Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

DISTRICT OF COLUMBIA MEDICAID FRAUD CONTROL UNIT: 2015 ONSITE REVIEW

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EXECUTIVE SUMMARY: DISTRICT OF COLUMBIA MEDICAID FRAUD CONTROL UNIT: 2015 ONSITE REVIEW
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WHY WE DID THIS STUDY

The Office of Inspector General (OIG) administers the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, 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. The reviews assess the Units' performance in accordance with the 12 MFCU performance standards its compliance with applicable Federal requirements.

HOW WE DID THIS STUDY

We conducted an onsite review of the District of Columbia (D.C.) Unit in January 2015. We based our review on an analysis of data from seven sources: (1) a review of policies, procedures, and documentation related to the Unit's operations, staffing, and caseload for fiscal years (FYs) 2012 through 2014; (2) a review of financial documentation for FYs 2012 through 2014; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with Unit management; (6) an onsite review of a sample of files for cases that were open at any time in FYs 2012 through 2014; and (7) an onsite observation of Unit operations.

WHAT WE FOUND

Our review of the D.C. Unit identified several findings that may undermine Unit efficiency and effectiveness. We identified delays in case progress that may have been explained by Unit management practices that we observed, including a lack of documented supervisory reviews intended to ensure cases progress at a reasonable pace as well as a lengthy clearance process for documents. We also found that the Unit did not use its case management system to allow efficient access to case information, and that it investigated seven cases that were outside of the Unit's authority. Until July 2015, the Unit's MOU with D.C.'s Medicaid agency was out of date. Formal communication between the Unit and the Medicaid agency was infrequent, and the Unit did not report all relevant information to Federal partners within required timeframes.

WHAT WE RECOMMEND

We recommend that the Unit implement effective management practices that ensure cases progress at a reasonable pace, and that supervisory reviews of Unit case files are conducted and documented. The Unit should use its case management system in a way that allows for efficient access to case information, and the Unit should repay Federal matching funds spent on the cases that were not eligible for Federal funding. The Unit should communicate regularly with the D.C. Medicaid agency. Finally, we recommend that the Unit report all relevant information to the OIG and the National Practitioner Data Bank within the required timeframe. The Unit concurred with all six recommendations.

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OBJECTIVE

To conduct an onsite review of the District of Columbia (D.C.) Medicaid Fraud Control Unit (MFCU or Unit).

BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under State law.[1] Pursuant to Title XIX of the SSA, each State must maintain a certified Unit unless the Secretary of Health and Human Services determines that operation of a Unit would not be cost-effective because minimal Medicaid fraud exists in that State and that the State has other adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.[2] Currently, 49 States and D.C. (States) have created such Units.[3] In fiscal year (FY) 2014, combined Federal and State grant expenditures for the Units totaled $235 million.[4, 5] That year, the 50 Units employed 1,958 individuals.[6]

To carry out its duties and responsibilities in an effective and efficient manner, each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.[7] Unit staff review complaints provided by the State Medicaid agency and other sources and determine their potential for criminal prosecution and/or civil action. In FY 2014, the 50 Units collectively obtained 1,318 convictions and 874 civil settlements and

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[1] Social Security Act (SSA) § 1903(q).

[2] SSA § 1902(a)(61). Regulations at 42 CFR § 1007.11(b)(1) add that the Unit's responsibilities may include reviewing complaints of misappropriation of patients' private funds in residential health care facilities.

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

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

[5] Office of Inspector General (OIG), *MFCU Statistical Data for Fiscal Year 2014*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.htm on May 1, 2015.

[6] Ibid.

[7] SSA § 1903(q)(6); 42 CFR §1007.1.

judgments.[8] That year, the Units reported recoveries of approximately $2 billion.[9]

Units are required to have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority.[10] In 44 States, the Units are located within offices of State Attorneys General; in D.C. and the remaining 5 States, the Units are located in other State agencies.[11, 12] The D.C. Unit is located in the D.C. Office of Inspector General. Generally, Units located outside of an Attorney General's Office must refer cases to other offices with prosecutorial authority.

Each Unit must be a single, identifiable entity of State government, distinct from the single State Medicaid agency, and each Unit must develop a formal agreement (i.e., a memorandum of understanding (MOU)) that describes the Unit's relationship with that agency.[13]

Oversight of the MFCU Program

The Secretary of Health and Human Services delegated to the Office of Inspector General (OIG) the authority both to annually certify the Units, and to administer grant awards to reimburse States for a percentage of their costs of operating certified Units.[14] All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.[15] To receive Federal reimbursement, each Unit must submit an initial application to OIG.[16] OIG reviews the application and notifies the Unit if the application is approved and the Unit is certified. Approval and certification are for a 1-year period; the Unit

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[8] OIG, *MFCU Statistical Data for Fiscal Year 2014*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.htm on May 1, 2015.

[9] Ibid.

[10] SSA § 1903(q)(1).

[11] OIG, *Medicaid Fraud Control Units*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp on February 25, 2015.

[12] Among those States with a Unit, the Unit shares responsibility for protecting the integrity of the Medicaid program with the section of the State Medicaid agency that functions as the program integrity unit. Some States also employ an Office of Medicaid Inspector General that conducts and coordinates activities to combat fraud, waste, and abuse for the State agency.

[13] SSA § 1903(q)(2); 42 CFR § 1007.9(d).

[14] The portion of funds reimbursed to States by the Federal Government for its share of expenditures for the Federal Medicaid program, including the MFCUs, is called Federal Financial Participation.

[15] SSA § 1903(a)(6)(B).

[16] 42 CFR § 1007.15(a).

must be recertified each year thereafter.[17] In addition to conducting annual recertification, OIG performs periodic onsite reviews of the Units.

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.[18] OIG developed and issued 12 performance standards to further define the criteria it applies in assessing whether a Unit is effectively carrying out statutory functions and meeting program requirements. Examples of standards include maintaining an adequate caseload through referrals from various sources, maintaining an annual training plan for all professional disciplines, and establishing policy and procedure manuals to reflect the Unit's operations.[19] See Appendix A for a description of each of the 12 performance standards.

D.C. Unit

The D.C. Unit expended $2,708,824 in combined State and Federal funds in FY 2014.[20] At the time of our review, the Unit's 23 employees were located in a single office. The Unit employs 4 attorneys, 9 investigators, 3 auditors, 2 program analysts, and a staff assistant. The Unit's management is composed of a director, a deputy director, and two supervisory investigators. Five months after the completion of our onsite review, the Unit director was removed from her position and the Unit deputy director was appointed Acting Director.[21]

Referrals. The Unit tracks and reviews referrals as they are received. The Unit receives referrals from a variety of sources including, but not limited to, the D.C. Medicaid agency (Department of Health Care Finance), the D.C. Department on Disability Services, providers, and the Unit's hotline. A Unit staff member records referrals in the Unit's case management system. Unit staff, including at least one attorney, review referrals to determine whether the allegation is within the Unit's

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[17] 42 CFR § 1007.15(b) and (c).

[18] SSA § 1902(a)(61).

[19] The performance standards referred to in this report were published on June 1, 2012, and were in effect for the majority of our review period. 77 Fed. Reg. 32645 (June 1, 2012). Previous performance standards, established in 1994, are found at 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at http://www.gpo.gov/fdsys/pkg/FR-1994-09-26/html/94-23692.htm on August 29, 2014.

[20] OIG, *MFCU Statistical Data for Fiscal Year 2014*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.htm on May 1, 2015.

[21] All references to Unit director in this report are to the individual who was the Unit director during our onsite review in January 2015.

jurisdiction. Unit referrals by referral source, for FYs 2012 through 2014, may be found in Appendix B.

Investigations. If the Unit's director or deputy director believes a referral falls within the Unit's jurisdiction, he or she assigns an interdisciplinary team to investigate the matter. The team consists of an attorney and an investigator, with an auditor and/or program analyst as needed. If this investigation yields sufficient evidence to move forward with legal action, Unit attorneys work with attorneys in the United States Attorney's Office (USAO) to pursue criminal prosecution.

Prosecutions. The Unit relied on the USAO for prosecution of its criminal cases during the period we reviewed; the USAO serves as both the local and the Federal prosecutor for D.C. Although the Unit has authority to prosecute misdemeanor criminal fraud cases, the Unit's deputy director reported that it has not exercised that authority for any of its cases. All of the Unit attorneys are sworn Special Assistant United States Attorneys (SAUSAs), and therefore able to represent the D.C. Office of Inspector General in D.C. Superior Court and Federal District Court on matters originated by the Unit. As SAUSAs, the Unit attorneys are co-counsel with the assigned Assistant United States Attorney (AUSA) during all phases of litigation on criminal and civil Unit cases.

The Unit relies on the D.C. Office of the Attorney General for execution of global civil settlements and judgments. This was the D.C. Office of the Attorney General's only role with respect to the Unit's operations.

Unit Reporting to Federal Entities

Reporting to OIG. OIG excludes any person or entity from participation in Federal health care programs who is convicted of a criminal offense related to the delivery of an item or service under Medicaid or to the neglect or abuse of patients in residential health care facilities. No payment may be made by Medicaid, Medicare, or other Federal health care programs for an item or service provided, ordered, or prescribed by an excluded individual or entity.[22] Convictions resulting from Unit investigations must be reported to OIG for program exclusion within 30 days from the date of sentencing.[23]

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[22] SSA § 1128(a); 42 CFR § 1001.1901.

[23] Performance Standard 8(f).

Reporting to National Practitioner Data Bank. Separate from the reporting of convictions to OIG for exclusion purposes, Federal regulations require that all State and Federal government agencies report any final adverse actions to the National Practitioner Data Bank (NPDB).[24] Adverse actions include actions resulting from investigations or prosecutions of healthcare providers and suppliers. Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions. Final adverse actions must be reported to the NPDB "within 30 days following the action."[25] In addition to Federal regulations, Performance Standard 8(g) states that Units should report all "qualifying cases to the Healthcare Integrity & Protection Databank, the NPDB, or successor data bases."

Previous Review

A 2009 OIG onsite review of the Unit found that the Unit's MOU with the D.C. Medicaid agency was not signed by the D.C. Medicaid agency director and therefore was never executed. Subsequent to that onsite review, the Unit director provided OIG with a copy of the revised MOU that had been finalized, signed, and executed by the D.C. Medicaid agency.

The 2009 review also resulted in a suggestion for improving the Unit's official case files; the case files did not contain an index identifying the information contained within the file. In 2013, the Unit implemented an electronic case file management system that contained a case log identifying information contained within the file. We address the implementation of this case file management system in this report.

METHODOLOGY

We conducted the onsite review in January 2015. We based our review on an analysis of data from seven sources: (1) a review of policies, procedures, and documentation related to the Unit's operations, staffing, and caseload for FYs 2012 through 2014; (2) a review of financial documentation for FYs 2012 through 2014;

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[24] 45 CFR § 60.5. The NPDB was established by the Department of Health and Human Services 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).

[25] 45 CFR § 60.5.

(3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with Unit management; (6) an onsite review of a sample of files for cases that were open at any time in FYs 2012 through 2014; and (7) onsite observation of Unit operations. Appendix C provides a detailed methodology.

Standards

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

FINDINGS

Our review of the D.C. Unit identified several findings that may undermine Unit efficiency and effectiveness. We identified delays in case progress that may have been explained by Unit management practices that we observed, including a lack of documented supervisory reviews and a lengthy clearance process for documents. We also found that the Unit did not use its case management system to allow efficient access to case information, and that it investigated several cases that were outside of the Unit's authority. Until July 2015, the Unit's MOU with the D.C. Medicaid agency was out of date. Regular meetings between the Unit and the Medicaid agency were not always held, and the Unit did not report all relevant information to Federal partners within required timeframes.

From FYs 2012 through FY 2014, the Unit reported 14 convictions, 33 civil judgments and settlements, and recoveries of $15 million

For FYs 2012 through 2014, the Unit reported 14 criminal convictions and 33 civil judgments and settlements. Of the Unit's 14 convictions over the 3-year period, 9 convictions involved allegations of fraud and 5 involved allegations of patient abuse or neglect. All but one of the 33 civil settlements and judgments involved "global" cases, totaling $10.6 million.[26] The remaining civil judgment of $771,271 was part of a False Claims Act judgment against a D.C. health care provider, which resulted from an investigation by multiple Federal and State partners.

The Unit reported no nonglobal civil settlements and judgments in FYs 2012 and 2014 and no criminal recoveries in FY 2012. The Unit reported $7,572 in criminal recoveries in FY 2014. See Table 1 for yearly convictions, civil judgments and settlements, recoveries, and expenditures.

[26] "Global" cases are civil false claims actions involving the U.S. Department of Justice and other State MFCUs. The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases on behalf of the States.

Table 1: D.C. MFCU Outcomes, FYs 2012–2014

Outcomes	FY 2012	FY 2013	FY 2014	Total
Criminal Convictions	4	7	3	14
Civil Settlements and Judgments--Global	8	13	11	32
Civil Settlements and Judgments--Nonglobal	0	1	0	1
Criminal Recoveries	$0	$3,933,198	$7,572	$3,940,770
Civil Recoveries—Global	$3,799,116	$3,097,014	$3,748,169	$10,644,299
Civil Recoveries—Nonglobal	$0	$771,271	$0	$771,271
Total Recoveries*	**$3,799,116**	**$7,801,483**	**$3,755,741**	**$15,356,340**
Total Expenditures	**$2,725,291**	**$2,473,055**	**$2,708,824**	**$7,907,169**

Source: OIG analysis of Unit-submitted documentation, FYs 2012–2014, 2015.

Unit management practices may explain the delays we found in 20 percent of cases

Sixty-eight percent of cases lacked documentation of periodic supervisory reviews intended to ensure cases progress at a reasonable pace

Sixty-eight percent of the Unit's case files lacked documentation of periodic supervisory reviews.[27] OIG performance standards state that supervisors should review progress of cases, ensuring that each stage of an investigation is completed in an appropriate timeframe. A document should be included in the case file that shows that the reviews took place.[28] Further, the Unit's policy stated that quarterly case reviews "are intended to ensure cases are progressing at a reasonable pace, to share ideas and strategies, to discuss problems or issues, and provide necessary assistance."

Twenty percent of cases were not progressing at a reasonable pace

Through an indepth review of case documentation, OIG found that 20 percent of cases did not progress at a reasonable pace, and that the lack of progress could not be attributed to resource constraints or other exigencies.[29, 30] The Unit director confirmed that the cases were

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[27] Appendix D contains the point estimate and 95-percent confidence interval for the 68-percent statistic.

[28] Performance Standards 5(b) and 7(a).

[29] According to Performance Standard 5(c), delays during the investigative phase should be limited to situations imposed by resource constraints or other exigencies.

[30] Appendix D contains the point estimate and 95-percent confidence interval for the 20-percent statistic.

not progressing towards closure timely, explaining that one or more of the following problems occurred in each of the cases: reassignment to other attorneys or investigators; failure to investigate timely; delay of 3 months in approval of a request for information from the D.C. Medicaid agency; and lack of reports of investigation or interviews in the case file. OIG determined that in 60 percent of the cases with delays in progression, reviews were conducted by a supervisor; however, no input or direction was given to the investigator on how to proceed with these cases.

A lengthy document clearance process impeded case progress

In response to our staff survey, 25 percent of staff reported that the document clearance process affected the Unit's ability to complete investigations timely. Specifically, Unit staff reported delays in obtaining approval of documents (e.g., closing memos, subpoenas, arrest warrants) from the Unit director. An investigator reported that he had used a template to write a subpoena and submitted it for approval 10 weeks prior to OIG's onsite review. At the time of the onsite review, the subpoena still had not been approved. Similarly, staff reported closing memos that remained in the clearance process for a year, and reported losing momentum in case progress due to the lengthy closure process. The Unit director reported that the clearance process was necessary to improve the quality of documents.

The Unit did not use its case management system to allow efficient access to case information

OIG's review of case files demonstrated a lack of knowledge among Unit staff on how to use the Unit's electronic case management system. Case documentation was incomplete (e.g., some investigators listed a witness interview completed in the case management system; however, there was no report of the interview in the case file) and the Unit was unable to report accurate case-related statistics to OIG for the purposes of oversight. According to Performance Standard 7, the Unit should maintain case files in an effective manner and develop a case management system that allows efficient access to case information.

The Unit confirmed having difficulties reporting case-related statistics to OIG as far back as 2008, and had implemented a new case management system in 2013. However, the Unit's problems reporting accurate case-related statistics to OIG persisted at the time of our review. The Unit director reported that all case-related

statistics reported to OIG since 2013 were inaccurate, because those statistics were calculated on the basis of the dates cases were received rather than the dates cases were opened. The Unit discovered this inaccuracy during our onsite review in January 2015.

The Unit investigated seven cases that were not eligible under Federal regulations for Federal matching funds

Seven cases were not eligible for Federal matching funds because of either (1) the location of the alleged incident, or (2) the type of fraud investigated. In six of these seven cases, the Unit reviewed complaints of abuse and neglect (i.e., patient funds) that occurred outside of health care facilities or board and care facilities; therefore, these cases are ineligible for Federal matching funds.[31] In the seventh case, the Unit investigated the case of a recipient who fraudulently cashed a paycheck belonging to someone else. This case was unrelated to Medicaid and therefore ineligible for Federal matching funds.

The Unit's involvement with these seven cases may be attributed to confusion about its authority with regard to complaints of patient abuse or neglect. In explaining why the Unit investigated cases not eligible for Federal matching funds, the Unit director informed OIG that she believed that the Unit's investigative authority allowed for investigations whenever a person receives Medicaid-funded services.

[31] SSA § 1903(q)(4)(A)(ii) & 42 CFR § 1007.19(d).

Until July 2015, the Unit's MOU with the D.C. Medicaid agency was out of date and did not reflect current Federal legal requirements; further, formal communication was infrequent

The Unit's MOU with the D.C. Medicaid agency was last updated in December 2008 and did not address Federal payment suspension regulations that went into effect in March 2011.[32] Specifically, the MOU did not include a provision describing the referral process between the Unit and the D.C. Medicaid agency for providers that are subject to a payment suspension on the basis of a credible allegation of fraud. According to Performance Standard 10, the Unit must review its MOU with the State Medicaid agency at least every 5 years, and ensure that the MOU meets current Federal legal requirements.

The MOU between the Unit and the D.C. Medicaid agency stipulates that the entities meet on a quarterly basis to discuss which preliminary investigations completed by the D.C. Medicaid agency warrant full investigations, and to discuss the terms of the MOU.[33] The D.C. Medicaid agency reported that these quarterly meetings did not always occur as scheduled. A February 2014 Centers for Medicare & Medicaid Services review of the D.C. Medicaid agency also found that the quarterly meetings had not taken place, and identified ineffective interagency communication between the Unit and the D.C. Medicaid agency.[34] The Unit deputy director reported that he would like to establish communication with the new D.C. Medicaid director. D.C. Medicaid agency officials reported that they would like to "get the meetings back on track."

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[32] The Patient Protection and Affordable Care Act, P.L. No. 111-148 § 6402(h)(2) (March 23, 2010), as amended by the Health Care Reconciliation Act of 2010, P.L. No. 111-152 (March 30, 2010) requires State Medicaid programs, as a condition of receiving Federal Financial Participation, to suspend payments to providers for whom there is a credible allegation of fraud, unless good cause exists to not suspend payments. One way to establish good cause is for the MFCU to inform the State Medicaid agency that the suspension would compromise or jeopardize its investigation of the provider. CMS and OIG implemented this provision in revisions to 42 CFR §§ 455.23 and 1007.9(e) effective March 25, 2011 (76 Fed. Reg. 5862).

[33] MOU between Department of Health Care Finance and the MFCU, Section VII(A)(3), December 31, 2008.

[34] CMS, *Medicaid Integrity Program District of Columbia Comprehensive Program Integrity Review Final Report*, p. 9, February 2014. Accessed at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/DCfy12.pdf on March 19, 2015.

A revised MOU between the Unit and D.C. Medicaid agency was finalized on July 2, 2015. This MOU includes a provision describing the referral process between the Unit and the D.C. Medicaid agency for providers that are subject to a payment suspension on the basis of a credible allegation of fraud. The MOU also reiterates that the Unit and D.C. Medicaid agency agree to meet no less than quarterly to discuss matters pertaining to the terms of the MOU.

The Unit did not report all convictions to OIG or adverse actions to the NPDB within required timeframes

The Unit did not report convictions to OIG within the required timeframe

The Unit obtained 14 convictions in the review period but, according to its own data, did not report any of those sentenced individuals to OIG for program exclusion within the required timeframe. OIG received reports of 9 of the 14 convictions within 30 days. These cases were likely reported to OIG by another agency that jointly investigated or prosecuted the case. According to Performance Standard 8(f), when an individual is sentenced, the Unit should report the conviction to OIG within 30 days of sentencing for the purposes of program exclusion. Reports ranged from 1 day late to 299 days late; on average, the convictions were reported 88 days late. Late reporting of convictions to OIG could delay the initiation of the program exclusion process, resulting in improper payments to providers.

The Unit did not report convictions to the NPDB within the required timeframe

The Unit did not report information for any of its 14 convictions to the NPDB within the required timeframe. According to Federal regulation, final adverse actions, such as criminal convictions, must be reported to the NPDB "within 30 days following the action."[35] The Unit reported information to the NPDB between 48 days late and 954 days late; on average, the adverse actions were reported 583 days late. The Unit reported all adverse actions to the NPDB after the start of the review. Late reports of adverse actions to the NPDB may prevent it from fulfilling its intended purpose, the restriction of health care providers' ability to move from State to

[35] 45 CFR § 60.5.

State without disclosure or discovery of previous medical malpractice and adverse actions.

The Unit maintained proper fiscal control of its resources

The Unit maintained proper fiscal control of its resources during the review period. According to Performance Standard 11, the Unit should exercise proper fiscal control over the Unit's resources. On the basis of the review conducted by OIG auditors, the Unit's financial documentation indicated that the Unit's requests for reimbursement for FYs 2012 through 2014 represented allowable, allocable, and reasonable costs. In addition, the Unit maintained adequate internal controls relating to accounting, budgeting, personnel, procurement, property, and equipment.

Other observation: The Unit did not have a process for reporting collections information

The Unit director reported that there is no process in place for the Unit to obtain collections information (i.e., monies actually collected from criminal or civil judgments), which are reported to OIG as part of the Quarterly Statistical Reports (QSR). According to the terms and conditions of the grant, the Unit "must submit QSRs as described by OIG."[36] The Unit did not report data related to collections for any quarter of the 3-year review period in either the original or revised QSR submissions. Among the 50 Units, the D.C. Unit was the only Unit not to report any collections data for FYs 2012 through 2014.

Other observation: Policies and procedures were not widely circulated to staff

The Unit deputy director reported that "policies and procedures were an evolving process," and had not been widely circulated prior to our onsite review. Staff reported being unaware of policies and procedures until the start of the review. According to Performance Standard 3, the Unit should ensure that staff are familiar with, and adhere to, policies and procedures. Unit policies and procedures are established to ensure a productive Unit and govern, in part, the

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[36] OIG, *Definitions and Instructions for Completion of the State Medicaid Fraud Control Unit Quarterly Statistical Report*, 2007. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/forms/Quarterly%20Statistical%20Report%20Instructions.pdf on March 12, 2015.

investigation and case review process, procedures for written documents, chain of command, and training.

CONCLUSION AND RECOMMENDATIONS

Our review of the D.C. Unit identified several findings that may undermine Unit efficiency and effectiveness. We identified delays in case progress that may have been explained by Unit management practices that we observed, including a lack of documented supervisory reviews and a lengthy clearance process for documents. We also found that the Unit did not use its case management system to allow efficient access to case information, and that it investigated several cases that were outside of the Unit's authority. Until July 2015, the Unit's MOU with the D.C. Medicaid agency was out of date. Regular meetings between the Unit and the Medicaid agency were not always held, and the Unit did not report all relevant information to Federal partners within required timeframes.

We recommend that the District of Columbia Unit:

Ensure that periodic supervisory reviews are documented in Unit case files

The Unit should ensure that periodic supervisory reviews of case files are conducted consistent with the Unit's case file review policy and that these reviews are documented in the case files.

Ensure that delays in case progress are limited to situations imposed by resource constraints or other exigencies, and documents are cleared timely

To demonstrate that extended delays were imposed by resource constraints or other exigencies, the Unit could implement a policy to document such occurrences in the case files. To ensure that documents are cleared in a timely manner, the Unit could revise its document clearance process to minimize delays.

Ensure that use of its case management system allows for efficient access to case information

The Unit should ensure that the Unit's staff use of the case management system allows for efficient access to case information such as interview summaries, case-related statistics, and standardized reports. The Unit could provide additional training and guidance in how to input and extract case information for the system.

Repay Federal matching funds spent on the cases that were not eligible for Federal funding and implement procedures to ensure that cases are within grant authority

The Unit should work with OIG to identify the staff hours and expenditures associated with the seven ineligible cases and repay those Federal matching funds. The Unit should develop and implement procedures to ensure that Unit staff investigate cases solely within the Unit's grant authority.

Communicate regularly with the D.C. Medicaid agency

The Unit should follow the terms of the MOU by maintaining formal communication, including regular meetings, with the D.C. Medicaid agency.

Ensure that all relevant information is reported to OIG and NPDB within required timeframes

The Unit should ensure that it reports individuals and entities to OIG for exclusion within 30 days of sentencing, consistent with Performance Standard 8(f). Similarly, the Unit should report all adverse actions to the NPDB within 30 days of the action, as specified in Federal regulation.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The District of Columbia Unit concurred with all six of our recommendations.

Regarding the first recommendation, the Unit stated that it streamlined operations, reducing the number of case file reviews that supervisors need to complete from 18 to 4 per quarter thereby making it easier to ensure that case reviews are completed and documented in case files in a timely fashion.

Regarding the second recommendation, the Unit stated that it is re-evaluating its caseload and closing marginal cases to focus on truly meritorious cases. The Unit stated that it has also revised its document clearance process and is developing new policies to ensure documents are processed timely.

Regarding the third recommendation, the Unit stated that it is working with its case management software vendor to improve the quality of case-related statistics and standardized reports. The Unit stated that management has taken a series of steps to ensure the timely preparation of interview summaries and submissions into the case management system. The Unit also stated that management is also working with its vendor to develop additional training and guidance to improve the staff's ability to input and extract case information.

Regarding the fourth recommendation, the Unit stated that it has amended its complaint review process to immediately close and refer elsewhere allegations occurring outside of Medicaid-funded facilities. The Unit stated that it will repay funds in the amount of $8,025.

Regarding the fifth recommendation, the Unit stated that it has worked to improve the quality and frequency of communication with the D.C. Medicaid agency since the appointment of the new Unit director in May 2015. The Unit further states that it intends to fully comply with the terms of the newly developed MOU requiring formal communication with the Medicaid agency, including regular meetings.

Regarding the sixth recommendation, the Unit stated that it will amend its policies and procedures to ensure timely reporting sentencings to OIG and adverse actions to NPDB. The Unit stated that it will also amend its case management software to generate

notices to Unit staff to prepare the documents necessary to transmit information to OIG and NPDB.

The Unit's comments are provided in Appendix E.

APPENDIX A

2012 Performance Standards[37]

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.

[37] 77 Fed. Reg. 32645, June 1, 2012.

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

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

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

APPENDIX B

Table B-1: Unit Referrals by Referral Source for FYs 2012 Through 2014

	FY 2012			FY 2013			FY 2014		
Referral Source	**Fraud**	**Abuse & Neglect**	**Patient Funds**	**Fraud**	**Abuse & Neglect**	**Patient Funds**	**Fraud**	**Abuse & Neglect**	**Patient Funds**
D.C. Medicaid agency	4	0	0	24	0	0	10	0	0
D.C. agency – other	1	0	0	0	9	0	0	0	0
D.C. survey and certification agency	0	3	2	0	0	0	0	0	0
Other State agencies[38]	15	110	17	5	38	9	3	58	7
D.C. Board of Nursing	0	1	0	0	0	0	2	0	0
Law enforcement	1	2	0	2	0	0	2	0	0
Office of Inspector General	0	0	0	1	0	0	0	0	0
Prosecutors	4	0	0	2	1	0	0	0	0
Providers	1	2	3	0	7	3	2	11	2
Provider associations	0	0	0	0	0	0	0	0	0
Private health insurer	0	0	0	0	0	0	0	0	0
Long-term-care ombudsman	0	0	0	0	2	1	1	0	0
Adult protective services	0	0	0	0	0	0	0	0	0
Private citizens	7	5	0	3	2	1	5	3	0
MFCU hotline	6	1	1	1	0	0	28	0	0
Other	8	0	0	29	1	1	27	0	1
Total	**47**	**124**	**23**	**67**	**60**	**15**	**80**	**72**	**10**
Annual Total			**194**			**142**			**162**

Source: OIG analysis of Unit-submitted documentation, FYs 2012–2014, 2015.

[38] The Unit reported that referrals from the D.C. Department on Disability Services make up the majority of these referrals.

APPENDIX C

Detailed Methodology

Data collected from the seven sources below were used to describe the caseload and assess the performance of the D.C. Unit.

Data Collection

Review of Unit Documentation. Prior to the onsite visit, we analyzed information from several sources 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 QSRs, annual reports, recertification questionnaire, policy and procedures manuals, and MOU with the D.C. Medicaid agency. Additionally, we confirmed with the Unit director that the information we had was current as of January 2015.

Review of Unit Financial Documentation. To evaluate internal control of fiscal resources, OIG auditors determined whether the Unit (1) claimed expenditures that represented allowable, allocable, and reasonable costs in accordance with applicable Federal regulations, and (2) maintained adequate internal controls related to accounting, budgeting, personnel, procurement, property, and equipment for FYs 2012 through 2014. OIG auditors also (1) reviewed quarterly and final financial status reports and supporting documentation that the Unit submitted, (2) judgmentally selected and reviewed transactions within the direct cost categories, and (3) confirmed whether indirect costs were accurately reported using the negotiated and approved indirect cost rates during the period of our review. Finally, auditors reviewed records in the Department of Health and Human Services' Payment Management System and determined whether there was any unallowable Federal reimbursement.

Interviews with Key Stakeholders. In December 2014 and February 2015, we interviewed key stakeholders, including officials in the USAO (Civil Division), the D.C. Office of the Attorney General, and other agencies that interacted with the Unit (i.e., Federal Bureau of Investigation, D.C. Health Care Facilities Licensing, and D.C.

Department on Disability Services). We also interviewed supervisors from OIG's Region III offices who work regularly with the Unit.

During our onsite review, we interviewed officials with the USAO (Criminal Division, Fraud and Public Corruption Section) and the D.C. Medicaid agency's Program Integrity Unit. We focused these interviews on the Unit's relationship and interaction with OIG and other Federal and State authorities. We used the information collected from these interviews to develop subsequent interview questions for Unit management.

Survey of Unit Staff. In December 2014, we conducted an online survey of all 17 nonmanagerial Unit staff within each professional discipline (i.e., investigators, auditors, and attorneys) as well as support staff. The response rate was 94 percent. The survey focused on operations of the Unit, opportunities for improvement, and practices that contributed to the effectiveness and efficiency of Unit operations and/or performance. The survey also sought information about the Unit's compliance with applicable laws and regulations.

Onsite Interviews with Unit Management. We conducted structured interviews with the Unit's management during our onsite review. We interviewed the Unit's director, the Unit's deputy director, and the Unit's two supervisory criminal investigators. We asked these individuals to provide information related to (1) the Unit's operations, (2) 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 2012 through 2014. This list of 648 cases included, but was not limited to, the current status of the case; whether the case was criminal, civil, or global; and the date on which the case was opened. From this list of cases, we excluded 70 cases that were categorized as "global" and 133 that were categorized as "referrals."

We removed 44 cases categorized as "patient funds" from the universe of 648 cases to examine separately. We reviewed all 44 cases while onsite to determine if these cases were eligible for Federal matching funds. We conducted this review because of concerns raised by stakeholders and Unit staff prior to the onsite review.

We then selected a simple random sample of 100 cases from the remaining 401 cases. This sample of 100 cases included 92 cases that were open longer than 90 days. We reviewed all 100 sampled case files.

During the onsite review, one sampled case file was determined to be a global case. As a result, the number of eligible case files in our sample was reduced from 100 to 99. To project the number of eligible case files in the entire population, we used the proportion of the eligible case files from our sample. Our estimates of the percentages of all case files with certain characteristics apply to the estimated population of 397 files for nonglobal cases that were open during the period of our review. The point estimate and 95-percent confidence interval for the projection can be found in Appendix D.

From the initial sample of 100 case files, we selected a further simple random sample of 50 files for an OIG investigator to conduct an indepth review of selected issues, such as the timeliness of investigations and case development.

Onsite Review of Unit Operations. During our January 2015 site visit, we observed the Unit's offices and meeting spaces; security of data and case files; location of select equipment; and the general functioning of the Unit. We also determined whether the Unit reported convictions to OIG for program exclusion and whether the Unit reported adverse actions to the NPDB.

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] We based our findings on data analysis, statements from Unit staff, and our own judgment.

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

APPENDIX D

Table D-1: Point Estimates and 95-Percent Confidence Intervals Based on Reviews of Case Files

Estimate	Sample Size*	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of files for cases that were open longer than 90 days that did not contain documentation of periodic supervisory review	92**	68.5%***	59.6%	76.2%
Percentage of cases that had delays in case progression	49*	20.4%	12.2%	32.1%
Percentage of cases with delays in case progression that had documentation of periodic supervisory review	10	60%	32.9%	82%

*The original sample size for the in depth review of 50 case files was reduced by 1 due to a global case being included.
**The original sample size of 100 was reduced by 1 due to a global case being included, and further reduced by 7 to exclude those cases open for less than 90 days.
***The actual percentage is 68.48 percent. The number 68.48 rounds to 68.5. As a whole number, however, this percentage rounds to 68 percent.
Source: OIG analysis of D.C. MFCU case files, 2015.

APPENDIX E

Unit Comments

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General

OIG

VIA Electronic Mail

September 18, 2015

Jordan R. Clementi, JD
Program Analyst
Office of Inspector General
Office of Evaluations and Inspections
Medicaid Fraud Policy and Oversight Division
U.S. Department of Health and Human Services
1201 Walnut Street, Suite 934
Kansas City, MO 64106

Re: Comments on 2015 HHS Onsite Review Report # OEI-07-14-00660

Dear Ms. Clementi:

We are in receipt of the Onsite Review Team's draft report (#OEI-07-14-00660) reflecting its observations from its review of the District of Columbia's Medicaid Fraud Control Unit (D.C. MFCU) in January 2015, as well as its related recommendations. As discussed during our Exit Conference on July 21, 2015, we concur with the team's recommendations.

Recommendation 1: Ensure that periodic supervisory reviews are documented in Unit case files.

The D.C. MFCU concurs with this recommendation. Per the structural reorganization that is currently being implemented, D.C. MFCU is being divided into four separate teams that will work with one another almost exclusively on their cases. It is believed this reorganization will streamline operations, significantly reducing the number of case reviews that supervisors need to complete from 18 per quarter to 4, thereby making it easier to ensure that case reviews are completed and documented in case files in a timely fashion.

Recommendation 2: Ensure that delays in case progress are limited to situations imposed by resource constraints or other exigencies, and documents are cleared timely.

The D.C. MFCU concurs with this recommendation, but believes that some of the extended delays noted by the Onsite Review Team arose due to "resource constraints" unintentionally created by past management practices that resulted in staff members maintaining caseloads, which significantly exceeded the national average for other MFCUs. D.C. MFCU is

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systematically re-evaluating its caseload and closing marginal cases in an effort to focus its efforts on truly meritorious cases, with an eye toward reducing its investigators' caseloads consistent with the national average for other MFCUs.

D.C. MFCU has already revised its document clearance process to ensure cases are closed promptly once the closing decision has been made, and D.C. MFCU is working to implement new policies that will ensure other documents (e.g., subpoenas, Requests for Information, etc.) are processed in a more timely fashion. D.C. MFCU is also working to implement new policies to ensure that any extended delays in case progress occur only as a result of resource constraints or other exigencies, and to ensure that any such occurrences are properly documented in the case files.

Recommendation 3: Ensure that use of its case management system allows for efficient access to case information.

The D.C. MFCU concurs with this recommendation, and is working to address this concern in three ways.

First, D.C. MFCU is already working with Journal Technologies (specifically, its case management software vendor) to improve the quality of case-related statistics and standardized reports generated by JustWare. If our case management system cannot be relied upon to generate reliable reports and statistics, it is failing to accomplish one of its core objectives and we will take appropriate steps to remedy those problems.

Second, D.C. MFCU management has made the timely preparation of interview summaries a point of emphasis. All investigators have been directed to draft a Memorandum of Interview (MOI) within 10 days after completing each interview, and to upload the MOI into JustWare within the same timeframe, in accordance with established policy. The two supervisory criminal investigators have been directed to maintain "Tickler" systems for tracking the line investigators' compliance with this policy. The D.C. MFCU attorneys have been directed to ensure that MOIs for all interviews memorialized in the case log or mentioned in draft closing memos have been uploaded into JustWare, and to review the same before closing memos are submitted to D.C. MFCU management. The Director and Deputy Director also will not authorize cases to be closed until all MOIs have been uploaded into JustWare.

Third, D.C. MFCU management will work with Journal Technologies to develop additional training and guidance to improve the staff's ability to input case information into JustWare and to extract case information from the system in a timely fashion.

Recommendation 4: Repay Federal matching funds spent on the cases that were not eligible for Federal funding and implement procedures to ensure that cases are within grant authority.

The D.C. MFCU concurs with this recommendation. The D.C. MFCU has repaid Federal matching funds in the amount of $8,025.59 for salaries and fringe benefits related to the time its employees worked on the seven cases identified as being outside its grant authority.

Recommendation 5: Communicate regularly with the State Medicaid agency.

The D.C. MFCU concurs with this recommendation.

D.C. MFCU has worked to improve the quality and frequency of its communications with the D.C. Department of Health Care Finance (DHCF) since the new Director's appointment on May 29, 2015.[1] Consequently, D.C. MFCU intends to fully comply with the MOU's terms requiring formal communication with DHCF, including regular meetings. The D.C. MFCU encourages the Onsite Review Team to obtain DHCF's feedback regarding the impact of these recent efforts on the quality of the overall relationship between the two agencies.

Recommendation 6: Ensure that all relevant information is reported to OIG and NPDB within required timeframes.

The D.C. MFCU concurs with this recommendation. D.C. MFCU is working to amend its policies and procedures to ensure that its attorneys report individuals and entities to HHS OIG for exclusion within 30 days of sentencing, and also report all adverse actions in their assigned cases to the NPDB within 30 days of the action. Additionally, D.C. MFCU is working to modify its JustWare business rules to automatically generate notices to D.C. MFCU management and assigned case attorneys to prepare the documents necessary to transmit this information to HHS OIG and NPDB within the required timeframes.

Thank you for the opportunity to respond in this matter, and feel free to contact me or Mr. Wolfingbarger if you have any questions or need additional information.

Sincerely,

Daniel W. Lucas
Inspector General

DWL/bww
Enclosures

[1] The current Director served as Acting Director of the MFCU between May 29 and July 12, 2015, when he was permanently appointed Director of the MFCU.

ACKNOWLEDGEMENTS

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

Teresa Dailey served as the project leader for this study. Other Office of Evaluation and Inspections staff who conducted the study include Tricia Fields, Conswelia McCourt, and Dennis J. Tharp. Office of Investigations staff also participated in the review. Central office staff who contributed include Jordan Clementi, Christine Moritz, and Jacquelyn Towns. Office of Audit Services staff who contributed to this study include Marilyn Carrion, Valerie Johnson, and Michael Jones.

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