The Unit's inventory logs did not include many of the items purchased by the Unit, and physical inventory results had not been reconciled with equipment records.

We recommend that the West Virginia Unit:

Open cases referred to the Unit within 60 days of the receipt of referral and document all investigative activity

The Unit should make certain that complaints referred to the Unit are investigated and opened, if appropriate, within the 60-day timeframe established in the Unit's policy. Additionally, the Unit should account for all investigative activity that occurs while cases are in the preliminary investigation status.

Ensure that all case files contain documented supervisory approvals of opening and closing cases and documentation of periodic supervisory reviews

The Unit should ensure that supervisors are approving the opening and closing of investigations and that documentation thereof is contained in all case files. Additionally, the Unit should ensure that supervisory reviews are conducted periodically and are also noted in each case file.

Refer individuals to OIG for exclusion within the appropriate timeframe

The Unit should make certain that individuals convicted of fraud, abuse, and/or neglect are reported within 30 days of their sentencing, in accordance with performance standard 8(f) of the revised MFCU performance standards.

The Unit should continue sharing case lists with OIG, as agreed between the Unit and OIG

The Unit should re-establish collaborative efforts with the Northern and Southern Offices of United States Attorneys

Upgrade the Unit's case management and tracking system

The Unit should implement a new case management and tracking system that is not vulnerable to data discrepancies and inaccuracies. The new system should also ensure that accurate QSR data is submitted to OIG.

The Unit should ensure accurate reporting of recovery data

The Unit should ensure that all items purchased by the Unit are documented in the inventory log

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The West Virginia Unit concurred with all eight of our recommendations. However, for two of the recommendations, the Unit disagreed with the associated finding but stated that it agreed with the recommendation.

Regarding our first recommendation, involving opening cases timely and documenting all investigative activity, the Unit concurred. The Unit was aware of this issue and initiated action to correct this deficiency prior to the onsite review. Supervisors are conducting formal, monthly meetings with each investigator and reviewing case documentation to ensure appropriate progression in referrals and cases. The Unit will implement a new case management system in June 2014.

Regarding our second recommendation, involving the Unit's efforts to ensure that case files contained required documentation, the Unit concurred. Unit supervisors now formally meet each month to ensure that every case is being reviewed and that these reviews are documented. Effective February 2013, case opening and closing approvals are part of the case files.

Regarding our third recommendation, involving referring individuals for exclusion to OIG within the appropriate timeframe, the Unit concurred. The Unit is currently monitoring all cases that have been referred for prosecution and will contact the prosecutors on a monthly basis to monitor the progress of each case. Effective May 2013, the Unit began submitting exclusion referrals to OIG within the 30-day timeframe.

Regarding our fourth recommendation, involving the Unit's sharing case lists with OIG, the Unit concurred with the recommendation to continue sharing cases lists with OIG. However, the Unit disagreed with the finding that the Unit did not provide OIG and other Federal agencies with timely information about cases. In response to the recommendation, the Unit stated that it began sharing its entire caseload list with OIG in May 2013 and will continue to do so.

Regarding our fifth recommendation, involving re-establishing collaborative efforts with the Northern and Southern Office of United States Attorneys, the Unit concurred with the recommendation. However, the Unit disagreed with the finding related to this recommendation and asserts that it cooperates fully and coordinates with Federal partners. The Unit stated that it currently collaborates with the Southern District and has reached out to the Northern District to improve communications, collaboration, and relationships.

Regarding our sixth recommendation, involving upgrading the case management and tracking system, the Unit concurred. A new system should be fully implemented by the end of June 2014.

Regarding our seventh recommendation, involving accurate reporting of recovery data, the Unit concurred. The Unit has taken a number of steps to ensure accurate reporting of recovery data and is working to correct the report function of the current case-tracking software so that all data will be captured and reported accurately.

Regarding our eighth recommendation, involving inventory logs, the Unit concurred. The Unit director asserted that, by February 2013, the Unit addressed all inventory deficiencies identified in the review, and, effective July 2013, the Unit implemented an employee equipment log to track inventory items issued to each employee.

We did not make changes to the report based on the Unit's comments. The full text of the Unit's comments is provided in Appendix G.

APPENDIX A

1994 Performance Standards³¹

1. **A Unit will be in conformance with all applicable statutes, regulations and policy transmittals.** In meeting this standard, the Unit must meet, but is not limited to, the following requirements:
 - a. The Unit professional staff must consist of permanent employees working full-time on Medicaid fraud and patient abuse matters.
 - b. The Unit must be separate and distinct from the State Medicaid agency.
 - c. The Unit must have prosecutorial authority or an approved formal procedure for referring cases to a prosecutor.
 - d. The Unit must submit annual reports, with appropriate certifications, on a timely basis.
 - e. The Unit must submit quarterly reports on a timely basis.
 - f. The Unit must comply with the Americans with Disabilities Act, the Equal Employment opportunity requirements, the Drug Free workplace requirements, Federal lobbying restrictions, and other such rules that are made conditions of the grant.
2. **A Unit should maintain staff levels in accordance with staffing allocations approved in its budget.** In meeting this standard, the following performance indicators will be considered:
 - a. Does the Unit employ the number of staff that was included in the Unit's budget as approved by the OIG?
 - b. Does the Unit employ the number of attorneys, auditors, and investigators that were approved in the Unit's budget?
 - c. Does the Unit employ a reasonable size of professional staff in relation to the State's total Medicaid program expenditures?
 - d. Are the Unit office locations established on a rational basis and are such locations appropriately staffed?
3. **A Unit should establish policies and procedures for its operations, and maintain appropriate systems for case management and case tracking.** In meeting this standard, the following performance indicators will be considered:
 - a. Does the Unit have policy and procedure manuals?

³¹ 59 Fed. Reg. 49080, Sept. 26, 1994.

- b. Is an adequate, computerized case management and tracking system in place?
- 4. A Unit should take steps to ensure that it maintains an adequate workload through referrals from the State Medicaid agency and other sources.** In meeting this standard, the following performance indicators will be considered:
- a. Does the Unit work with the State Medicaid agency to ensure adequate fraud referrals?
 - b. Does the Unit work with other agencies to encourage fraud referrals?
 - c. Does the Unit generate any of its own fraud cases?
 - d. Does the Unit ensure that adequate referrals of patient abuse complaints are received from all sources?
- 5. A Unit's case mix, when possible, should cover all significant provider types.** In meeting this standard, the following performance indicators will be considered:
- a. Does the Unit seek to have a mix of cases among all types of providers in the State?
 - b. Does the Unit seek to have a mix of Medicaid fraud and Medicaid patient abuse cases?
 - c. Does the Unit seek to have a mix of cases that reflect the proportion of Medicaid expenditures for particular provider groups?
 - d. Are there any special Unit initiatives targeting specific provider types that affect case mix?
 - e. Does the Unit consider civil and administrative remedies when appropriate?
- 6. A Unit should have a continuous case flow, and cases should be completed in a reasonable time.** In meeting this standard, the following performance indicators will be considered:
- a. Is each stage of an investigation and prosecution completed in an appropriate time frame?
 - b. Are supervisors approving the opening and closing of investigations?
 - c. Are supervisory reviews conducted periodically and noted in the case file?

7. A Unit should have a process for monitoring the outcome of cases.

In meeting this standard, the following performance indicators will be considered:

- a. The number, age, and type of cases in inventory.
- b. The number of referrals to other agencies for prosecution.
- c. The number of arrests and indictments.
- d. The number of convictions.
- e. The amount of overpayments identified.
- f. The amount of fines and restitution ordered.
- g. The amount of civil recoveries.
- h. The numbers of administrative sanctions imposed.

8. A Unit will cooperate with the OIG and other Federal agencies, whenever appropriate and consistent with its mission, in the investigation and prosecution of health care fraud. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit communicate effectively with the OIG and other Federal agencies in investigating or prosecuting health care fraud in their State?
- b. Does the Unit provide OIG regional management, and other Federal agencies, where appropriate, with timely information concerning significant actions in all cases being pursued by the Unit?
- c. Does the Unit have an effective procedure for referring cases, when appropriate, to Federal agencies for investigation and other action?
- d. Does the Unit transmit to the OIG, for purposes of program exclusions under section 1128 of the Social Security Act, reports of convictions, and copies of Judgment and Sentence or other acceptable documentation within 30 days or other reasonable time period?

9. A Unit should make statutory or programmatic recommendations, when necessary, to the State government. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit recommend amendments to the enforcement provisions of the State's statutes when necessary and appropriate to do so?
- b. Does the Unit provide program recommendations to State Medicaid agency when appropriate?

- c. Does the Unit monitor actions taken by State legislature or State Medicaid agency in response to recommendations?

10. A Unit should periodically review its memorandum of understanding (MOU) with the State Medicaid agency and seek amendments, as necessary, to ensure it reflects current law and practice. In meeting this standard, the following performance indicators will be considered:

- a. Is the MOU more than 5 years old?
- b. Does the MOU meet Federal legal requirements?
- c. Does the MOU address cross-training with the fraud detection staff of the State Medicaid agency?
- d. Does the MOU address the Unit's responsibility to make program recommendations to the Medicaid agency and monitor actions taken by the Medicaid agency concerning those recommendations?

11. The Unit director should exercise proper fiscal control over the Unit resources. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit director receive on a timely basis copies of all fiscal and administrative reports concerning Unit expenditures from the State parent agency?
- b. Does the Unit maintain an equipment inventory?
- c. Does the Unit apply generally accepted accounting principles in its control of Unit funding?

12. A Unit should maintain an annual training plan for all professional disciplines. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit have a training plan in place and funds available to fully implement the plan?
- b. Does the Unit have a minimum number of hours training requirement for each professional discipline, and does the staff comply with the requirement?
- c. Are continuing education standards met for professional staff?
- d. Does the training undertaken by staff add to the mission of the Unit?

APPENDIX B

2012 Revised Performance Standards³²

- 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

³² 77 Fed. Reg. 32645, June 1, 2012.

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.
- 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.
 - 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.
 - 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.

- 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 dollar amount of overpayments identified.
 - 6. 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.
 - 7. The number of criminal convictions and the number of civil judgments.
 - 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 prefilings 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 C

Population and Sample Distribution of Case Files Open at Any Time During Fiscal Years (FY) 2010 Through 2012

Data Element Description	Population of Case Files	Population of Case Files (Percentage)	Sample Case Files	Sample Case Files (Percentage)
Fraud—Civil (Open)	6	3	3	3
Fraud—Civil (Closed)	47	23.7	20	20
Fraud—Criminal (Open)	39	19.7	18	18
Fraud—Criminal (Closed)	32	16.2	14	14
Abuse—Civil (Open)	0	0	0	0
Abuse—Civil (Closed)	0	0	0	0
Abuse—Criminal (Open)	28	14.1	17	17
Abuse—Criminal (Closed)	29	14.6	17	17
Patient Funds— Civil (Open)	0	0	0	0
Patient Funds— Civil (Closed)	0	0	0	0
Patient Funds—Criminal (Open)	7	3.5	5	5
Patient Funds—Criminal (Closed)	10	5.1	6	6
Total	198	100	100	100

Source: Office of Inspector General analysis of West Virginia's Medicaid Fraud Control Unit Quarterly Statistical Reports, FYs 2010–2012.

APPENDIX D

Investigations Opened and Closed By Provider Category for Fiscal Years (FY) 2010 Through 2012

Table D-1: Fraud Investigations

Provider Category	FY 2010		FY 2011		FY 2012	
Facilities	Opened	Closed	Opened	Closed	Opened	Closed
Hospitals	0	1	0	0	0	0
Nursing Facilities	0	0	3	1	0	1
Other Long-Term Care Facilities	0	0	1	0	1	1
Substance Abuse Treatment Centers	0	0	0	0	0	0
Other	2	0	2	1	0	1
Subtotal	2	1	6	2	1	3
Practitioners	Opened	Closed	Opened	Closed	Opened	Closed
Doctors of Medicine or Osteopathy	1	6	4	1	5	3
Dentists	1	0	0	0	1	1
Podiatrists	0	0	0	1	0	0
Optometrists/Opticians	0	1	0	0	0	0
Counselors/Psychologists	0	0	0	0	0	0
Chiropractors	0	0	0	0	0	0
Other	0	0	0	0	0	0
Subtotal	2	7	4	2	6	4
Medical Support	Opened	Closed	Opened	Closed	Opened	Closed
Pharmacies	0	0	0	1	1	1
Pharmaceutical Manufacturers	10	10	18	15	7	10
Durable Medical Equipment and/or Supplies	0	2	0	0	1	1
Laboratories	0	0	1	0	1	1
Transportation Services	1	0	0	1	1	4
Home Health Care Agencies	0	2	3	2	3	1
Home Health Care Aides	4	0	3	1	11	3
Nurses, Physician Assistants, Nurse Practitioners, Certified Nurse Aides	1	1	0	0	0	1
Radiologists	0	0	0	0	0	0
Medical Support—Other	1	0	0	0	0	1
Subtotal	17	15	25	20	25	22

Table D-1 (Continued): Fraud Investigations

Program Related	Opened	Closed	Opened	Closed	Opened	Closed
Managed Care	1	1	0	0	0	0
Medicaid Program Administration	0	0	0	0	0	0
Billing Company	0	0	0	0	0	0
Other	0	0	0	0	0	0
Subtotal	1	1	0	0	0	0
Total Provider Categories	22	24	35	24	32	30

Source: Office of Inspector General (OIG) analysis of Unit Annual Reports, FYs 2010–2012.

Table D-2: Patient Abuse and Neglect Investigations

Provider Category	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing Facility	2	0	1	1	1	1
Other Long-Term Care	1	0	0	0	1	0
Nurses/Physician's Assistant/Nurse Practitioner/	0	0	1	1	1	0
Certified Nurse Aides	0	0	1	0	0	1
Home Health Aides	7	4	3	11	7	7
Other	4	3	0	1	0	0
Total	14	7	6	14	10	9

Source: OIG analysis of Unit Annual Reports, FYs 2010-2012.

Table D-3: Patient Funds Investigations

Provider Category	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Non-Direct Care	0	0	1	2	0	0
Nurses/Physician's Assistant/Nurse Practitioner/	0	0	0	0	0	0
Certified Nurse Aides	0	0	0	0	0	0
Other	2	5	2	4	4	1
Total	2	5	3	6	4	1

Source: OIG analysis of Unit Annual Reports, FYs 2010-2012.

APPENDIX E

Point Estimates and 95-Percent Confidence Intervals Based on Our Reviews of Case Files

We calculated confidence intervals for key data points for the case file reviews. The sample sizes, point estimates, and 95-percent confidence intervals are given for the each of the following:

Table E-1: Confidence Intervals for Case File Review Data

Data Element Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Cases opened more than 60 days of receiving the respective referrals	76	69.7%	61.9%–76.6%
Case files missing supervisory approval for the opening of investigations	81	19.8%	14.3%–26.7%
Case files missing documented supervisory approval for the closing of investigations	52	26.9%	19.2%–36.4%
Abuse and neglect case files missing documented periodic supervisory reviews (30-day case review)	44	72.7%	62.4%–81.1%
Fraud case files missing documented periodic supervisory reviews (90-day case review)	35	34.3%	24.0%–46.2%
Case files missing documented periodic supervisory reviews (any case)	79	55.7%	47.8%–63.3%

Source: Office of Inspector General analysis of West Virginia's Medicaid Fraud Control Unit case files, 2013.

APPENDIX F

Medicaid Fraud Control Unit Referrals by Provider Category for Fiscal Years (FY) 2010 Through 2012

Referral Source	FY 2010			FY 2011			FY 2012		
	Fraud	Abuse & Neglect	Patient Funds	Fraud	Abuse & Neglect	Patient Funds	Fraud	Abuse & Neglect	Patient Funds
Medicaid Agency – (Bureau for Medical Services, Office of Quality and Program Integrity) – PI/SURS ¹	1	1	0	10	3	4	33	10	21
Medicaid Agency – Other	20	4	2	18	12	7	4	0	2
State Survey & Certification	4	93	9	3	92	8	6	52	13
Other State Agencies	11	8	3	10	2	3	0	0	0
Licensing Board	1	0	0	0	0	0	1	0	0
Law Enforcement	0	0	1	1	1	1	1	1	0
Office of Inspector General	2	0	0	1	0	0	3	1	0
Prosecutors	0	0	0	0	0	0	0	0	0
Providers	2	0	0	6	1	0	12	4	2
Provider Associations	0	0	0	0	0	0	0	0	0
Private Health Insurer	0	0	0	0	0	0	0	0	0
Long Term Care Ombudsman	0	0	0	0	0	0	0	0	0
Adult Protective Services	0	5	0	3	10	6	0	5	0
Private Citizens	19	4	4	15	5	1	22	1	2
MFCU Hotline	0	0	1	0	0	0	0	1	0
Other	24	12	1	29	10	3	29	10	1
Total	84	127	21	96	136	33	111	85	21
Annual Total	232			265			237		

¹ "PI" = "program integrity"; "SURS" = "Surveillance and Utilization Review Subsystem."

Source: Office of Inspector General analysis of West Virginia's Medicaid Fraud Control Unit Quarterly Statistical Reports, FYs 2010-2012.

APPENDIX G

Unit Comments



Earl Ray Tomblin
Governor

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL
MEDICAID FRAUD CONTROL UNIT
408 LEON SULLIVAN WAY
Charleston, West Virginia 25301
Telephone: (304) 558-1858 Fax: (304) 558-3498

Karen L. Bowling
Cabinet Secretary

July 31, 2013

Stuart Wright
Deputy Inspector General
for Evaluation and Inspections
Room 5660 Cohen Building
330 Independence Avenue, SW
Washington, DC 20201

RE: West Virginia Medicaid Fraud Control Unit 2013 Onsite Review, OEI-07-13-00080

Mr. Wright,

The West Virginia Medicaid Fraud Control Unit is in receipt of the HHS-OIG Onsite Review report. We appreciate the opportunity to respond to this report, and the unit would like to express its appreciation for the professionalism and courtesy exhibited by your staff during the review process. As the MFCU management team is relatively new in their respective positions, this onsite review afforded the unit an opportunity to identify the unit's best practices and areas that need improvement.

Per your request, below you will find a response to each of the findings and recommendations. In each instance, the unit has already taken steps to address the identified deficiencies and will continue to work diligently to fully resolve all issues.

Finding: *The time from receipt of referral to the opening of the case exceeded 60 days for 70 percent of cases; two cases were open for an extended period and lacked documentation of case progression.*

Recommendation: *Open cases referred to the unit within 60 days of the receipt of referral and document all investigative activity.*

Response: The unit concurs with this finding and recommendation.

Analysis: The unit has experienced significant turnover in recent years. Throughout the review period, the unit consisted of 17 positions. During this period, 14 new personnel were hired, three existing personnel were promoted to different positions, and one transferred out of a supervisory position. Due to the high turnover rate and the time required to recruit, hire and train new employees, some cases were not opened within the allotted time or remained dormant for a period of time after opening. Additionally, the unit did not have enough staff compared to the volume of referrals. Further, problems with the current case management system make it difficult to enter documentation in a timely manner. The system is frequently inaccessible thereby requiring investigative staff to keep case notes outside the system, then paste into the system once it becomes available.

Plan: The unit was aware of this issue and had initiated action to correct this deficiency prior to the onsite review. Supervisors are conducting formal, monthly meetings with each investigator and reviewing case documentation to ensure appropriate progression in referrals and cases. Any case not handled in the appropriate time frame requires an explanation to the Director. Implementation of a new case management system should afford more efficient, automated tracking. This new system should be fully implemented by June 2014. Lastly, the unit was approved for eight additional positions in late 2012 and is currently working to fill those positions now that a previously imposed hiring restriction has been lifted. Although non-competitive salaries continue to create recruitment challenges, the unit will attempt to have all vacancies filled by June 2014.

Finding: *Case files lacked documentation of supervisory approval for key stages of investigations and periodic reviews.*

Recommendation: *Ensure that all case files contain documented supervisory approvals of opening and closing cases and documentation of periodic supervisory reviews.*

Response: The unit concurs with this finding, in part, and disagrees, in part. The unit concurs with the recommendation.

Analysis: The unit agrees that supervisory reviews were not always documented in the case files, specifically, supervisory reviews of the abuse and neglect cases were often done informally and not always well-documented.

The unit disagrees, however, that the case files lacked documented supervisory approval of openings and closings. Every case opening memo and case closure memo during the review period was composed by the Investigator, reviewed and approved by the Supervisor, then reviewed and approved by the Director. The Director then forwarded the case memo, via email, to the Office Assistant with instructions to either open or close the case. The Office Assistant then placed the opening or closing memo in the case file.

Plan: Expectations have been reinforced and Supervisors are currently having formal, monthly meetings with each investigator. Every case is being reviewed and these reviews are documented.

2

Effective February 2013, case opening and closing approvals sent to the Office Assistant by the Director are also copied to the case investigator and that email becomes part of the case file. Additionally, the new case management system will be configured for electronic approvals and tracking.

Finding: *The unit made all required referrals to OIG for program exclusions; however, in 10 of 20 instances, the unit sent the referral more than 30 days after sentencing.*

Recommendation: *Refer individuals for exclusion to OIG within the appropriate timeframe.*

Response: The unit concurs with this finding and recommendation.

Analysis: The unit refers cases to prosecutorial authorities within the state, which includes 55 county Prosecuting Attorneys' Offices and the United States Attorneys in the Northern and Southern Districts of West Virginia. The unit is not routinely notified of plea or sentencing hearings. Attempts to obtain this information are not always consistent or successful. Further, the unit has encountered difficulty obtaining signed sentencing orders or final orders in a timely manner. In West Virginia, it is not uncommon for an order to be signed by a Circuit Court Judge up to 30 days or more after a hearing, thus preventing the unit from meeting the 30 day deadline. The unit submits all exclusion referrals immediately upon receiving all final orders.

Plan: The West Virginia MFCU has made it a priority to build relationships with county prosecutors statewide. The Deputy Director attended the Summer Conference for the West Virginia Prosecuting Attorneys' Institute in June 2013 and is scheduled to give a presentation about the MFCU at the Winter Conference in January 2014. The unit has found that by educating the county prosecutors about the exclusion process and building relationships, the unit is provided with more timely information about the progression of cases.

The unit is currently monitoring all cases that have been referred for prosecution. The unit will more systematically contact the prosecutors on a monthly basis to monitor the progress of each case.

Effective May 2013, the unit began submitting exclusion referrals to the OIG within the 30-day timeframe, even if all adjudication paperwork was not available. The appropriate paperwork is then forwarded at a later date, immediately upon receipt.

Finding: *The Unit did not provide OIG and other federal agencies with timely information concerning significant actions in cases pursued by the unit.*

Recommendation: *The unit should continue sharing case lists with OIG, as agreed between the unit and OIG.*

Recommendation: *The unit should re-establish collaborative efforts with the northern and southern offices of United States Attorneys.*

Response: The unit does not concur with this finding but does agree with the recommendations.

Analysis: The review team cites Performance Standard 8(b) in this finding, which states: “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.”

The MFCU does, in fact, cooperate fully and coordinate with federal partners on all cases being pursued jointly and cases involving the same suspects (if known). Any cases referred to the unit by the OIG are worked jointly with the HHS agents or the unit is advised by HHS at the time of the referral that HHS has no interest in the case. The onsite review revealed that the MFCU does, in fact, share information in a timely manner any time the unit is requested to do so.

The unit maintains a good working relationship with HHS/OIG/OI. MFCU management meets regularly with HHS/OIG/OI management to discuss joint cases and to discuss how both agencies can work together to maximize the impact on healthcare crimes in West Virginia. The unit and HHS have worked a number of joint cases together throughout the review period and continue to do so. In response to a request from HHS/OIG/OI, the unit recently agreed to assist in a special investigative initiative and those efforts are ongoing.

The unit Director and the HHS OIG Special Agent in Charge agreed to share caseload lists as part of a deconfliction process. While the unit has always responded to specific requests from HHS/OIG/OI regarding investigative targets or other information, the unit began routinely sharing its entire caseload list in May 2013. The unit has not yet received reciprocal information from HHS/OIG/OI.

The unit disagrees with the assertion that the United States Attorney’s Offices (USAOs) “are no longer included in the Unit’s investigations or prosecutions.” In the preliminary draft report, the review team indicated the USAOs stated they have not worked any cases with the MFCU for several years, with the exception of one case. However USAOs did report that they do receive requested information from the MFCU in a timely manner. The unit identified, and presented to the review team, twenty cases that the unit worked with HHS/OIG/OI and the USAOs, both Northern and Southern District, during the review period. The twenty cases identified include a civil case against a nursing home, settled for \$2.25 million, that was initiated by the MFCU pursuant to a referral from the state licensing agency; a criminal case against a physician, worth \$3.7 million, that was initiated by an MFCU investigative auditor; a civil and criminal case against a pharmacy, with a judgment of \$250,000.00; a civil case against a podiatrist, with a judgment of \$1.4 million; a criminal case against a physician, tried and convicted, worth \$132,000.00, that was initiated by the MFCU pursuant to a referral from the Single State Agency; and a civil case against a transportation provider, settled for over \$1 million, initiated by the MFCU. The unit disagrees with the review team’s findings related to the unit’s relationship with federal partners.

Plan: The unit will continue to share the case list with HHS/OIG/OI and will continue to build relationships. The unit is currently collaboratively working cases with the USAO, Southern District of West Virginia, and will continue to strive to improve the working relationships. MFCU management has reached out to the Northern District AUSA in an effort to improve communications, collaboration and relationships but has received no response.

Finding: *The unit's case management and tracking system was inadequate.*

Recommendation: *Upgrade the unit's case management and tracking system.*

Response: The unit concurs with this finding and recommendation.

Analysis: Pursuant to the recommendation from the 2007 onsite review, the unit acquired and implemented a new case management and tracking system. This system was an improvement over what the unit used previously and did allow for the generation of required federal reports. However, as the unit's caseload increased and technology progressed, it became apparent the current system was unable to keep pace.

Plan: The unit began reassessing its case management needs in the fall of 2010 and published an RFQ in 2011. A contract was signed in 2012 and a kickoff meeting was held in May 2013. The new system should be fully implemented by the end of June 2014.

Finding: *The unit reported inaccurate recovery data.*

Recommendation: *The unit should ensure accurate reporting of recovery data.*

Response: The unit concurs with this finding and recommendation.

Analysis: The inaccurate reporting of recovery data has two main causes: failure of the computerized case management system and human error. The case management system, while an improvement over the previous system, does not adequately track and store the necessary information. The recovery data for each case must be manually calculated and entered into the system. The reports generated by the case management system do not accurately capture the data that has been entered. Therefore, case information must also be manually entered into spreadsheets and then compared to the reports generated by the case management system to determine the recovery data. The opportunities for human error are multiplied by this process. The onsite review has highlighted this weakness in our internal process of recording and reporting recovery data.

Plan: The unit has taken a number of steps to ensure accurate reporting of recovery data. The unit is working to correct the report function of the current case tracking software so that all data will be captured and reported accurately.

Internal controls have been developed to aid in ensuring the accurate recording and reporting of recovery data. Control activities include the segregation of duties, accurate and timely recording of events, review by Investigative Supervisors and approval by the Director. The processes are still being refined and new procedures will be finalized by the end of August 2013.

Additionally, the unit has begun the process of implementing a new case management system which will aid in improved accuracy and efficiency in maintaining data and creating accurate reports. The full implementation of the case management system should be complete by the end of June 2014.

Finding: *The unit's inventory logs did not include all property purchased by the unit.*

Recommendation: *The unit should ensure that all items purchased by the unit are documented in the inventory log.*

Response: The unit concurs with this finding and recommendation.

Analysis: The unit agrees that all items purchased by the unit should be documented in the inventory log and the results of a physical inventory should be reconciled with equipment records. The onsite review brought to light the fact that the unit inventory process was incomplete and the DHHR inventory records did not adequately meet the Performance Standard.

Plan: By February 2013, the unit addressed all inventory deficiencies identified in the review. All identified items are accounted for on the inventory logs. The unit will perform annual audits of the inventory logs in March of each year. The annual audit will include a physical verification and reconciliation of each item.

Effective July 2013, the unit implemented an employee equipment log to track inventory items issued to each employee. This log will be signed by each employee and either the Logistics Manager or the employee's Supervisor and will be continually updated when items are assigned to or returned by an employee. When an employee leaves the service of the MFCU, the log will be utilized to ensure that all items are returned to the unit.

Conclusion: The unit would like to thank the review team for its work on this evaluation and express appreciation for highlighting areas of deficiency and opportunities for improvement. Additionally, the unit would like to thank the review team for recognizing and reporting the unit's recent accomplishments as well. The Chief Investigative Auditor and the Healthcare Fraud Investigative Supervisor were credentialed as Certified Fraud Examiners and the unit's Nurse Investigator became a Certified Coding Professional. The unit's improved relationship with the Single State Agency was cited as a best practice in a recent CMS review of the Single State Agency. This collaboration has resulted in an improved referral process. The unit has also increased its outreach efforts to raise public awareness of the MFCU's mission and objectives, which resulted in an increase in quality referrals.

The West Virginia Medicaid Fraud Control Unit is dedicated to protecting West Virginia's vulnerable citizens and the integrity of its healthcare programs, and is committed to continuous improvement and exceeding the established Performance Standards. We look forward to the challenges ahead. Please let us know if you require further information or have any additional questions.

Sincerely,

/S/

Trina C. Crowder, Director
West Virginia Medicaid Fraud Control Unit
Office of Inspector General
West Virginia Department of Health and Human Resources

ACKNOWLEDGEMENTS

This report was prepared under the direction of Brian T. Pattison, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office.

Brian T. Whitley served as the team leader for this study. Other Office of Evaluation and Inspections staff who conducted the study include Thomas Brannon, Michael J. Brown, and Jordan R. Clementi. Office of Investigations staff who conducted the study include Shawn McAleer. Central office staff who contributed include Christine Moritz and Sherri Weinstein.

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

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. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.