

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**WISCONSIN STATE MEDICAID
FRAUD CONTROL UNIT:
2016 ONSITE REVIEW**



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EXECUTIVE SUMMARY: WISCONSIN STATE MEDICAID FRAUD CONTROL UNIT: 2016 ONSITE REVIEW OEI-07-16-00240

WHY WE DID THIS STUDY

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

HOW WE DID THIS STUDY

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

WHAT WE FOUND

For FYs 2013 through 2015, the Wisconsin Unit reported significant results including 24 convictions, 24 civil judgments and settlements, and combined criminal and civil recoveries of approximately \$137 million. This amounted to recovery of more than \$32 for every \$1 spent in the review period. However, we identified several operational deficiencies and found a lack of current and comprehensive written policies and procedures, which may have contributed to the Unit's noncompliance with Federal regulations and nonadherence to certain performance standards. Specifically, of the 41 Unit case files that we reviewed, 28 lacked documentation of supervisory approval to open the cases and 24 lacked documentation of periodic supervisory reviews. The Unit did not report half of its convictions and one adverse action to Federal partners, and it reported others outside of required timeframes. Furthermore, the Unit lacked a written training plan for its professional employees and investigated five cases that were outside of its grant authority. Finally, the Unit did not always maintain adequate internal controls related to personnel and accounting.

WHAT WE RECOMMEND

In addition to reimbursing OIG for Federal financial participation claimed for investigations of ineligible cases and unallowable expenditures for salary, fringe, and associated indirect costs, we recommend that the Wisconsin Unit: (1) ensure that it documents supervisory approval to open cases and supervisory reviews of Unit case files; (2) ensure that it consistently reports convictions and adverse actions to Federal partners within required timeframes; (3) establish written training plans for the Unit's professional disciplines; and (4) improve internal controls related to personnel and accounting. The Unit concurred with all six of our recommendations.

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OBJECTIVE

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

BACKGROUND

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

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

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

- be a single, identifiable entity of State government, distinct from the single State Medicaid agency;⁷
- develop a formal agreement, such as a memorandum of understanding, that describes the Unit's relationship with the State Medicaid agency;⁸ and

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

² Social Security Act § 1902(a)(61).

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

⁴ Social Security Act § 1903(q)(6); 42 CFR § 1007.13.

⁵ Office of Inspector General (OIG), *MFCU Statistical Data for Fiscal Year 2015*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm on February 17, 2016.

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

⁷ Social Security Act § 1903(q)(2); 42 CFR § 1007.5 and 1007.9(a).

⁸ 42 CFR § 1007.9(d).

- have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority.⁹

MFCU Funding

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

Oversight of the MFCU Program

The Secretary delegated to OIG the authority to administer the MFCU grant program.¹³ To receive Federal reimbursement, each Unit must submit an initial application to OIG for approval and be recertified each year thereafter.¹⁴

In annually recertifying the Units, OIG evaluates Unit compliance with Federal requirements and adherence to performance standards. The Federal requirements for Units are contained in the Social Security Act, regulations, and policy guidance.¹⁵ In addition, OIG has published 12 performance standards that it uses to assess whether a Unit is effectively performing its responsibilities.¹⁶ The standards address topics such as staffing, maintaining adequate referrals, and cooperation with Federal authorities. Appendix A of this report contains the performance standards.

OIG also performs periodic onsite reviews of the Units, such as this review of the Wisconsin MFCU. During each onsite review, OIG evaluates a Unit's compliance with laws, regulations, and policies, as well as the Unit's adherence to the 12 performance standards. OIG also makes observations about best practices, provides recommendations to the Units, and monitors

⁹ Social Security Act § 1903(q)(1).

¹⁰ Social Security Act § 1903(a)(6)(B).

¹¹ Ibid.

¹² OIG, *MFCU Statistical Data for Fiscal Year 2015*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm on February 17, 2016.

¹³ The Social Security Act authorizes the Secretary to award grants to the Units; the Secretary delegated this authority to OIG.

¹⁴ 42 CFR § 1007.15(a)(c).

¹⁵ On occasion, OIG issues policy transmittals to provide guidance and instructions to MFCUs.

¹⁶ 77 Fed. Reg. 32645 (June 1, 2012). Accessed at <http://www.oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf> on April 7, 2016.

the implementation of the recommendations. OIG's evaluations of MFCUs differ from other OIG evaluations in that they support OIG's direct administration of the MFCU grant program. These evaluations are subject to the same internal quality controls as other OIG evaluations, including internal peer review.

OIG provides additional oversight, including the collection and dissemination of performance data, training, and technical assistance.

Wisconsin MFCU

Located in Madison, the Unit—a division of the Wisconsin Department of Justice (DOJ)—investigates and prosecutes cases of Medicaid fraud and patient abuse or neglect. At the time of our June 2016 onsite review, the Unit employed 11 staff members: a director, an investigator supervisor, 2 attorneys, 5 senior auditors, a legal associate, a legal secretary, and no investigators. Unit investigators and auditors perform similar functions, despite holding different job classifications. The Unit director supervises attorneys, investigators, and support staff; the investigator supervisor oversees auditors. In FY 2015, combined Federal and State expenditures for Wisconsin's Medicaid program were approximately \$1.5 million.¹⁷

The Unit experienced significant management changes in 2015 and 2016. In September 2015, the Unit's investigator supervisor resigned. In October 2015, a Unit attorney was appointed as acting director. In February 2016, the acting Unit director became the Unit director. In April 2016, a Unit investigator was promoted to the position of investigator supervisor. At the time of our June 2016 onsite visit, the new management was creating and implementing new policies and procedures for the Unit's operations and conducting interviews for vacant investigator positions. We note that this review reflects Unit operations under previous management.

Referrals. The Unit receives referrals from a variety of sources, including the State Medicaid agency, private citizens, and others. Appendix B provides a breakdown of Unit referrals by referral source for the review period, FYs 2013 through 2015. The Unit director or his/her designee determines whether a case that is referred to the Unit should be opened for investigation.

Investigations and Prosecutions. Opened cases are assigned to an attorney and an investigator or auditor. During the review period, the Unit used a paper filing system. Although the Unit did not have a written policy

¹⁷ OIG, *MFCU Statistical Data for Fiscal Year 2015*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.pdf on February 18, 2016.

regarding review of cases, Unit management reported that Unit practice was to conduct monthly case review meetings with the investigator or auditor and the investigator supervisor. Unit management reported that the director also attended these meetings every other month. Periodic supervisory reviews were documented on a form within the case file titled “Administrative Reviews.” In November 2015, the Unit implemented an electronic case management system to track prosecutorial proceedings and was preparing to implement an electronic case management system for investigations following our onsite review.

Unit attorneys prosecute cases of criminal and civil Medicaid fraud, patient abuse, patient neglect, and misappropriation of patient funds. During the review period, Unit attorneys prosecuted civil cases in State court under the Wisconsin State False Claims Act. A relator provision of the law, which allows a private person to bring a lawsuit on behalf of the State, was repealed in July 2015.^{18,19}

Previous Onsite Review

In 2010, OIG issued a report regarding its onsite review of the Wisconsin Unit. The report found that a MFCU attorney had engaged in a minimal amount of non-MFCU work and that the Unit did not maintain time records regarding these activities. OIG recommended that the Unit request an exception before engaging in future unauthorized activities and after receiving approval, maintain strict time records for such activities. In addition, OIG recommended that the Unit employ an individual with medical or nursing expertise. Our 2016 onsite review found no evidence that Unit management failed to maintain time records for staff; however, we identified new issues related to timekeeping. We also found that the Unit employed a senior auditor who is a registered nurse, as recommended in our 2010 report.

METHODOLOGY

Data Collection and Analysis

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

¹⁸ Wisconsin False Claims for Medical Assistance Act, Wis. Stat. § 20.931.

¹⁹ The Unit director stated the Unit will continue to participate in multi-State qui tam (whistleblower) cases and can proceed in applying False Claims Act procedures through a nonrelator provision.

were open in FYs 2013 through 2015; and (7) observation of Unit operations. Appendix C provides details of our methodology.

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

Our review of the Wisconsin Unit found that it reported significant results during the review period: 24 criminal convictions; 24 civil judgments and settlements; and approximately \$137 million in combined criminal and civil recoveries. The Unit recovered more than \$32 for every \$1 spent.

However, we also identified several operational deficiencies. We found that the Unit did not have current and comprehensive written policies and procedures, which may have contributed to its noncompliance with Federal regulations and nonadherence to certain performance standards. In addition, the Unit did not always maintain adequate internal controls related to personnel and accounting.

For FYs 2013 through 2015, the Unit reported 24 criminal convictions; 24 civil judgments and settlements; and combined criminal and civil recoveries of approximately \$137 million

For FYs 2013 through 2015, the Unit reported 24 criminal convictions and 24 civil judgments and settlements. Table 1 illustrates the Unit's convictions and civil judgments and settlements for each fiscal year. Of the Unit's 24 convictions over the 3-year period, 21 involved provider fraud and 3 involved patient abuse or neglect.

Table 1: Wisconsin MFCU Criminal Convictions and Civil Judgments and Settlements, FYs 2013–2015

Outcomes	FY 2013	FY 2014	FY 2015	3-Year Total
Criminal Convictions	9	10	5	24
Civil Judgments and Settlements	2	10	12	24

Source: OIG analysis of Unit-submitted documentation, 2016.

The Unit reported criminal and civil recoveries of approximately \$137 million for FYs 2013 through 2015, with a range over the 3 years from \$34 million per year to \$55 million per year (shown in Table 2).

Table 2: Wisconsin MFCU Recoveries and Expenditures, FYs 2013–2015

Type of Recovery	FY 2013	FY 2014	FY 2015	3-Year Total
Civil (combined global and nonglobal)*	\$54,702,494	\$48,459,509	\$32,003,558	\$135,165,561
Criminal	\$54,750	\$550,803	\$1,547,374	\$2,152,927
Total Recoveries	\$54,757,244	\$49,010,312	\$33,550,932	\$137,318,488
Total Expenditures	\$1,274,531	\$1,359,679	\$1,512,865	\$4,147,075

Source: OIG, MFCU statistical data FYs 2013–2015 and OIG analysis of Unit-submitted documentation, 2016.

* "Global" recoveries derive from civil settlements or judgments involving the U.S. Department of Justice and a group of State MFCUs and are facilitated by the National Association of Medicaid Fraud Control Units. Prior to FY 2015, OIG did not require Units to report global and nonglobal civil recoveries as separate items. For this review, the Unit was unable to provide breakdowns (global vs. nonglobal) for its civil recoveries in FYs 2013 and 2014. For FY 2015, the Unit reported global recoveries of \$2,728,557 and nonglobal recoveries of \$29,275,001.

Prior to January 2017, the Unit lacked current and comprehensive written policies and procedures

At the time of our review, the Unit lacked current and comprehensive written policies and procedures governing Unit practices, which may have contributed to the Unit's noncompliance with Federal regulations and nonadherence to certain performance standards. During our onsite visit, the Unit provided a "Policy and Procedure Manual" dated October 2009 that addressed some aspects of Unit operations, such as the scope of the Unit's authority and policies governing referrals and closings. However, the manual did not address other important aspects of Unit operations, including (among several others) case reviews and case files. The Unit director acknowledged that during the review period, some policies were informal in nature, the manual was "out of date, and staff did not widely adhere to [the manual]." Staff survey responses also reflected that the existing manual was outdated, noting that previous Unit management used "verbal rules" (i.e., ad hoc procedures).

Performance Standard 3 states that a Unit should establish written policies and procedures for its operations and ensure that staff are familiar with, and adhere to, these policies and procedures. Written policies and procedures help ensure that a Unit conducts its operations, case file reviews, and training consistently. Following the onsite review, on July 1, 2016, the Unit distributed a new version of a Unit policies and procedures manual containing basic information (e.g., Unit jurisdiction, Unit

authority, Federal performance standards, etc.) On January 3, 2017, the Unit distributed updated policies and procedures that addressed additional aspects of operations, including administrative case reviews, reporting of convictions, and basic training for professional staff.

Of the 41 Unit case files that we reviewed, 28 lacked documentation of supervisory approval to open the cases, and 24 lacked documentation of periodic supervisory reviews

Of the 41 Unit case files that we reviewed, 28 lacked documentation of supervisory approval to open the case. However, only 3 cases of the 28 closed case files that we reviewed lacked documentation of supervisory approval to close the case.²⁰ Performance Standard 5(b) states that Unit supervisors should approve the opening and closing of cases. Unit policy requires that the director approve the opening and closing of cases. Supervisory approval to open cases indicates that Unit supervisors are monitoring the intake of cases, thereby facilitating progress in the investigation. Supervisory approval of the closing of cases helps ensure the timely completion and resolution of cases.

Of the 41 Unit case files that we reviewed, 24 lacked documentation of periodic supervisory reviews. In particular, these files lacked supervisor initials and/or notes regarding reviews on the administrative-review form within each case file. However, the Unit reported that its practice was to hold supervisory review meetings monthly.²¹ The current director stated that the monthly reviews included the investigator supervisor and the individual assigned to the case. Reviews held every other month also included the director. Performance Standards 5(b) and 7(a) state that supervisors should periodically review the progress of cases, consistent with Unit policies and procedures; ensure that each stage of an investigation and prosecution is completed in an appropriate timeframe; and note in the case file that the reviews take place. The director stated that the Unit is working to formalize processes and establish a written policy regarding supervisory case reviews.

²⁰ The Unit could not locate 7 of the 126 paper files for cases we requested for our sample. We excluded these cases from our review.

²¹ In the Unit's 2015 recertification questionnaire, the Unit reported that it held monthly supervisory reviews.

The Unit did not report half of its convictions and one adverse action to Federal partners and reported others outside of required timeframes

The Unit did not report half of its convictions to OIG for the purpose of program exclusion from Federal health care programs and one adverse action to the National Practitioner Data Bank (NPDB).²² An additional 10 convictions and 14 adverse actions were reported outside of required timeframes. Performance Standard 8(f) states that within 30 days of sentencing, the Unit should transmit to OIG reports of all convictions for the purpose of exclusion from Federal health care programs. Additionally, Federal regulations require that Units report any adverse actions resulting from investigations or prosecutions of healthcare providers to the NPDB within 30 days of the date of the final adverse action.²³

The Unit did not report half of its convictions to OIG; it did not report others within the required timeframe

The Unit did not report 12 of its 24 convictions (50 percent) to OIG for the purpose of program exclusion.²⁴ In addition, the Unit reported 10 convictions more than 30 days after sentencing dates. Table 3 shows the number of convictions that the Unit reported to OIG after the required timeframe. Late reporting of convictions to OIG delays the initiation of the program exclusion process, which may result in improper payments to providers by Medicare or other Federal health care programs or possible harm to beneficiaries. However, our analysis found that no Medicare or Medicaid claims were paid to the providers that the Unit reported late.

Table 3: Number of Convictions Reported to OIG After Required Timeframe

Federal Partner Reported To	Convictions Reported Within 31 to 60 Days After Sentencing	Convictions Reported Within 61 to 90 Days After Sentencing	Convictions Reported More Than 90 Days After Sentencing	Total Convictions Reported More Than 30 Days After Sentencing
OIG	2	1	7	10

Source: OIG analysis of Unit convictions and dates reported to OIG, 2016.

²² The Department of Health and Human Services established the NPDB as “a national health care fraud and abuse data collection program... for the reporting of certain final adverse actions... against health care providers, suppliers, or practitioners.” SSA § 1128E(a); 45 CFR § 61.1(2012). This information used to be housed in a separate databank called the Healthcare Integrity and Protection Databank (HIPDB). The HIPDB and the NPDB were merged into one databank in May 2013. 78 Fed. Reg. 20473 (April 5, 2013).

²³ SSA § 1128E(b)(4) and 45 CFR § 60.5.

²⁴ Following the onsite review, OIG recommended that the Unit submit all missing convictions to OIG. OIG confirmed that as of February 27, 2017, the Unit had submitted information for 7 of the 12 convictions remaining.

The Unit director explained that the reason these convictions were not reported or were reported late was that the Unit lacked current and comprehensive written policies and procedures and that management failed to monitor reporting to OIG.

The Unit reported all but one of its adverse actions to the NPDB; it did not report two-thirds within the required timeframe

The Unit reported all but one of its adverse actions to the NPDB. The Unit reported 14 of 21 adverse actions (67 percent) to the NPDB more than 30 days after the adverse action. Table 4 shows the number of adverse actions that the Unit reported to the NPDB after the required timeframe. Performance Standard 8(g) states that Units should report any adverse actions generated as a result of investigations or prosecutions of healthcare providers to the NPDB within 30 calendar days of the date of the final adverse action.²⁵ The NPDB is intended to restrict the ability of physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice and/or adverse actions. If a Unit fails to report adverse actions to the NPDB, individuals may be able to find new healthcare employment with an organization that is not aware of the adverse actions against them.

Table 4: Number of Adverse Actions Reported to the NPDB After Required Timeframe

Federal Partner Reported To	Adverse Actions Reported Within 31 to 60 Days After the Action	Adverse Actions Reported Within 61 to 90 Days After the Action	Adverse Actions Reported More Than 90 Days After the Action	Total Adverse Actions Reported More Than 30 Days After the Action
NPDB	5	2	7	14

Source: OIG analysis of Unit adverse actions and dates reported to the NPDB, 2016.

The Unit director stated that the Unit reported adverse actions to the NPDB late because of a lack of current and comprehensive written policies and procedures.

The Unit lacked a written training plan

Although Unit staff participated in introductory Medicaid training through

²⁵ Performance Standard 8(g) states that the Unit should report “qualifying cases to the Healthcare Integrity & Protection Databank [HIPDB], the National Practitioner Data Bank, or successor data bases.” The HIPDB and the NPDB were merged during our review period (FYs 2013 through 2015); therefore, we reviewed the reporting of adverse actions under NPDB requirements. 78 Fed. Reg. 20473 (April 5, 2013). Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions. See 45 CFR § 60.3.

the National Association of Medicaid Fraud Control Units and other training related to health care fraud and investigation techniques, the Unit did not have a formal written training plan during the review period. According to Performance Standard 12(a) and 12(d), a Unit should have a training plan that includes an annual number of required training hours for each professional discipline and should participate in MFCU-related training. Both the Unit director and investigator supervisor indicated that the unwritten rule was to provide one out-of-State training per year for staff, and they said that the Unit is currently working to address immediate training needs in the areas of investigative techniques, interviewing, and report writing.

The Unit investigated five sampled cases that were not eligible for Federal funding

In our review of the sampled cases, we found that the Unit investigated five cases that were ineligible for Federal matching funds—specifically, a Federal share of \$5,107.

In two cases, the Unit investigated alleged fraud committed by two funeral-service providers funded through the Wisconsin Funeral and Cemetery Aids Program (WFCAP).²⁶ The Medicaid statute and Federal regulations establish that a Unit may receive Federal Financial Participation only for fraud investigations that involve allegations of fraud in the administration of the Medicaid program, in the provision of medical assistance, or in the activities of Medicaid providers under the State Medicaid plan.²⁷ However, a funeral service provider is not a provider under the State Medicaid plan; the WFCAP is not included in the State's Medicaid plan or waivers; the WFCAP does not meet the definition of medical assistance; and funerals are not covered by the Federal Medicaid program. Therefore, the investigation of these cases was not eligible for Federal funding.²⁸

In two other cases, the Unit investigated complaints of patient abuse or neglect in private residences. Since the complaints occurred outside of health care facilities or board and care facilities, these cases were also ineligible for Federal funding.²⁹

²⁶ Wisconsin's Department of Health Services administers the WFCAP, under which funeral and cemetery costs for decedents who received Medicaid benefits are eligible for reimbursement up to \$2,500.

²⁷ SSA § 1903(q)(3) and 42 CFR §§ 1007.11(a) and 1007.19(d).

²⁸ SSA § 1905; Wis. Stat. 49.43(8); Wis. Stat. 49.785(1).

²⁹ SSA § 1903(q)(4)(A) and 42 CFR § 1007.19(d).

In a fifth case, the Unit investigated an attorney who allegedly manipulated his client's application for Medicaid to meet eligibility requirements. However, investigations of eligibility fraud that do not involve suspected conspiracy with a provider are not eligible for Federal funds.³⁰

The Unit did not always maintain adequate internal controls related to personnel and accounting, and it reported unallowable expenses to the grant program

The Unit did not always maintain adequate internal controls related to personnel and accounting, and it did not always ensure that personnel expenditures were allowed and adequately supported in accordance with Federal regulations. Also, some timecards did not contain documentation of supervisory approval. Additionally, multiple transactions related to costs shared among the Unit and other entities lacked an allocation methodology.

Personnel costs were improperly charged

The Unit claimed a net \$25,095 (with a Federal share of \$18,821) in unallowable expenditures for salary, fringe, and associated indirect costs during the review period.³¹ Federal regulations generally describe allowable costs incurred by State governments as necessary; reasonable; allocable; consistent; not used for other Federal awards cost-sharing; and adequately documented.³² However, OIG auditors found the Unit duplicated charges for nine pay periods of an employee's salary and fringe costs. The auditors also identified three payroll transactions in which the Unit incorrectly submitted the costs incurred by the employee rather than the Unit's portion of those costs. Lastly, the Unit made an unsupported adjustment to an employee's salary and fringe costs.

Timecards did not always contain documentation of supervisory approval

Supervisors did not always approve time and attendance records for the Unit's employees. For 1 of the pay periods reviewed, 4 of the 13 timecards did not contain documentation of supervisory approval. Performance Standard 11(c) states that "[t]he Unit maintains an effective time and attendance system and personnel activity records." In addition, Federal cost principles require charges to Federal awards for salaries and wages to "be based on payrolls documented in accordance with generally accepted

³⁰ 42 CFR § 1007.19(e)(5).

³¹ Fringe costs are the costs for fringe benefits (i.e., the nonwage compensation that an employer provides to an employee.)

³² 2 CFR pt. 225, Appendix A and 45 CFR § 92.20(b)(6).

practice of the [Unit] and approved by a responsible official(s) of the [Unit].”³³ The Unit’s parent agency—the Wisconsin DOJ—had a policy stating that supervisors were responsible for “ensuring all hours are correctly tabulated and reported.” Although the Unit generally practiced supervisory approval of timecards in accordance with Wisconsin DOJ policy, the Unit lacked a written policy explicitly requiring supervisory approval of timecards prior to being processed.

Multiple transactions lacked an allocation methodology

The Unit was unable to provide an allocation methodology to support multiple transactions related to costs shared by the Unit and other entities in the Wisconsin DOJ. In order to be allowable under a Federal award, costs must be allocable.³⁴ Regulations state: “A cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received.”³⁵ Failing to allocate costs based on criteria such as numbers of employees or hours worked could lead to incorrect apportionment of shared costs. The auditors reviewed 11 sample items that did not have documentation to support the basis of the percentages charged. The sample items included allocated expenditures for chairs, law library subscriptions, equipment leases, and other direct costs shared among the Unit and other entities in the Wisconsin DOJ. Although the percentages charged to the Unit appear to be reasonable, the Unit should have a written methodology in place that supports that the allocation is in accordance with the relative benefits received. The Unit stated that it planned to reassess and document all allocations.

³³ 2 CFR pt. 225, Appendix B, § 8.h(1).

³⁴ 2 CFR pt. 225, Appendix A, § C.1.b.

³⁵ 2 CFR pt. 225, Appendix A, § C.3.a.

CONCLUSION AND RECOMMENDATIONS

Our review of the Wisconsin Unit found that it reported significant results during the review period: 24 criminal convictions; 24 civil judgments and settlements; and approximately \$137 million in combined criminal and civil recoveries. The Unit recovered more than \$32 for every \$1 spent.

However, we identified a number of operational deficiencies. Specifically, the Unit's policies and procedures were outdated and incomplete for the entire review period. The lack of current and comprehensive written policies and procedures may have contributed to the Unit's noncompliance with Federal regulations and nonadherence to certain performance standards. For example, the Unit did not report some convictions and adverse actions to Federal partners and reported others outside of required timeframes. Further, the Unit lacked a written training plan for its professional employees.

Through our review of case files, we identified other areas in which the Unit should improve its operations. Of the 41 Unit case files that we reviewed, 28 lacked documentation of supervisory approval to open the case, and 24 case files open longer than 30 days lacked documentation of supervisory case reviews. In addition, the Unit investigated five cases that were not eligible for Federal funding.

Finally, the Unit did not exercise adequate fiscal control of its resources, and reported \$25,095 (\$18,821 in Federal matching funds) in unallowable expenditures for salary, fringe, and associated indirect costs during the review period.

We recommend that the Wisconsin Unit:

Take appropriate steps to ensure that it documents supervisory approval to open cases and supervisory reviews of Unit case files

The Unit should ensure that it documents supervisory approval to open cases and supervisory reviews of Unit case files. To ensure that new policies and related processes are working as intended, the Unit could review a sample of its own case files to determine whether the changed policies and processes are effective. If the Unit finds that some reviews are not being documented, it should further revise its processes to ensure the documentation of supervisory case reviews.

Ensure that convictions and adverse actions are consistently reported to Federal partners within required timeframes

The Unit should ensure that convictions are consistently reported to OIG within 30 days of sentencing and that adverse actions are reported to the NPDB within 30 days of the action.

Establish written training plans for the Unit's professional disciplines

The Unit should develop and implement formal training plans in accordance with Performance Standard 3 and Performance Standard 12. The Unit may work with the National Association of Medicaid Fraud Control Units or OIG to identify additional relevant training opportunities for staff.

Improve internal controls related to personnel and accounting

The Unit should ensure that personnel expenditures are allowable and adequately supported by documentation in accordance with Federal regulations. The Unit should also develop a policy that expands and clarifies existing Wisconsin DOJ policy and explicitly requires supervisory approval of timecards before they can be processed. Finally, the Unit should identify and use a consistent written allocation methodology for costs that are shared among the Unit and other entities in the Wisconsin DOJ.

Repay Federal matching funds spent investigating cases that were ineligible for Federal funding

The Unit should work with OIG to repay the \$5,107 Federal matching funds related to expenditures associated with investigating the five ineligible cases.

Repay Federal matching funds spent on unallowable expenditures for salary, fringe, and associated indirect costs

The Unit should work with OIG to repay the \$18,821 Federal matching funds related to unallowable expenditures for salary, fringe, and associated indirect costs during the review period.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Wisconsin Unit concurred with all six of our recommendations.

Regarding the first recommendation, the Unit stated that it has implemented policies requiring written approval for all case openings and written documentation of quarterly supervisory case reviews.

Regarding the second recommendation, the Unit stated that it has established policies requiring the reporting of convictions and adverse actions to Federal partners within 30 days of sentencing.

Regarding the third recommendation, the Unit stated that it has implemented a policy regarding basic training for professional staff.

Regarding the fourth recommendation, the Unit explained that it has taken several steps to improve internal controls related to personnel and accounting, including (1) quantifying and paying actual Unit costs where possible and appropriate; (2) implementing a practice whereby the Unit director personally approves all Unit expenses; and (3) implementing a practice whereby the Unit director reviews, approves, and certifies quarterly Federal Financial Reports.

Regarding the fifth and sixth recommendations, the Unit agreed to reimburse Federal matching funds associated with (1) investigating ineligible cases and (2) unallowable expenditures for salary, fringe, and associated indirect costs by offsetting the current-year grant.

The Unit's comments are provided in Appendix D.

APPENDIX A

2012 Performance Standards³⁶

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

³⁶ 77 Fed. Reg. 32645, June 1, 2012.

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

4. The number of referrals received by the Unit and the number of referrals by the Unit to other agencies.
5. The number of cases criminally prosecuted by the Unit or referred to others for prosecution, the number of individuals or entities charged, and the number of pending prosecutions.
6. The number of criminal convictions and the number of civil judgments.
7. The dollar amount of overpayments identified.
8. The dollar amount of fines, penalties, and restitution ordered in a criminal case and the dollar amount of recoveries and the types of relief obtained through civil judgments or pre-filing 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 <i>CMS Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit</i> .

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

APPENDIX B

Unit Referrals by Referral Source for FYs 2013 Through 2015

Referral Source	FY 2013		FY 2014		FY 2015		Total
	Fraud	Abuse/ Neglect ¹	Fraud	Abuse/ Neglect	Fraud	Abuse/ Neglect	
State Medicaid agency – Program Integrity Unit	26	1	17	2	57	40	143
State Medicaid agency - other	4	27	8	13	0	0	52
Managed care organizations	0	0	0	0	0	0	0
State survey and certification agency	0	0	0	0	0	0	0
Other State agencies	0	0	1	0	2	0	3
Licensing board	0	0	0	0	0	0	0
Law enforcement	0	2	0	0	1	0	3
OIG	0	0	0	0	0	0	0
Prosecutors	1	0	0	0	0	0	1
Providers	1	1	0	0	0	0	2
Provider associations	0	0	0	0	0	0	0
Private health insurer	0	0	0	0	0	0	0
Ombudsman	0	0	0	0	0	0	0
Adult protective services	0	0	0	0	0	0	0
Private citizens	10	5	2	0	6	2	25
MFCU hotline ²	0	0	0	0	NA	NA	0
Anonymous ³	NA	NA	NA	NA	0	0	0
Other ⁴	82	1	59	1	56	0	199
Total	124	37	87	16	122	42	428
Annual Total		161		103		164	

Source: OIG analysis of Unit Quarterly and Annual Statistical Reports, FYs 2013–2015, 2016.

¹ The category of referrals of abuse and neglect includes referrals regarding misappropriation of patients' funds.

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

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

⁴ The referral source "Other" includes qui tam False Claims Act cases, a referral from a Medicaid Personal Care waiver program, and a referral from the California Department of Justice.

APPENDIX C

Detailed Methodology

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

Data Collection

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

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

Review of Unit Financial Documentation. To evaluate internal control of fiscal resources, we reviewed policies and procedures related to the Unit's budgeting, accounting systems, cash management, procurement, property, and staffing. We reviewed records in the Payment Management System (PMS)³⁷ to identify unusual patterns of drawdown amounts, and we reviewed Federal Financial Reports (FFRs) that the Unit submitted for FYs 2013 through 2015. We also obtained the Unit's claimed grant expenditures from its FFRs and the supporting schedules. We requested from the Unit and reviewed its supporting documentation for the selected items from the supporting schedules.

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

1. To assess the Unit's expenditures, we selected a purposive sample of 56 of the 952 transactions within the direct cost categories across the 3 years of the review period. We reviewed supporting documentation to determine whether the costs claimed were allowable, allocable, and reasonable, in accordance with Federal regulations.

³⁷ The PMS is a grant payment system operated and maintained by the Department of Health and Human Services, Program Support Center, Payment Management Services. The PMS provides disbursement, grant monitoring, reporting, and cash management services to awarding agencies and grant recipients, such as MFCUs.

2. To assess inventory, we selected and verified a purposive sample of 24 items from the current inventory list of 91 items.
3. To assess employee time and effort, we reviewed timecard records from 3 pay periods across the 3 years of the review period for all Unit employees on staff.

Interviews with Key Stakeholders. In May and June 2016, we interviewed key stakeholders including officials in the U.S. Attorneys' Offices, the State Attorney General's Office, and other State agencies that interacted with the Unit (i.e., the Medicaid Program Integrity Unit, the Office of Caregiver Quality, and the State Long-Term Care Ombudsman). We also interviewed an investigator from OIG's Region V office who works regularly with the Unit, as well as officials from the Internal Revenue Service and the U.S. Department of Labor. The interviews focused on the Unit's relationship and interaction with OIG and other Federal and State authorities, and 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 May 2016, we conducted an online survey of all nine nonmanagerial Unit staff (i.e., auditors, attorneys, and support staff). The response rate was 100 percent. Our questions focused on Unit operations, opportunities for improvement, and practices that contributed to the effectiveness and efficiency of Unit operations and/or performance. The survey also sought information about the Unit's compliance with applicable laws and regulations.

Onsite Interviews with Unit Management. We conducted structured interviews with the Unit's management during the onsite review in June 2016. We interviewed the Unit's director and investigator supervisor. We asked these individuals to provide information related to (1) the Unit's operations; (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance; (3) opportunities for the Unit to improve its operations and/or performance; and (4) clarification regarding information obtained from other data sources.

Onsite Review of Case Files and Other Documentation. We requested that the Unit provide us with a list of cases that were open at any point during FYs 2013 through 2015. For the 722 open cases, we requested data including, but not limited to, the current status of the case; whether the case was criminal, civil, or global; and the date on which the case was opened. Because global cases are civil false claims actions that typically involve multiple agencies, such as the U.S. DOJ and a group of State MFCUs, we exclude those cases from our review of a Unit's case files. Therefore, we excluded from our list 225 cases that were categorized as

“global.” We also excluded 32 cases that had been opened after the end of our review period, 3 cases that had been closed prior to the beginning of our review period, and 6 cases that were duplicated in the population.

From the universe of 456 cases, we selected a purposive sample of 16 cases: 15 cases categorized as “misappropriation of patient funds” and 1 criminal case. We reviewed 14 of the 16 cases while on site; the Unit could not locate the remaining 2 case files. We conducted this review of 14 cases because of concerns identified in Unit staff surveys prior to the onsite review.

From the remaining 440 cases, we selected a simple random sample of 110 cases for review. From this initial sample of 110 case files, we selected a simple random sample of 55 files for a more in-depth review of selected issues, such as the timeliness of investigations and case development.

Sixty-five sampled cases were not reviewed. Fifty-eight cases were global cases, and two cases did not represent cases investigated by the Unit. The Unit could not locate the files for remaining five cases. After excluding the ineligible cases, we reviewed a total of 45 case files, for which all of the cases had been open long enough to require supervisory review. Thirty of the 45 reviewed cases had been closed. After receiving our preliminary unsigned draft report, the Unit provided comments identifying 4 of the 45 cases as ineligible for supervisory reviews. Specifically, the Unit categorized the cases as *qui tams* for which the Unit was neither the lead investigator nor lead prosecuting attorney. We subsequently excluded those four cases.³⁸

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

Data Analysis

We analyzed data to identify any opportunities for improvement and any instances in which the Unit did not fully meet the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.³⁹

³⁸ The additional exclusion from the sample left 41 eligible cases for review out of the 110 sampled cases. Twenty-eight of the cases were closed.

³⁹ All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu>.

APPENDIX D

Unit Comments



STATE OF WISCONSIN
DEPARTMENT OF JUSTICE

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May 9, 2017

Suzanne Murrin
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Office of Evaluations and Inspections
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U.S. Department of Health and Human Services
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Rm. 5660
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Re: Wisconsin Medicaid Fraud Control Unit: 2016 on-site review
OEI-07-16-00240

Dear Ms. Murrin:

We are writing to provide the Wisconsin Department of Justice's comments to the Office of Inspector General, Office of Evaluations and Inspections' draft report dated March 31, 2017.

We are pleased that OIG recognized our Unit's highly successful work over the past four years, including the specific finding that we recovered nearly \$137 million for the hardworking taxpayers of Wisconsin. As OIG found, "[t]he Unit recovered more than \$32 for every \$1 spent." We are proud of this excellent return on investment.

OIG's draft report includes six recommendations. Each recommendation is discussed below as well as the affirmative steps the Unit has taken in response.

Suzanne Murrin
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Recommendation #1: Take appropriate steps to ensure that [the Unit] documents supervisory approval to open cases and supervisory reviews of Unit case files.

Comment: The Unit concurs with Recommendation #1 and has taken steps to comply with this recommendation by implementing policies requiring written approval of all case openings and written documentation of quarterly supervisory case reviews.

Recommendation #2: Ensure that convictions and adverse actions are consistently reported to Federal partners within required timeframes.

Comment: The Unit concurs with Recommendation #2 and has taken steps to comply with this recommendation by implementing policies requiring the reporting of convictions within 30 days of sentencing.

Recommendation #3: Establish written training plans for the Unit's professional disciplines.

Comment: The Unit concurs with Recommendation #3 and has taken steps to comply with this recommendation by implementing a Unit policy regarding written basic training for professional staff.

Recommendation #4: Improve internal controls related to personnel and accounting.

Comment: The Unit concurs with Recommendation #4 and has taken steps to comply with this recommendation, including the following: quantifying and paying actual Unit costs where possible and appropriate, implementing a practice where the Unit Director personally approves all Unit expenses, and implementing a practice where the Unit Director reviews, approves, and certifies quarterly Federal financial reports (SF425).

Recommendation #5: Repay Federal matching funds spent investigating cases that were ineligible for Federal funding.

Comment: The Unit concurs with Recommendation #5 and has agreed with OIG to reimburse funds associated with investigating ineligible cases by offsetting the current year grant.

Suzanne Murrin
May 9, 2017
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Recommendation #6: Repay Federal matching funds spent on unallowable expenditures for salary, fringe, and associated indirect costs.

Comment: The Unit concurs with Recommendation #6 and has agreed with OIG to reimburse funds associated with unallowable expenditures by offsetting the current year grant.

* * * *

Throughout the on-site review and audit process, the Unit has aspired to be responsive and communicative, candid about its operations, open to OIG recommendations, and quick to implement affirmative remedial measures.

The Unit thanks the OIG team for the professionalism of its staff during the on-site review process and appreciates the opportunity to provide these comments to the draft report.

Sincerely,



Timothy C. Samuelson
Assistant Attorney General
Director, Medicaid Fraud Control & Elder
Abuse Unit

TCS:lg

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ACKNOWLEDGMENTS

This report was prepared under the direction of Brian T. Whitley, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office, and Jennifer King, Deputy Regional Inspector General; and in consultation with Richard Stern, Director of the Medicaid Fraud Policy and Oversight Division.

Tricia Fields, of the Kansas City regional office, served as project leader for this study. Other Office of Evaluation and Inspections staff who conducted the review include Dana Squires. Other Medicaid Fraud Policy and Oversight Division staff who participated in the review include Frantzy Clement. Office of Investigations staff also participated in the review. Office of Audit Services staff who conducted a financial review include Dave Markulin and Laura Behnke. Central office staff who contributed include Kevin Farber, Lonie Kim, Joanne Legomsky, and Christine Moritz.

Office of Inspector General

<http://oig.hhs.gov>

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