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Wisconsin Medicaid Fraud Control Unit: 2024 Inspection

REPORT HIGHLIGHTS



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Why OIG Did This Review

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

What OIG Found



The Unit shared supervision of its special agent positions with another division in the Wisconsin Department of Justice, but lacked a memorandum of understanding (MOU) to ensure that these positions are supervised in compliance with Federal requirements.



The Unit's electronic case management system did not allow the Unit to efficiently access and maintain case information and performance data.



The Unit lacked adequate policies and procedures for effectively maintaining case files.



The Unit did not consistently document periodic supervisory reviews or supervisory approvals to open cases in its case files during our review period.



The Unit maintained positive working relationships with Federal law enforcement partners but lacked policies for deconflicting cases with these partners.



The Unit did not report four convictions and one adverse action to Federal partners during the review period, as required.



The Unit's MOU with the State Medicaid agency did not reflect several legal requirements.

What OIG Recommends

To address the findings, we recommend that the Unit (1) establish an MOU with the Division of Criminal Investigations to ensure that special agents are supervised in accordance with Federal requirements; (2) implement a comprehensive case management system that allows the Unit to efficiently access and maintain case information and performance data; (3) establish policies and procedures to help ensure that case files are maintained effectively; (4) ensure that supervisory reviews and supervisory approvals to open cases are consistently documented in accordance with Unit policy; (5) establish written policies for deconflicting cases with Federal partners; (6) take steps to report all convictions and adverse actions to Federal partners within the appropriate timeframes; and (7) revise its MOU with the State Medicaid agency to reflect applicable legal requirements.

The Unit reported taking alternative steps to address the first recommendation and concurred with the other six recommendations.

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BACKGROUND

OBJECTIVE

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

Medicaid Fraud Control Units

MFCUs investigate Medicaid provider fraud and patient abuse or neglect and prosecute those cases under State law or refer them to other prosecuting offices.^{1, 2, 3} Under the Social Security Act (SSA), a MFCU must be a “single, identifiable entity” of State government, “separate and distinct” from the State Medicaid agency, and employ one or more investigators, attorneys, and auditors.⁴ Each State must operate a MFCU or receive a waiver.⁵ Currently, 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operate MFCUs.⁶

MFCUs are funded jointly by Federal and State governments. Each Unit receives a Federal grant award equivalent to 90 percent of total expenditures for new Units and 75 percent for all other Units.⁷ In Federal fiscal year (FY) 2023, combined Federal and State expenditures for the MFCUs totaled approximately \$369 million, of which approximately \$277 million represented Federal funds.⁸

¹ SSA § 1903(q)(3)–(4). Regulations at 42 CFR § 1007.11(b)(1) clarify that a Unit’s responsibilities include the review of complaints of misappropriation of patients’ private funds in health care facilities.

² As of December 27, 2020, MFCUs may also receive Federal financial participation to investigate and prosecute abuse or neglect of Medicaid beneficiaries in a noninstitutional or other setting. Consolidated Appropriations Act, 2021, Public Law 116-260, Division CC, § 207.

³ References to “State” in this report refer to the States, the District of Columbia, and the U.S. territories that operate MFCUs.

⁴ SSA § 1903(q).

⁵ SSA § 1902(a)(61).

⁶ The territories of American Samoa, Guam, and the Northern Mariana Islands have not established Units.

⁷ SSA § 1903(a)(6). For a Unit’s first 3 years of operation, the Federal Government contributes 90 percent of funding and the State contributes 10 percent. Thereafter, the Federal Government contributes 75 percent and the State contributes 25 percent.

⁸ OIG analysis of MFCU annual statistical reporting data for FY 2023.

OIG Grant Administration and Oversight of Medicaid Fraud Control Units

The Office of Inspector General (OIG) administers the grant award to each Unit and provides oversight of Units.^{9, 10} As part of its oversight, OIG conducts a desk review of each Unit during the annual recertification process. OIG also conducts periodic inspections and reviews. Finally, OIG provides ongoing training and technical support to the Units.

In its annual recertification review, OIG examines the Unit's reapplication materials, case statistics, and questionnaire responses from Unit stakeholders. Through the recertification review, OIG assesses a Unit's performance, as measured by the Unit's adherence to published performance standards;¹¹ the Unit's compliance with applicable laws, regulations, and OIG policy transmittals;¹² and the Unit's case outcomes.

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

Wisconsin MFCU

The Wisconsin Unit is located within the Department of Justice (DOJ) in Madison and has Statewide jurisdiction to prosecute Medicaid provider fraud and patient abuse and neglect cases. At the time of our inspection in May 2024, the Unit had an approved staff size of 15, and it employed 13 staff—4 attorneys (including the Director and Deputy Director¹³), 5 investigators (including 4 investigators without law enforcement authority and 1 investigator with law enforcement authority, referred to as a "special agent"), 2 auditors, and 2 paralegals. The Unit had two vacancies at the time of the inspection, for one auditor and one special agent. During the review

⁹ As part of grant administration, OIG receives and examines financial information from Units, such as budgets and quarterly and final Federal Financial Reports that detail MFCU income and expenditures.

¹⁰ The SSA authorizes the Secretary of Health and Human Services to award grants (SSA § 1903(a)(6)) and to certify and annually recertify the Units (SSA § 1903(q)). The Secretary delegated these authorities to OIG in 1979.

¹¹ MFCU performance standards are published at [77 Fed. Reg. 32645](#) (June 1, 2012) and [89 Fed. Reg. 76431](#) (Sept. 18, 2024). The performance standards were developed by OIG in conjunction with the MFCUs and were originally published at 59 Fed. Reg. 49080 (Sept. 26, 1994).

¹² OIG occasionally issues policy transmittals to provide guidance and instruction to MFCUs. Policy transmittals are located at <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp>.

¹³ The Deputy Director is an attorney but serves as the Investigation Supervisor within the Unit and does not prosecute cases or serve as an attorney on case teams.

period of FYs 2021–2023, the Unit spent approximately \$4.9 million, with a State share of approximately \$1.2 million.

Referrals

The Unit receives referrals of potential Medicaid provider fraud and of patient abuse or neglect from several sources, including the State survey and certification agency, known as the Division of Quality Assurance; the Department of Health Services' Office of the Inspector General (DHS-OIG); and local law enforcement agencies. The Director and Deputy Director review each referral and may request additional information from the referring agency if needed to evaluate the referral. The Director and Deputy Director decide whether to open a case or decline it for investigation.

Investigations and Prosecutions

Once the Unit decides to open a case, the Deputy Director assigns the matter to an investigator. Throughout the investigative phase of a case, Unit attorneys advise on cases and auditors assist with data analysis. Investigators participate in periodic supervisory reviews of their cases with the Director; the Deputy Director; and the auditor and attorney assigned to the case. Upon completion of investigative activities, the case is closed, charged criminally, or filed civilly.

Wisconsin Medicaid Program

DHS administers the Wisconsin Medicaid program. As of April 2024, the program served approximately 1.2 million enrollees.¹⁴ Approximately 82 percent of Wisconsin Medicaid enrollees received services through managed care entities as of July 2022,¹⁵ and as of August 2024, services were provided through 19 managed care entities.¹⁶ In FY 2023, Wisconsin's Medicaid expenditures were approximately \$12.5 billion.¹⁷

DHS-OIG is responsible for Medicaid program integrity efforts. DHS-OIG investigates complaints of potential Medicaid fraud, including those received from managed care entities, and refers cases of suspected fraud to the Unit when appropriate.

Methodology

OIG conducted an onsite inspection of the Wisconsin MFCU in May 2024. Our inspection covered the 3-year period of FYs 2021–2023. We based our inspection on an analysis of data and information from 7 sources: (1) Unit documentation;

¹⁴ Centers for Medicare and Medicaid Services (CMS), [Updated April 2024 State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data](#). Accessed on Sept. 16, 2024.

¹⁵ Kaiser Family Foundation, [Share of Medicaid Population Covered under Different Delivery Systems](#). Accessed on Sept. 16, 2024.

¹⁶ OIG analysis of DHS data.

¹⁷ OIG, [MFCU Statistical Data for FY 2023](#). Accessed on Sept. 11, 2024.

(2) financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with the Unit's managers and other selected staff; (5) a review of a random sample of 80 case files from the 297 nonglobal case files that were open at some point during the review period; (6) a review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period; and (7) an onsite review of Unit operations. See the Detailed Methodology.

In examining the Unit's operations and performance, we applied the published performance standards,¹⁸ but we did not assess adherence to every performance indicator for every standard.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency. These inspections differ from other OIG evaluations in that they support OIG's direct administration of the MFCU grant program. They are subject to the same internal quality controls as are other OIG evaluations, including internal and external peer review.

¹⁸ The performance standards were updated on September 18, 2024, but our inspection evaluated the Unit's compliance with the applicable 2012 performance standards.

PERFORMANCE ASSESSMENT

In assessing the performance and operations of the Wisconsin Unit, we identified the Unit’s case outcomes, evaluated whether the Unit complied with legal requirements, and assessed whether the Unit adhered to each of the 12 MFCU performance standards. We identified seven findings and made several observations regarding the Unit’s performance and operations, and we made seven recommendations for improvement.

Case Outcomes

The Unit reported 27 indictments, 15 convictions, and 23 civil settlements for FYs 2021–2023.

Of the 15 convictions reported by the Unit, 10 involved provider fraud and 5 involved patient abuse or neglect.¹⁹



27 Indictments

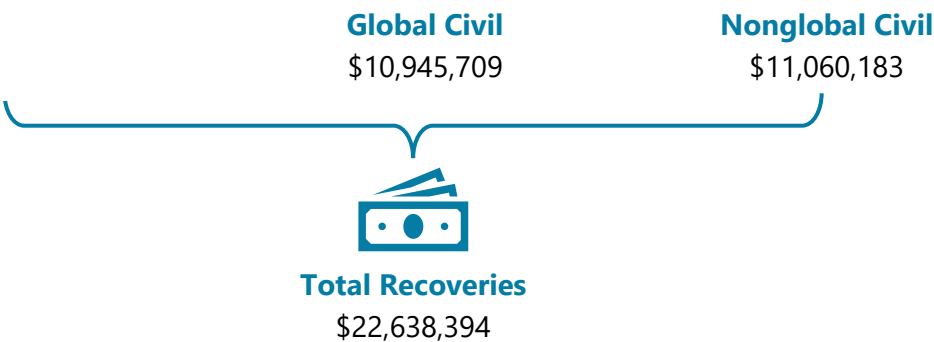


15 Convictions



23 Civil Settlements

The Unit reported combined criminal and civil recoveries of approximately \$22.6 million for FYs 2021–2023.



Source: OIG analysis of Unit statistical data, FYs 2021–2023.

Note: “Global” civil recoveries derive from civil settlements or judgments in global cases, which are cases that involve the U.S. Department of Justice and a group of State MFCUs and are facilitated by the National Association of Medicaid Fraud Control Units (NAMFCU).

¹⁹ OIG provides information on MFCU operations and outcomes but does not direct or encourage MFCUs to investigate or prosecute a specific number of cases. MFCU staff should apply professional judgment and discretion in determining what criminal and civil cases to pursue.

Performance Standard 1: Compliance with Requirements

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

Finding: The Unit shared supervision of its special agent positions with another division in the Wisconsin Department of Justice, but lacked a memorandum of understanding (MOU) to ensure that these positions are supervised in compliance with Federal requirements.

Federal regulation requires that a Unit's professional employees be under the direction and supervision of the Unit director,²⁰ and the SSA requires that a Unit be "organized in such a manner as is necessary to promote the effective and efficient conduct" of its activities.²¹ The Unit had two investigative positions—referred to as "special agents"—that reported both to the Director and to a supervisor from the Wisconsin DOJ's Division of Criminal Investigations (DCI).²² These two special agent positions were the only investigative positions in the Unit with full law enforcement authorities.²³ According to the Director, Wisconsin statutes prohibit the administrator of the Unit's DOJ division from supervising DOJ functions related to criminal investigations.²⁴

Although the Unit's Director and Deputy Director primarily supervised the special agents' day-to-day activities, Unit managers and staff reported that DCI managers maintained substantial involvement in the supervision of the Unit's two special agent positions. DCI managers were involved in staffing decisions for these positions; assigned non-MFCU tasks and DCI-specific training to the agents; and reviewed and approved the agents' investigative reports for MFCU cases.

However, the Unit and DCI lacked a written agreement for this shared supervisory arrangement. Without appropriate safeguards, this supervisory structure could give rise to conflicting instructions or otherwise infringe on the Unit Director's supervision of professional employees, which may result in operational inefficiencies. The lack of a written agreement could also limit the Unit's ability to monitor whether time spent on non-MFCU tasks is appropriately removed from the Federal grant. Further, sharing investigative reports outside of the Unit may limit the Unit's ability to guard the privacy rights of individuals whose data are under the Unit's control and to provide adequate safeguards to protect sensitive information, as required by Federal

²⁰ 42 CFR § 1007.13(d)(4).

²¹ SSA § 1903(q)(6).

²² The Unit is housed in a different DOJ division, the Division of Legal Services.

²³ The Unit's other investigators are not considered law enforcement officers and report solely to the Unit's Director and Deputy Director.

²⁴ Wisconsin Statute § 230.08(4)(b)(2) states that DOJ division administrators in the "unclassified service" cannot supervise DOJ functions related to criminal investigations. Wisconsin Statute § 165.055(4) states that the administrator of the Unit's DOJ division shall be appointed in the "unclassified service." The Director reported that the DOJ considers the activities of Unit investigators without law enforcement authorities exempt from this supervisory restriction.

regulation.²⁵ In OIG's judgment, the lack of an MOU between the Unit and DCI may limit the Unit's capabilities to maintain a clear and consistent supervisory structure that promotes the efficient conduct of its activities and complies with applicable Federal requirements.

Performance Standard 2: Staffing

A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.

Observation: The Unit's staffing levels were low relative to the State's Medicaid program expenditures.

According to Performance Standard 2(b), the Unit should employ 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 an appropriate volume of case referrals and workload. In FY 2023, Wisconsin's Medicaid expenditures were over \$12.5 billion, and the Unit employed 10 staff.²⁶ We observed that the Unit's staff size was low compared to that of other Units in States with similar Medicaid expenditures. Specifically, our analysis indicated that a Unit in a State with a similar level of Medicaid expenditures would, on average, employ 29 staff.^{27, 28}

Despite the Unit's relatively low staffing levels, Unit managers did not report declining worthwhile cases due to lack of staffing, and investigators reported that their caseloads were generally manageable. However, Unit managers and staff reported that an additional attorney could help improve the timeliness of cases. Further, Unit managers reported that the Unit's workload may increase in the future due to DHS-OIG's ongoing efforts to increase referrals to the Unit and because the Unit anticipates engaging in more substantial data mining efforts to generate additional referrals.^{29, 30}

²⁵ 42 CFR § 1007.11(f).

²⁶ The Unit had an approved staff size of 13 during FY 2023, and it had 3 vacancies at the end of the FY. Additionally, the Unit requested, and was approved for, two additional staff positions in FY 2024.

²⁷ We assessed the Unit's staffing levels using a linear regression model to compare State Medicaid expenditures to staff size.

²⁸ OIG does not prescribe MFCUs' staffing levels. Factors other than Medicaid expenditures, such as the volume of case referrals received, may also influence the size of a MFCU.

²⁹ Pursuant to 42 CFR § 1007.20, the Unit is approved by OIG to conduct data mining. Data mining is defined as "the practice of electronically sorting Medicaid or other relevant data, including, but not limited to, the use of statistical models and intelligent technologies, to uncover patterns and relationships within that data to identify aberrant utilization, billing, or other practices that are potentially fraudulent." 42 CFR § 1007.1.

³⁰ The Unit employed only one auditor during the review period, and Unit managers reported that this limited the Unit's data mining capabilities. Prior to our onsite inspection, the Unit hired an additional auditor.

Observation: The Unit experienced substantial director and investigator turnover; Unit managers took steps to help retain investigators.

During our review period, the Unit experienced turnover of two directors and six investigators.³¹ Unit managers and staff reported that the directors left the Unit for promotions or personal reasons, and that the Unit relied on its other long-term staff to maintain continuity of its functions during periods of director turnover.

The Unit also experienced substantial investigator turnover during the review period, which may have impacted case progression in some instances. The Unit had a total of six investigative positions, and six investigators left the Unit during the review period. Five of the six investigator separations occurred during or shortly following FY 2023, and the Unit only had two investigators who remained with the Unit for the entirety of FY 2023. Unit managers and staff explained that most of the investigators left the Unit for personal reasons, such as not enjoying the work or accepting a position closer to their home. Unit managers and staff reported that the investigator turnover slowed down cases and may have impacted morale in some instances. For example, the Deputy Director said that “no one’s excited to get assigned to a case that’s been passed around, trying to figure out where it left off.” Nonetheless, we observed that morale appeared to be high among Unit investigators and other staff despite the turnover.

Although it experienced substantial investigator turnover during the review period, we found that the Unit took some steps to help improve investigator retention. The Unit worked to secure promotions for two of its senior investigators during the review period, and these two investigators remained employed with the Unit at the time of our inspection. The Unit also offered workplace flexibilities that included hybrid work schedules, which the Director said he believed helped with recruitment and retention.

Performance Standard 3: Policies and Procedures

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

Observation: The Unit’s policies and procedures manual lacked adequate guidance for some aspects of conducting and documenting investigations.

We found that the Unit maintained a written policy manual, but the manual lacked specific policies and procedures for conducting investigations. Specifically, the manual lacked detailed procedures for documenting investigations and maintaining case files in the Unit’s electronic case management systems (see finding on page 12). Additionally, the policies and procedures manual lacked policies for deconflicting cases with Federal partners (see finding on page 14). The Deputy Director said she believed the manual needed to be more specific to the Unit’s operations, and that the

³¹ One of the six investigators who separated from the Unit left 9 days after the end of FY 2023 but prior to our onsite inspection.

lack of specific written procedures posed challenges for explaining Unit processes to new staff.

Performance Standard 4: Maintaining Adequate Referrals

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

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

Consistent with Performance Standard 4, the Unit took steps to encourage referrals of fraud and patient abuse or neglect from key referral sources during the review period. The Unit maintained a strong working relationship and frequent communication with DHS-OIG, including participating in multiple regular meetings. The Unit, DHS-OIG, and managed care entities met quarterly to discuss prospective cases and to engage in cross-training, which included topics such as interview techniques and issues involving specific provider types. Unit managers also participated in monthly meetings with DHS-OIG managers and regularly reviewed information on potential referrals from DHS-OIG.

Although the Unit maintained positive working relationships with managed care entities via the quarterly meetings with these entities and DHS-OIG, the Unit reported receiving only eight referrals of potential fraud originating from managed care entities during the review period.³² DHS-OIG reported that it was taking steps to increase managed care referrals to the Unit, including establishing expectations for the number of referrals managed care entities should send to DHS-OIG each year.

The Unit also took steps to maintain positive working relationships with agencies that provide referrals of patient abuse or neglect, including the Office of Caregiver Quality (OCQ), part of DHS's Division of Quality Assurance. The Unit engaged in regularly scheduled meetings with OCQ, and OCQ reported communicating with the Unit every 2 months on the status of referred cases. Although the Unit received few referrals of patient abuse or neglect from other entities, the Director said the Unit also met with county Adult Protective Services agencies and engaged in quarterly meetings with the long-term care ombudsman.

During the review period, the Unit reported that it received 128 fraud referrals, of which 99 came from DHS-OIG; 8 of the fraud referrals from DHS-OIG originated from managed care entities. Of the 99 fraud referrals from DHS-OIG, the Unit opened 57 as cases. The Unit also received 171 patient abuse or neglect referrals during the review period, primarily from OCQ, and opened 23 as cases. See Appendix A for all sources of referrals involving fraud and patient abuse or neglect during FYs 2021–2023.

³² Managed care entities referred instances of potential fraud to DHS-OIG. DHS-OIG then reviewed the referrals and determined whether to send them to the Unit.

Performance Standard 5: Maintaining Continuous Case Flow

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

Observation: The Unit took steps to maintain a continuous case flow and to complete cases within appropriate timeframes.

Consistent with Performance Standard 5, the Unit reported that it took steps to maintain a continuous case flow, including conducting periodic supervisory reviews of cases. According to Unit policy, supervisory reviews of case files should be conducted quarterly, but Unit managers and staff reported that they engaged in case review meetings more frequently than required. Case review meetings included the Director; the Deputy Director; and the investigator, auditor, and attorney assigned to the case. Unit staff reported that the supervisory case review meetings were collaborative and helped ensure regular case progression.

In addition to conducting supervisory reviews of case files, the Director reported meeting quarterly with the Deputy Director to review every case and identify any stagnating cases. The Director said they also evaluated the appropriateness of staff members' caseloads and discussed the Unit's overall mix of cases during these meetings.

Performance Standard 6: Case Mix

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

Observation: The Unit's case mix included both fraud and patient abuse or neglect cases; the Unit's nonglobal civil work may have been limited by changes to Wisconsin's False Claims statutes.

Of the 366 cases that were open during FYs 2021–2023, 89 percent (327 cases) involved provider fraud and 11 percent (39 cases) involved patient abuse or neglect. During this period, the Unit's cases covered 44 different provider types, including pharmaceutical manufacturers, retail pharmacies, and personal care services attendants.

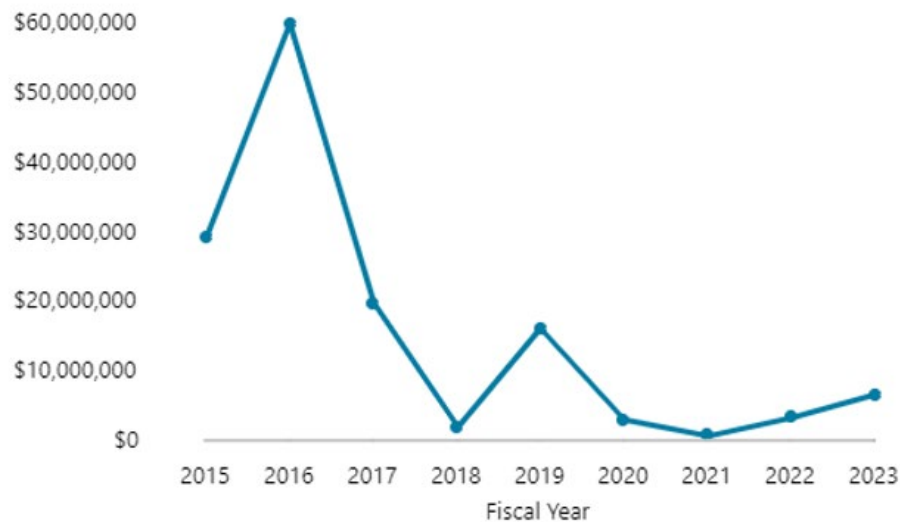
Although the Unit reported working 116 nonglobal civil cases during the review period, the Unit's attorney who specialized in civil cases reported that the 2015 repeal of private citizen qui tam relator provisions of Wisconsin's False Claims statutes substantially limited the Unit's nonglobal civil work.^{33, 34} We found that the Unit's

³³ Wisconsin Statute § 20.931 (repealed in 2015) allowed any person to bring a civil action as a qui tam plaintiff against a person who committed qualifying acts involving false claims for medical assistance. However, the Unit reported that it continued litigation of qui tam actions pursuant to this statute in cases in which the alleged fraud occurred prior to the effective date of the repeal.

³⁴ Wisconsin Statute § 49.485 allows the Unit to bring "False Claims" actions but does not contain private citizen qui tam relator provisions.

nonglobal civil recoveries declined greatly after FY 2016, which may have been attributable to the changes to Wisconsin’s False Claims statutes (see Exhibit 1 below).

Exhibit 1: The Unit’s nonglobal civil recoveries declined substantially following the 2015 changes to Wisconsin’s False Claims statutes



Source: OIG analysis of Unit statistical data, FYs 2015–2023.

Performance Standard 7: Maintaining Case Information

A Unit maintains case files in an effective manner and develops a case management system that allows efficient access to case information and other performance data.

Finding: The Unit’s electronic case management system did not allow the Unit to efficiently access and maintain case information and performance data.

We found that the Unit’s electronic case management system posed challenges for efficiently accessing and reporting case information and performance data. Unit managers reported that the Unit was required to use this system, which was deployed across the Unit’s parent division. However, they reported that the system did not allow the Unit to add data fields needed for reporting performance data to OIG. To compensate for this deficiency in the system, the Unit opened separate case files in its case management system for the referral, investigation, and prosecution stages of each case. Although this workaround allowed Unit managers and staff to access and report on certain case information such as referral and case opening dates, opening multiple files for each case contributed to organizational challenges. Further, Unit managers and staff reported that the system still could not track certain case information, such as restitution amounts and information on joint cases with other agencies. They said that they had to track some case information using spreadsheets and that preparing the Unit’s annual statistical report to OIG required substantial manual effort, which may have resulted in inaccuracies.

The electronic case management system also lacked functionality for efficiently maintaining case information during the investigative stage of cases. Unit managers and staff reported that the system was not “investigator-friendly” and could not generate structured investigative reports. As a result, investigators used a secondary case management system, which was designed for use by law enforcement entities, to generate and store investigative reports and other case information during the investigative stage. However, the Unit’s reliance on two separate case management systems contributed to challenges with effectively organizing case information.

Additionally, we found that the electronic case management system presented technical challenges for efficiently accessing case information. Specifically, Unit staff reported, and we observed, that the Unit’s case management system was difficult to navigate and slow. Unit staff said that the system is not user-friendly and that it freezes or shuts down frequently. We experienced similar difficulties using the system during our onsite review of Unit case files. For example, the system stopped working when we attempted to access multiple documents from a case, which also caused the system to temporarily stop working for Unit staff.

At the time of the inspection, the Unit’s parent division was in the process of replacing the Unit’s primary case management system. Unit managers reported that the Unit had substantial input regarding the features it needed in the new system, and they believed that the new system would meet the Unit’s needs and allow for improved access to case information and reporting capabilities. The Director estimated that the new system would be implemented in 2025. However, Unit managers said that the Unit would likely continue using its secondary case management system for writing investigative reports because the new primary system would not have better report-writing capabilities than the secondary system. The Director said he was uncertain whether the new primary case management system would be able to automatically synchronize files from the secondary system.

Finding: The Unit lacked adequate policies and procedures for effectively maintaining case files.

We found that the Unit’s policies and procedures manual lacked specific procedures for documenting investigations and maintaining case files in the Unit’s electronic case management systems, which also contributed to ineffective case file organization. Investigators reported that during the investigative phase, they typically maintained investigative reports in the secondary case management system, while they stored referrals; documents such as subpoenas and warrants; and other case data in the primary system. However, the Unit’s policies and procedures manual did not specify which case management system—or which case file within the primary system—should contain each type of case information during the investigative phase. The manual also did not specify how case documents should be organized within folders in these systems. Investigators reported that, in practice, case information was often stored in duplicate locations across the primary and secondary systems. Further, during our review of Unit case files, we observed that the case files lacked

standardized organization and naming conventions, which made it difficult to efficiently locate case information.

Although the Unit used its primary case management system as its permanent repository for case information, the Unit lacked policies and procedures to ensure that staff consistently moved case information to this system at the conclusion of an investigation. Unit managers said that when a case is charged or closed, the investigator should notify one of the Unit's paralegals to move files from the secondary system to the primary system. However, the Unit's policies and procedures manual did not contain specific procedures for case closure and did not specify who was responsible for moving files from the secondary system to the primary system. During our onsite review of case files, we were unable to locate some case information in the primary system, including for charged and closed cases.³⁵ The Deputy Director said that this was likely because the files were not moved from the secondary system to the primary system.

Adequate policies and procedures for maintaining case files will continue to be important even after the Unit replaces its primary case management system. The Director said he believed that the Unit's new primary case management system would alleviate certain organizational challenges with the Unit's case files, but Unit managers reported that the Unit would likely continue to use two case management systems. The Unit's likely continued reliance on two case management systems emphasizes the need for adequate policies and procedures for effectively maintaining case files across these systems.

Finding: The Unit did not consistently document periodic supervisory reviews or supervisory approvals to open cases in its case files during our review period.

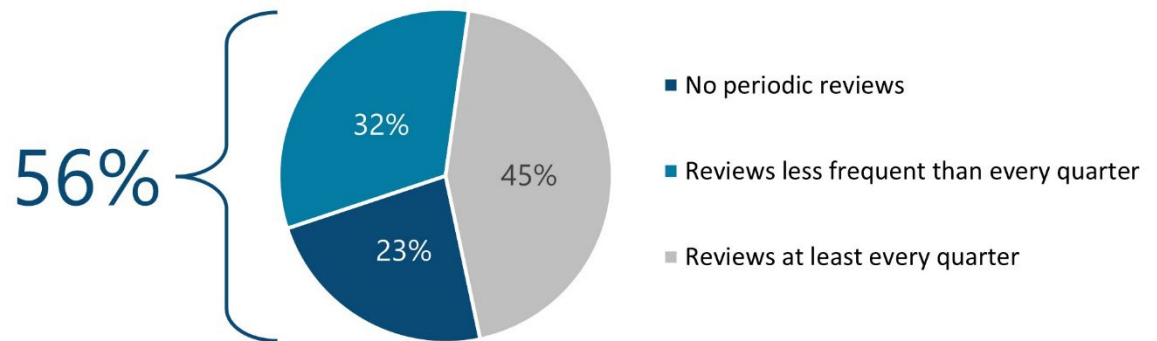
Performance Standards 7(a) and 5(b) state that supervisors should periodically review cases and approve the opening and closing of all investigations, and that documentation should be maintained in the case file. The Unit's policies and procedures manual stated that supervisory reviews should be conducted at least quarterly and that supervisors should document these reviews in the primary electronic case management system. The Unit's policies and procedures manual also stated that the Director was responsible for documenting supervisory approval to open cases, and that this documentation should be saved in the primary case management system.

We found that 56 percent of the Unit's case files during our review period did not have documentation in the primary case management system of periodic supervisory reviews at least every quarter (see Appendix B for point estimates and confidence intervals from our review of Unit case files). Specifically, 23 percent of the Unit's case files did not contain documentation of any periodic supervisory reviews, and 32 percent contained documentation of supervisory reviews less frequent than every quarter (see Exhibit 2). In interviews, Unit managers and staff reported that

³⁵ We did not have access to the Unit's secondary case management system during our onsite inspection. Unit managers attempted to move pertinent case information for our sampled cases from the secondary system to the primary system, but we still were unable to locate all case information.

supervisory reviews were conducted more frequently than each quarter, but the Deputy Director acknowledged that she did not consistently document the reviews. OIG's 2016 review of the Wisconsin Unit similarly found that more than half of cases lacked documentation of periodic supervisory reviews.³⁶

Exhibit 2: More than half of the Unit's case files were missing documentation of periodic supervisory reviews



Source: OIG analysis of Unit case files, FYs 2021–2023.

Note: The combined percentage of case files with no periodic reviews and case files with reviews less frequent than every quarter is 56 percent because of rounding.

We also found that 19 percent of cases lacked documentation in the primary case management system of supervisory approval to open the case. However, we did not identify any impact on the Unit's case development from the missing documentation. OIG's 2016 review also found that more than half of case files lacked documentation of supervisory approval to open the case.

Performance Standard 8: Cooperation with Federal Authorities on Fraud Cases

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

Finding: The Unit maintained positive working relationships with Federal law enforcement partners but lacked policies for deconflicting cases with these partners.

Performance Standards 8(a) and 8(b) and Federal regulations state that a Unit should regularly communicate and coordinate with OIG and other Federal partners and establish written policy regarding cooperation and coordination with these partners.³⁷ We found that the Unit maintained positive working relationships with OIG's Office of Investigations (OI) and the U.S. Attorney's Offices (USAOs), but the Unit did not have written procedures specifying how it should coordinate with these Federal partners. Although OI and the Unit reported that their collaboration was limited because OI currently has only one agent located in Wisconsin, the two entities worked 13 joint

³⁶ OIG, [Wisconsin State Medicaid Fraud Control Unit: 2016 Onsite Review \(OEI-07-16-00240\)](#), May 2017.

³⁷ 42 CFR § 1007.11(e)(2)–(e)(5).

cases during the review period. OI reported that agents and investigators communicated frequently on joint cases, and the two entities also reported coordinating via Health Care Fraud Task Force meetings every 6 months.

Additionally, the Unit maintained positive working relationships with the USAOs in the Eastern and Western Districts, and one of the Unit's attorneys was appointed as a Special Assistant U.S. Attorney. Staff from the Eastern and Western Districts reported that the Unit engaged in ad hoc communication on cases and coordinated with the USAOs through Health Care Fraud Task Force meetings every 6 months.

Although the Unit maintained positive working relationships with Federal law enforcement partners, we found that the Unit did not have policies or procedures for regularly coordinating, or "deconflicting," its cases with OI or the USAOs.³⁸ In interviews, staff from OI and the Eastern and Western Districts suggested that establishing procedures to consistently deconflict cases with the Unit would be beneficial.

Finding: The Unit did not report four convictions and one adverse action to Federal partners during the review period, as required.

Federal regulation requires Units, for the purpose of excluding convicted parties from Federal health care programs, to transmit information on all convictions to OIG within 30 days of sentencing, or "as soon as practicable" if the Unit encountered delays in receiving the necessary information from the court.³⁹ During the review period, the Unit did not report four convictions to OIG for program exclusion. Following our inspection, the Unit submitted the four convictions to OIG; these were submitted more than 1 year after sentencing. The Unit submitted its other 12 convictions during the review period to OIG as required. This represents an improvement from OIG's 2016 review of the Wisconsin Unit, which found that the Unit did not report half of its convictions to OIG, and most of the convictions it did report to OIG were not reported within the required timeframe.

Federal regulation also requires that any adverse actions resulting from investigations or prosecutions of health care providers be reported to the NPDB within 30 days of the final adverse action.^{40, 41} During the review period, the Unit did not report one adverse action to the NPDB. Following our inspection, the Unit submitted the adverse action to the NPDB; this was submitted more than 1 year after the action date. The

³⁸ Deconfliction is a process to identify and avoid any duplicative and overlapping actions by different law enforcement agencies.

³⁹ 42 CFR § 1007.11(g). Also, Performance Standard 8(f) states that Units should transmit convictions to OIG within 30 days of sentencing. The 2024 updated Performance Standard 8(g) reflects the regulatory language at 42 CFR § 1007.11(g).

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

⁴¹ The NPDB is intended to restrict the ability of physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice and adverse actions.

Unit also submitted one other adverse action to the NPDB between 31 and 60 days after the action date, but it submitted its other 15 adverse actions within the required timeframe. This also represents an improvement from OIG's 2016 review, which found that the Unit reported all but one of its adverse actions to the NPDB but did not report two-thirds of the actions within the required timeframe.

The Unit reported that its new case management system may offer opportunities to improve the Unit's compliance with submission requirements. One of the Unit's paralegals was responsible for submitting convictions and adverse actions to OIG and the NPDB but was unaware of the missing submissions until we identified them during our inspection. The paralegal said that she needed to create reminders to improve the timeliness of the Unit's submissions. The Director said he anticipated that the Unit's new case management system would allow the Unit to create a prompt when a case is closed to ask the user to confirm that required reporting has been completed.

Performance Standard 9: Program Recommendations

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

Observation: The Unit made recommendations to the State government during the review period.

According to Performance Standards 9(a) and 9(b), the Unit, when it is warranted and appropriate to do so, should make statutory or programmatic recommendations to the State legislature; the State Medicaid agency; and other agencies responsible for Medicaid operations or funding. In FY 2022, the Unit submitted a written recommendation to leaders of the Unit's DOJ division regarding provisions in the State's Medicaid fraud statute the Unit identified as presenting barriers to criminal prosecution of Medicaid fraud in Wisconsin. The Unit's recommendation was not implemented. The Unit also submitted a written letter in FY 2022 to DHS (in response to a DHS inquiry) in support of proposed legislation to restore the private citizen qui tam relator provisions of the State's False Claims statutes. The proposed legislation was not implemented.

Performance Standard 10: Agreement with Medicaid Agency

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

Finding: The Unit's MOU with the State Medicaid agency did not reflect several legal requirements.

Although the Unit and the State Medicaid agency had a current MOU that was last amended in 2020, we found that the MOU did not contain several legal requirements. First, we found that the MOU did not contain an agreement that the State Medicaid

agency “must” refer all cases of suspected provider fraud to the Unit, as required by Federal regulations.⁴² Instead, the MOU stated that the State Medicaid agency “may” refer cases to the Unit “or other appropriate law enforcement for criminal fraud investigation.” However, the Director said he believed that DHS-OIG referred all cases of suspected fraud to the Unit, as appropriate. DHS-OIG also reported that it referred all cases of suspected fraud to the Unit and that it did not typically refer cases to other law enforcement agencies.⁴³

Second, the MOU did not contain procedures by which the Unit will receive referrals from managed care entities, as required by Federal regulation.⁴⁴ Although the Unit and the State Medicaid agency reported that they had established procedures for managed care referrals, those procedures were not included in the 2020 amended MOU.

The MOU also did not contain procedures required by Federal regulation at 42 CFR § 1007.9(d)(3)(iii).⁴⁵ Specifically, the MOU did not contain procedures for (1) Unit referrals of providers to the Medicaid agency for payment suspension; (2) Unit requests to delay payment suspension notifications to providers; and (3) Unit notifications to the Medicaid agency of acceptance or declination of referrals.⁴⁶ Unit managers reported that the Unit and DHS-OIG had procedures for each of these processes, and DHS-OIG reported that the Unit submitted these referrals, requests, and notifications to DHS-OIG in accordance with requirements.

In addition to the MOU not containing several legal requirements, the MOU also did not incorporate by reference CMS’s “Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a MFCU,”⁴⁷ as stated in Performance Standard 10(e).

Performance Standard 11: Fiscal Control

A Unit exercises proper fiscal control over its resources.

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

From the Unit’s responses to a detailed fiscal controls questionnaire and follow-up with fiscal staff, we identified no issues related to the Unit’s budget process,

⁴² 42 CFR § 1007.9(d)(1) states that the MOU should contain an agreement from the Medicaid agency to comply with all requirements of 42 CFR § 455.21(a). 42 CFR § 455.21(a)(1) states that the Medicaid agency must refer all cases of suspected provider fraud to the Unit.

⁴³ DHS-OIG reported that it has considered referring cases to other law enforcement or prosecutorial agencies when the Unit had declined a referral that DHS-OIG considered to be strong.

⁴⁴ 42 CFR § 1007.9(d)(3)(iv).

⁴⁵ 42 CFR § 1007.9(d)(3)(iii) states that the Unit and the Medicaid agency should establish procedures in the MOU for 42 CFR §§ 1007.9(e)–(h).

⁴⁶ See 42 CFR §§ 1007.9(e), (f), and (g), respectively.

⁴⁷ Located at <https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/fraudreferralperformancestandardsstateagencytomfcu.pdf>.

accounting system, cash management, procurement, electronic data security, property, or personnel. In our inventory review, we accounted for all 26 inventory items.

Performance Standard 12: Training

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

Observation: Unit staff completed training that aided in the mission of the Unit.

From the information we reviewed, professional staff completed training that aided in the mission of the Unit, including training provided by the National Association of Medicaid Fraud Control Units. We also observed that, for part of the review period, the Unit did not specify an annual minimum number of training hours for professional staff. However, the Unit instituted a 40-hour annual training requirement for professional staff in January 2022.

CONCLUSION AND RECOMMENDATIONS

The Wisconsin MFCU reported case outcomes of 27 indictments; 15 convictions; 23 civil settlements; and approximately \$22.6 million in recoveries for FYs 2021–2023. From the information we reviewed, we observed that the Unit took steps to maintain an adequate volume and quality of referrals, took steps to maintain a continuous case flow, and maintained positive working relationships with Federal law enforcement partners. However, we identified seven areas in which the Unit should improve its adherence to performance standards or program requirements.

To address the findings identified in this report, we made the following recommendations to the Wisconsin Unit.

Establish an MOU with DCI to ensure that special agents are supervised in accordance with Federal requirements

The Unit should implement an MOU with DCI that establishes clear requirements and expectations for each entity pertaining to the Unit's special agent positions. The MOU should contain agreements that help ensure compliance with applicable Federal requirements for Units, including requirements for supervision of professional employees by the Unit Director. At a minimum, the MOU should establish processes and delineate each entity's authorities and responsibilities for (1) hiring and staffing the Unit's special agent positions; (2) assigning and documenting non-MFCU or DCI-specific duties and training for special agents, including removing hours spent on non-MFCU duties from the Federal grant; (3) reviewing and approving special agents' investigative reports for Unit investigations; and (4) safeguarding sensitive Unit case information.

Implement a comprehensive case management system that allows the Unit to efficiently access and maintain case information and performance data

At the time of the inspection, the Unit reported that its parent division was in the process of replacing the Unit's primary case management system. We recommend that the Unit, in adopting this system or another alternative, ensure that the system meets the Unit's needs for efficiently accessing and maintaining case information and performance data. This could include implementing a single case management system that fully meets the Unit's needs or implementing a system that can efficiently synchronize files from the Unit's secondary case management system.

Establish policies and procedures to help ensure that case files are maintained effectively

The Unit should establish policies and procedures for documenting investigations and organizing case information in its case management system. Further, until the Unit is able to implement a comprehensive case management system, it should establish policies and procedures specifying when case information should be moved between the two case management systems and who is responsible for doing so.

Ensure that supervisory reviews and supervisory approvals to open cases are consistently documented in accordance with Unit policy

The Unit should ensure that supervisory reviews of case files and supervisory approvals to open cases are documented consistent with Unit policy.

Establish written policies for deconflicting cases with Federal partners

The Unit should develop written policies for deconflicting cases with OIG's Office of Investigations and the U.S. Attorney's Offices.

Take steps to report all convictions and adverse actions to Federal partners within the appropriate timeframes

The Unit should take steps to report all convictions to OIG within 30 days of sentencing, or as soon as practicable if there are delays in receiving the necessary information from the court. The Unit should also take steps to report all adverse actions to the NPDB within 30 days of the action. These steps could include implementing automated reminders for staff to submit convictions and adverse actions when closing a case, as appropriate.

Revise its MOU with the State Medicaid agency to reflect applicable legal requirements

The Unit should revise its MOU with the State Medicaid agency to reflect applicable Federal legal requirements and MFCU Performance Standards. Specifically, the revised MOU should contain an agreement that the State Medicaid agency "must" refer all cases of suspected provider fraud to the Unit. The MOU should also contain procedures by which the Unit will receive referrals from managed care entities. Further, the revised MOU should contain procedures for (1) Unit referrals of providers to the Medicaid agency for payment suspension; (2) Unit requests to delay payment

suspension notifications to providers; and (3) Unit notifications to the Medicaid agency of acceptance or declination of referrals. Finally, the revised MOU should incorporate by reference CMS's "Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a MFCU."

UNIT COMMENTS AND OIG RESPONSE

The Wisconsin MFCU reported taking alternative steps to address one recommendation and concurred with the other six recommendations.

First, the Unit reported taking alternative steps to address our recommendation that it establish an MOU with DCI to ensure that special agents are supervised in accordance with Federal requirements. The Unit reported that it replaced the special agent positions with Unit investigators, and in followup correspondence, the Unit clarified that the new investigators are wholly supervised by Unit managers.

Second, the Unit concurred with our recommendation to implement a comprehensive case management system. The Unit reported that its parent agency has signed a contract to implement a more suitable case management system, which is scheduled to be implemented by July 2025.

Third, the Unit concurred with our recommendation to establish policies and procedures to help ensure that case files are maintained effectively. The Unit reported that it has implemented policies and procedures specifying where case information should be maintained and who is responsible for ensuring that all files are moved to the case management system.

Fourth, the Unit concurred with our recommendation to ensure that supervisory reviews and supervisory approvals to open cases are consistently documented in accordance with Unit policy. The Unit reported that it has taken steps to ensure compliance with pertinent Unit policies and that its new case management system will contain safeguards to ensure that supervisory reviews and supervisory approvals are documented in accordance with Unit policy.

Fifth, the Unit concurred with our recommendation to establish written policies for deconflicting cases with Federal partners. The Unit reported that it updated its policies and procedures to require investigators to enter appropriate case information in a database used by Federal and State entities for deconfliction.

Sixth, the Unit concurred with our recommendation to take steps to report all convictions and adverse actions to Federal partners within the appropriate timeframes. The Unit reported that it updated its policies and procedures to require a calendar event for any plea, trial, or event that may result in an adverse action. The Unit also reported that it will implement applicable safeguards through its new case management system.

Seventh, the Unit concurred with our recommendation to revise its MOU with the State Medicaid agency to reflect applicable legal requirements. The Unit reported that the MOU has been updated to reflect all applicable legal requirements and is awaiting signatures from the State Medicaid agency.

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

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

DETAILED METHODOLOGY

Data Collection and Analysis

We collected and analyzed data from the seven sources described below to identify any opportunities for improvement and instances in which the Unit did not adhere to the MFCU performance standards or did not operate in accordance with laws, regulations, or policy transmittals. We also used the data sources to make observations about the Unit's case outcomes, as well as the Unit's operations and practices concerning the performance standards.

Review of Unit Documentation

Before the onsite inspection, we examined the Unit's recertification materials for FYs 2021–2023, including (1) the Unit director's recertification questionnaires; (2) the Unit's MOU with the State Medicaid agency; (3) the program integrity director's questionnaires; and (4) the OIG Special Agent in Charge questionnaires. We also reviewed the Unit's policies and procedures manual and the Unit's self-reported case outcomes and referrals included in its annual statistical reports for FYs 2021–2023. Additionally, we examined the recommendations from the 2016 OIG onsite review and the Unit's implementation of those recommendations.

Review of Unit Financial Documentation

We conducted a limited review of the Unit's control over its fiscal resources. Before the onsite inspection, we analyzed the Unit's responses to a questionnaire about internal controls and conducted a desk review of the Unit's quarterly financial reports. We followed up with staff from the DOJ and the Unit to clarify issues identified in the questionnaire about internal controls. While onsite, we also verified all 26 items on the Unit's inventory list.

Interviews with Key Stakeholders

In March 2024, we interviewed key stakeholders, including officials from DHS-OIG, OCQ, and a managed care entity, as well as OI and USAO staff who work with the Unit. We focused these interviews on the Unit's relationships and interactions with the stakeholders, as well as opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management and other staff.

Onsite Interviews with Unit Management and Other Selected Staff

We conducted structured interviews with the Unit's management and other selected staff in April and May 2024. Of the Unit management, we interviewed the Director and Deputy Director. Of the other staff, we interviewed five investigators (including one special agent), two attorneys, and one auditor. In addition, we interviewed the supervisor of the Unit, the Deputy Administrator of the DOJ's Division of Legal Services. We asked these individuals questions related to (1) Unit operations; (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance; (3) opportunities for the Unit to improve its operations and/or performance; (4) clarification regarding information obtained from other data sources; and (5) the Unit's training and technical assistance needs.

Onsite Review of Case Files

To craft a sampling frame, we requested that the Unit provide us with a list of cases that were open at any time during FYs 2021–2023 and include the status of each case; whether the case was criminal, civil, or global; and the dates on which the case was opened and closed, if applicable. The total number of cases was 366.

We excluded all global cases from our review of the Unit's case files because global cases are civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a group of State MFCUs. We excluded 69 global cases, leaving 297 case files.

We then selected a simple random sample of 80 cases from the population of 297 cases. This sample allowed us to make estimates of the overall percentage of case files with various characteristics with absolute precision of no more than ± 10 percent at the 95-percent confidence level.

We reviewed the 80 case files for adherence to the relevant performance standards and compliance with statutes, regulations, and policy transmittals. During the review of the sampled case files, we consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation.

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

We also reviewed all 16 convictions submitted to OIG during the review period and all 17 adverse actions submitted to the NPDB during the review period. We reviewed whether the Unit submitted information on all sentenced individuals and entities to OIG for program exclusion and on all adverse actions to the NPDB for FYs 2021–2023. We also assessed the timeliness of the submissions to OIG and the NPDB.

Onsite Review of Unit Operations

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

APPENDICES

Appendix A: Unit Referrals by Source for Fiscal Years 2021–2023

Referral Source	FY 2021		FY 2022		FY 2023		3 Year Total		
	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Total
Adult Protective Services	1	1	0	0	0	0	1	1	2
HHS-OIG	1	0	1	0	0	0	2	0	2
Law enforcement—other									
Licensing board	1	0	0	0	0	0	1	0	1
Local prosecutor									
Long-Term Care Ombudsman	0	0	0	0	0	0	0	0	0
Medicaid agency—Program Integrity*									
Private citizen	1	1	2	1	0	0	3	2	5
Provider									
Provider association	0	0	0	0	0	0	0	0	0
State agency—other									
State survey and certification agency	0	47	0	66	0	41	0	154	154
Other									
Subtotal	38	56	42	71	48	44	128	171	299
Total	94		113		92		299		

* Note: The Unit received all referrals originating from managed care entities via the Program Integrity office.
Source: OIG analysis of Wisconsin MFCU data, 2024.

Appendix B: Point Estimates and 95-Percent Confidence Intervals of Case File Reviews

Estimate Description	Sample Size	Point Estimate	95 Percent Confidence Interval	
			Lower	Upper
Percentage of all cases without documentation of supervisory approval to open	80	18.8%	11.8%	27.6%
Percentage of applicable cases with no documentation of periodic supervisory reviews	77	23.4%	15.5%	33.0%
Percentage of applicable cases with documentation of periodic supervisory reviews, but less frequent than every quarter	77	32.5%	23.2%	42.8%
Percentage of all cases closed at the time of the review	80	71.3%	61.3%	79.8%
Percentage of closed cases without documentation of supervisory approval to close	57	1.8%	0.3%	8.8%

Source: OIG analysis of Wisconsin MFCU case files, 2024.

Appendix C: Unit Comments



STATE OF WISCONSIN DEPARTMENT OF JUSTICE

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January 13, 2025

Ann Maxwell
Deputy Inspector General for Evaluation and Inspections
Office of Inspector General
Office of Evaluations and Inspections
Medicaid Fraud Policy and Oversight Division
U.S. Department of Health and Human Services
330 Independence Avenue, SW
Rm. 5660
Washington, DC 20201

Re: Wisconsin Medicaid Fraud Control and Elder Abuse Unit: 2024
On-Site Review OEI-07-24-00220

Dear Ms. Maxwell:

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 December 2024.

We are pleased that OIG recognized our Unit's successful work during the audit period, including the high recoveries for Wisconsin taxpayers compared to the Unit's relatively low cost.

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

Recommendation #1: Establish an MOU with Division of Criminal Investigations to ensure special agents are supervised in accordance with federal requirements.

Comment: The recommendation is no longer applicable. The Unit and Division of Criminal Investigations worked diligently to harmonize state statutes with federal requirements for the Unit. After extensive discussions, the perceived conflict between the two led the Unit to ultimately return the previously assigned Medicaid special agents back to the Division of Criminal Investigations. The positions have since been filled with more traditional investigators. The Division of Criminal Investigations will instead assist the Unit on an “as needed” basis. We believe that this revamped relationship is in the best interest of the Unit.

Recommendation #2: Implement a comprehensive case management system that allows the Unit to efficiently access and maintain case information and performance data.

Comment: The Unit concurs with recommendation #2. The Division of Legal Services, within which the Unit is a part, had been in the process of finding a more suitable case management system since before the audit was announced. We are pleased to have a signed contract for a new case management system that we believe will meet all the recommendations posed by the audit team. The new system is scheduled to be fully implemented by July 1, 2025.

Recommendation #3: Establish policies and procedures to help ensure that case files are maintained effectively.

Comment: The Unit concurs with recommendation #3. The dual case management system employed by the Unit serves a meaningful purpose but can create challenges. The Unit agrees that more explicit policy and procedures regarding how certain information is to be housed, and when it should be compiled into a single location, would benefit the Unit. The Unit has already enacted policy and procedures requiring all reports and records to be saved into its report writing system “ACISS,” unless the file type is not compatible, or it is otherwise not practical to do so. The Unit has also enacted policy and procedures requiring the lead investigator to ensure that all files are moved into the corresponding matter within the Division of Legal Services’ case management system.

Recommendation #4: Ensure that supervisory reviews and supervisory approvals to open case files are consistently documented in accordance with unit policy.

Comment: The Unit concurs with recommendation #4. The Unit has taken steps to ensure compliance with its policy on this subject. Moreover, the integration of the new case management system will employ safeguards to ensure that supervisory reviews and supervisory approvals are documented in accordance with unit policy.

Recommendation #5: Establish written policies for deconflicting cases with federal partners.

Comment: The Unit concurs with recommendation #5. Federal partners identified DEA Internet Connectivity Endeavor (“DICE”) as the most comprehensive database available for deconfliction. We have already updated our policy and procedures to require all investigators to be admitted to “DICE” and to enter appropriate information into the “DICE” system for deconfliction upon assignment of an investigation. All employed investigators have requested access from DICE administrators.

Recommendation #6: Take steps to report all convictions and adverse actions to federal partners within appropriate timeframes.

Comment: The Unit concurs with recommendation #6. The Unit has already updated its policy and procedures to require a 20-day calendar event to accompany any plea, trial, or event that may result in adverse action. This safeguard should help eliminate any oversight of the Unit’s reporting requirements within applicable timeframes. The Unit will also be implementing safeguards through the new case management system. The new system will require an affirmative response from the user before a plea, conviction, or adverse action can be entered.

Recommendation #7: Revise MOU with State Medicaid agency to reflect applicable legal requirements.

Comment: The Unit concurs with recommendation #7. The Unit’s MOU with the State Medicaid agency was already up for review by December 2024. As of the drafting of this comment, the MOU has been updated to include all applicable legal requirements and is awaiting signatures from the State Medicaid agency.

Ann Maxwell
January 13, 2025
Page 4

Sincerely,

Rose Youngblood

Rose M. Youngblood, Deputy Unit Director
On Behalf of Daniel R. Hess, Unit Director

DRH:

ABOUT THE OFFICE OF INSPECTOR GENERAL

Office of Inspector General

<https://oig.hhs.gov>

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Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. [Learn more about complaints OIG investigates.](#)

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of [whistleblowing](#) or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

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