Department of Health and Human Services

Office of Inspector General

Alaska Medicaid Fraud Control Unit: 2023 Inspection

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July 2024, OEI-07-23-00240

July 2024 | OEI-07-23-00240

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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

Inconsistent communication and collaboration across professional disciplines and other ineffective Unit practices contributed to significant delays in nearly half of the Unit's cases.

The Unit did not maintain case files in an effective manner due to limitations of its case management system and inconsistent practices for maintaining case information.

The Unit did not maintain adequate staffing for its administrative functions.

The Unit took steps to encourage referrals but could expand these efforts.

The Unit maintained positive working relationships with its Federal partners but lacked procedures to communicate and coordinate regularly with them.

The Unit did not maintain an accurate, regularly updated equipment inventory, and one inventory item was not properly secured.

Some aspects of the Unit's supervisory review policies were ineffective and the Unit did not consistently follow other aspects of these policies.

The Unit did not conform with two Federal grant requirements.

What OIG Recommends

We made 13 recommendations for improvement across 8 aspects of the Unit's operations, including (1) maintaining a continuous case flow; (2) maintaining case information; (3) maintaining adequate staffing; (4) maintaining adequate referrals; (5) cooperating with Federal authorities; (6) exercising proper fiscal control; (7) conducting periodic supervisory reviews; and (8) complying with requirements. The Unit concurred with all 13 recommendations.

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BACKGROUND

OBJECTIVE

To examine the performance and operations of the Alaska 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 enrollees 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.

[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. The Federal FY 2023 was from October 1, 2022, through September 30, 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.

Alaska MFCU

The Alaska Unit is located within the Department of Law (DOL) in Anchorage and has Statewide jurisdiction to prosecute Medicaid provider fraud and patient abuse and neglect. At the time of our onsite inspection in June 2023, the Unit had an approved staff size of 12, and it employed 11 staff—3 attorneys (including the Director and Deputy Director), 6 investigators (including the Chief Investigator), a Forensic Accountant, and a paralegal. The Unit was also seeking to fill a vacant Law Office Assistant (LOA) position. During the review period of FYs 2020–2022, the Unit spent approximately $5.4 million, with a State share of approximately $1.4 million.

[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). 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.

Alaska Medicaid Program

The Alaska Department of Health administers the State Medicaid program. As of June 2023, the program served 265,952 enrollees, all of whom received services from the fee-for-service Medicaid program.[13] In FY 2022, Alaska's Medicaid expenditures were approximately $2.6 billion.[14] The Department of Health's Medicaid Program Integrity office is responsible for investigating Medicaid fraud complaints and, when appropriate, referring credible allegations to the MFCU.

Prior OIG Report

OIG conducted a previous onsite review of the Alaska Unit in 2016.[15] In that review, which covered FYs 2013–2015, OIG found that (1) the Unit's case files lacked documentation of periodic supervisory reviews; (2) the Unit's training plan did not specify the minimum number of training hours that Unit staff were required to complete; (3) the Unit did not fully secure its paper case files; and (4) the Unit did not appropriately remove costs associated with non-Unit activities from its Federal reimbursement request.

OIG recommended that the Unit (1) develop and implement procedures to ensure that all case files include documentation of periodic supervisory reviews; (2) revise its training plan to specify the minimum number of training hours that Unit staff are required to complete; (3) revise its policies and procedures manual to include procedures for securing paper case files; and (4) develop and implement internal controls to ensure that costs associated with non-Unit activities are removed from Federal reimbursement requests. On the basis of information received from the Unit, OIG considered the recommendations implemented as of January 2019.

Methodology

OIG conducted an onsite inspection of the Alaska MFCU in June 2023. Our inspection covered the 3-year period of FYs 2020–2022.[16] We based our inspection on an analysis of data and information from 7 sources: (1) Unit documentation; (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 simple random sample of 76 case files from the 289 nonglobal case files that were open at

[13] Centers for Medicare and Medicaid Services (CMS), *Updated January 2023 State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data*, accessed at https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html on November 11, 2023.

[14] OIG, *MFCU Statistical Data for FY 2022*, accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2022-statistical-chart.pdf on June 8, 2023.

[15] OIG, *Alaska State Medicaid Fraud Control Unit: 2016 Onsite Review* (09-16-00430) Sept. 15, 2017.

[16] Our review period coincided with the COVID-19 pandemic, which may have affected aspects of the Unit's operations.

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 Appendix A.

In examining the Unit's operations and performance, we applied the published performance standards, 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, but they are subject to the same internal quality controls as are other OIG evaluations, including internal and external peer review.

CASE OUTCOMES

The Unit reported 12 indictments, 15 convictions, and 17 civil settlements and judgments for FYs 2020–2022.

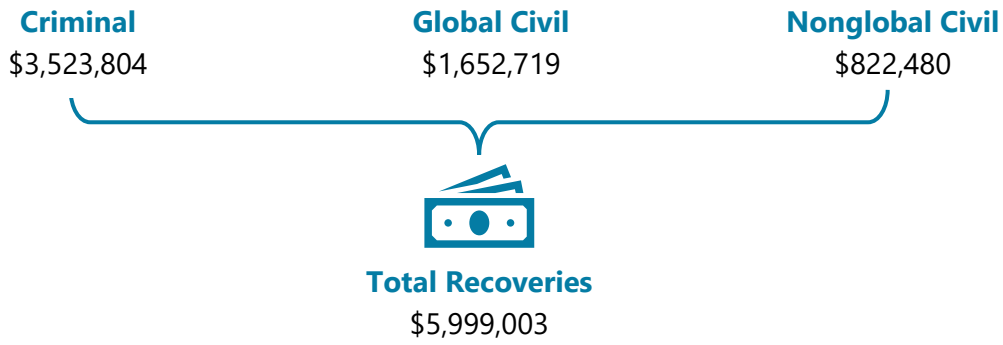
All 15 convictions involved Medicaid provider fraud; none of the convictions involved patient abuse or neglect. Of the 12 indictments, 11 involved provider fraud and 1 involved patient abuse or neglect.[17, 18]

12 Indictments

15 Convictions

17 Civil Settlements & Judgments

The Unit reported combined criminal and civil recoveries of approximately $6.0 million for FYs 2020–2022.



Source: OIG Analysis of Unit statistical data, FYs 2020–2022.
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).

[17] Of similarly sized MFCUs during the review period, indictments ranged from 3 to 71 with a median of 21; fraud convictions ranged from 3 to 25 with a median of 12; patient abuse and neglect convictions ranged from 0 to 28 with a median of 5; and civil settlements and judgments ranged from 13 to 71 with a median of 28. We defined similarly sized MFCUs as those with staff sizes ranging from 9 to 15 employees in FY 2022. This included 12 MFCUs other than the Alaska Unit. Although comparison across similarly sized MFCUs provides context for the case outcomes of a particular MFCU, many factors other than a MFCU's staff size can affect case outcomes.

[18] 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.

FINDINGS

Our review assessed the Unit's adherence to each of the 12 MFCU performance standards and evaluated whether the Unit complied with legal requirements. We made 8 findings regarding the Unit's performance and operations, and we made 13 recommendations for improvement. See the Performance Assessment on page 27 for our full assessment of the Unit's adherence to all 12 MFCU performance standards, including other observations of Unit operations and practices.

Inconsistent communication and collaboration across professional disciplines and other ineffective Unit practices contributed to significant delays in nearly half of the Unit's cases

Performance Standard 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.

We found that 43 percent of the Unit's applicable cases had significant delays during the investigative phase, and an additional 16 percent of cases lacked adequate documentation for us to determine whether the case had investigative delays (see Appendix B for point estimates and confidence intervals from our review of Unit case files). Cases progress through numerous steps and involve many different staff; see Exhibit 1 on the next page for a summary of these steps in the Unit's case flow. We found delays at multiple points in the Unit's case flow and identified several Unit practices that contributed to these delays. These practices included a lack of consistent communication and collaboration among the Unit's professional staff during the referral screening process and during investigations and ineffective procedures for timely opening, assigning, and closing cases.

In OIG's experience, significant case delays can reduce the overall effectiveness of a Unit's investigations and prosecutions. For example, when a Unit does not investigate a case for an extended period, evidence can become inaccessible or outdated. Additionally, lack of timely progress on cases may result in cases that exceed the pertinent statutes of limitations.

Exhibit 1: Summary of Steps in the Unit's Case Flow

Step in Case Flow	Primarily Assigned to
Initial Complaint or Referral Intake	Law Office Assistant (when employed)
Referral Screening	Chief Investigator
Case Opening	
Preliminary Investigation (if needed)	Chief Investigator and Forensic Accountant
Determination to Open	Chief Investigator
Opening in Case Management System	Law Office Assistant (when employed)
Case Assignment	
To Investigator	Chief Investigator
To Attorney	Director
To Auditor	N/A*
Investigation	Investigator, in consultation with assigned attorney and Forensic Accountant
Prosecution	Unit attorney
Case Closing	
Determination to Close	Attorney
Closure in Case Management System	Attorney

* Note: The Unit had one auditor (Forensic Accountant) who assisted with all cases, as appropriate.
Source: OIG analysis of Unit data, 2024.

Unit managers and staff did not consistently communicate and collaborate across professional disciplines during referral screening and investigations

Congress established the MFCU program based on a model of interdisciplinary collaboration among attorneys, auditors, and investigators.[19] In OIG's experience, consistent communication and collaboration across professional disciplines is essential for a Unit's effective operation. However, during our onsite inspection of the Alaska Unit, we observed a lack of consistent communication and collaboration among the Unit's professional staff during the referral screening process and during

[19] See House Report 95-393 (1977, page 81) and Senate Report 95-453 (1977, page 36).

investigations, which contributed to case delays and misunderstandings regarding when cases should be prosecuted or closed.

Referral screening. We found that the Unit's referral screening process did not fully align with new priorities that were established by Unit managers during the review period, which contributed to case delays. Although the Director and Deputy Director reported that the Unit's focus shifted to prioritize larger, more complex cases during the review period, the Unit's process for screening referrals did not reflect this change in priorities. The Unit reported opening large, complex cases during the review period, but that it also continued to open smaller cases involving lower dollar amounts or that were not viewed as involving a high level of potential impact. Investigators said they believed that Unit attorneys were sometimes reluctant to prosecute these cases.

Further, the shift in priorities to developing larger cases increased the amount of time required to investigate cases, but the Unit's referral screening process may not have accounted for this change. We found that the Unit often opened referrals as cases even when it lacked sufficient resources to investigate them promptly due to the additional time required to investigate existing cases. The Chief Investigator reported that, during the review period, the Unit typically had 50–60 cases pending investigation, and these cases could remain in a pending status for a year or longer until one of the Unit's other five investigators became available to investigate another case.[20] The Chief Investigator was responsible for screening referrals, but, in our judgment, his priorities when screening referrals may not have been fully aligned with other managers' priorities due to a lack of consistent interdisciplinary collaboration within the Unit.

We also found that the Unit's Forensic Accountant was not consistently included in screening referrals and the decision to open cases involving allegations of fraud. The Unit's policies and procedures manual stated that the Forensic Accountant was responsible for assisting with preliminary investigations, but the Forensic Accountant said she was not always consulted when cases required data analysis. She said that some analyses required little time for her to complete and would provide important information to help evaluate the merits of a referral.

In OIG's judgment, it is important for the referral screening process to incorporate the different perspectives and expertise offered by attorneys, investigators, and auditors. Further, it is more effective to decline referrals that do not align with Unit priorities or that cannot be investigated in an appropriate timeframe than to accept cases that do not align with prosecutorial priorities or that the Unit cannot investigate promptly.

[20] Unit managers stated they believed that the Unit did not have adequate staffing to timely investigate the Unit's caseload. They reported that the Unit submitted a request to the Department of Law (DOL) during the review period to add an additional investigator and a nurse to the Unit's staff, but the DOL did not approve this request. Although OIG agrees that additional staffing could improve the Unit's case flow, this report identifies several other opportunities to improve the efficiency and effectiveness of the Unit's operations.

Declining certain cases at the referral stage may reduce case delays and allow other entities to pursue appropriate criminal or administrative remedies.

Investigations. We found that the Unit's investigators and attorneys did not consistently collaborate across disciplines during the investigative phase of cases. Although the Director reported that attorneys regularly engaged with investigators on cases, we found that this engagement was inconsistent and did not result in shared understandings of case merits and priorities across disciplines. The Unit's policies and procedures manual stated that an attorney should be assigned to a new case concurrently with the investigator, but the Unit did not consistently assign attorneys at this stage. Unit staff noted that attorneys often became involved in cases later in the investigative phase, such as when a search warrant was needed. Similarly, we found that periodic case review meetings included the attorneys and the Chief Investigator but excluded case investigators, which further contributed to the lack of effective collaboration among the Unit's professional staff. In OIG's experience, excluding investigators from case review meetings is highly unusual among Units. Doing so may have resulted in Unit managers missing critical information and insight from case investigators and may have posed challenges for ensuring a continuous case flow.

We found that the lack of coordination between the Unit's investigators and attorneys also resulted in the Unit investigating cases that attorneys chose not to prosecute. The Director and Deputy Director reported that the Unit began prioritizing larger, more complex cases during the review period, but the Unit continued to assign investigators to work smaller cases. In interviews, investigators expressed frustration that attorneys were reluctant to prosecute some of the smaller cases in which investigators invested significant time and which they believed to be meritorious. In OIG's judgment, this represents a potential waste of resources, and it may be more effective to prosecute meritorious cases in which time and resources have been invested, even if the dollar amounts are not large. When MFCUs investigate and prosecute a mix of cases of varying scope that may not rise to the level of complex cases, they help establish a deterrent for fraudulent and criminal conduct by health care providers. Further, more active engagement across disciplines would allow the entire Unit to develop a shared understanding of case merits and priorities.

Unit practices contributed to significant delays in opening, assigning, and closing cases

In addition to the limitations of the Unit's referral screening process and the lack of communication and collaboration across disciplines, we found that Unit practices for opening, assigning, and closing cases contributed to case delays.

Performance Standard 5(a): Each stage of an investigation and prosecution is completed in an appropriate timeframe.

Case openings. We found that the Unit did not have practical policies and procedures to ensure that cases were opened timely. The

Unit's policies and procedures manual specified that cases should be opened within 1 day of receipt of a referral, but Unit managers acknowledged that it was not possible for them to meet this requirement.[21] Without a practical and enforceable deadline for when referrals should be opened, cases often stagnated at the referral stage. At one point during our inspection, the Unit had 46 referrals that were pending review; of these, 35 had been pending review for over a year, including 11 referrals that had been pending between 3–7 years. In OIG's judgment, specifying and enforcing achievable timelines for opening cases would help reduce case delays.

We also found that the extensive administrative tasks the Unit assigned to the Chief Investigator contributed to delays in opening cases. The Unit's electronic case management system posed challenges for efficiently entering case information, including the information needed to open cases; as a result, the Unit initially relied heavily on its Law Office Assistant (LOA) position to enter this information. However, because of turnover and vacancies in the Unit's LOA position, these duties were largely reassigned to the Chief Investigator beginning in FY 2022. We found that the additional tasks imposed a significant burden on the Chief Investigator, who told us that opening a case in the Unit's electronic case management system could take up to half a day of work. Unit managers and staff, including the Chief Investigator himself, acknowledged that the Chief Investigator was a "chokepoint" in the Unit's case flow because he lacked sufficient time to complete these administrative tasks in addition to his managerial duties.

Case assignments. We found that Unit practices contributed to significant delays in assigning cases to investigators. The Unit's practice was to open cases in the electronic case management system and temporarily assign these cases to the Chief Investigator until a case investigator had the capacity to work another case. The Chief Investigator estimated that throughout the review period, he typically had 50–60 cases temporarily assigned to himself. In our review of the Unit's case files, we found 11 cases (representing 14 percent of the Unit's case files) that were opened and assigned to the Chief Investigator with no evidence of subsequent investigative activities.[22] Seven of these cases contained no evidence of investigative activity for more than a year after the case was opened. In OIG's judgment, it is more effective, either as part of the initial referral screening process or after a preliminary investigation, to decline referrals that the Unit cannot investigate in an appropriate timeframe.

Case closings. We found that the Unit did not have a routine process for closing cases, which contributed to delays in case closings. Although the Unit's policies and procedures manual stated that the attorney assigned to a case was responsible for closing the case in the electronic case management system, the Unit did not have

[21] In March 2023, the Unit revised this policy to require cases to be opened within 7 days of receipt of a referral. Unit managers reported that they also could not meet this updated timeline.

[22] Our case file review protocol did not require reviewers to specifically indicate whether a case was assigned to the Chief Investigator. We identified the 11 cases on the basis of voluntary notes added by reviewers and the number may underestimate the proportion of Unit cases in this status.

timelines or procedures to ensure that it closed cases timely. Unit managers and staff acknowledged that the Unit needed to complete "a mass closing" of cases, and at the time of our onsite inspection, one of the Unit's attorneys estimated that the Unit could immediately close 50 open cases. Our review of Unit case files also found evidence of cases that the Unit could have closed but that remained open in the Unit's case management system. For example, a Unit investigator actively worked a case until December 2019, at which point the investigator recommended closing the case due to lack of support for the allegation. However, the case remained open as of June 2023.

The Unit did not maintain case files in an effective manner due to limitations of its case management system and inconsistent practices for maintaining case information

Performance Standard 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.

We found that the Unit's primary electronic case management system posed challenges for efficiently and securely maintaining case information for investigations; as a result, the Unit entered little investigative information into this system. Instead, the Unit relied on multiple alternative repositories for its investigative information, which posed challenges for accurately monitoring and reporting case information. We also found that Unit staff did not have consistent practices for maintaining case files, which contributed to difficulties in accessing case information.

The Unit's electronic case management system posed challenges for efficiently and securely maintaining case information for investigations

Performance Standard 7(e): The Unit has an information management system that manages and tracks case information from initiation to resolution.

We found that the Unit used an electronic case management system that was designed to manage information for prosecutions but lacked the capability to effectively manage case information for investigations. The Director reported that the Department of Law (DOL) purchased the system to manage and track cases across its criminal division, including the Unit. However, he explained that the Unit was the only entity in the DOL that employed investigators and that the DOL required the Unit to use this system, despite the system's unsuitability for maintaining investigative information. The Director said he believed that other State law enforcement entities employed case management systems that could potentially manage the Unit's investigations and better suit the Unit's needs. However, the Unit

had not sought approval from the DOL to obtain such a system during the review period.

We found that the Unit's electronic case management system was difficult to use for maintaining investigative information, and that case investigators did not use the system. The Director described the system as "very unwieldly, very confusing, and not user-friendly." He said that it takes a long time to open a case because the Unit must populate dozens of database fields. The Director also noted that the Unit frequently encountered technical problems with the system and that its file size limitations prevented the Unit from uploading some investigative documents. The Chief Investigator also said that the system was cumbersome and explained that this was why case investigators did not use the system. He further stated that a complex case could take 4–5 hours to open in the system, and that "the way things are going now, it will be years before we will be caught up" with entering the Unit's backlog of case information.

Another reason that the Unit limited its use of the electronic case management system was because of information security concerns. Unit managers reported that the Unit could not systematically restrict access to Unit case information to appropriate staff, as required by Federal regulation.[23] Therefore, the Unit significantly limited the sensitive case information it entered into the system. Because of the data entry challenges and the security concerns, the Unit primarily used the electronic case management system to maintain public prosecutorial documentation such as charging documents and filings and to monitor and report case summary statistics.

The Unit's repositories for case information posed challenges for accurately monitoring and reporting case information

Performance Standard 7(f): The Unit has an information management system that allows for the monitoring and reporting of case information.

Because of the limitations of its electronic case management system, the Unit maintained documents and case information across multiple repositories. The Unit largely stored case documents on a shared network drive rather than in the electronic case management system. The Unit used the electronic case management system as its primary source for tracking case statistics, but the Chief Investigator documented supervisory reviews and referrals that were unopened or pending review in separate spreadsheets. Additionally, the Unit did not have a process for tracking referrals that it had declined to open.

The Unit's repositories for case data did not allow for accurate monitoring of case information and performance data. Unit staff primarily relied on the electronic case management system to formally monitor case progression; for example, the Unit's

[23] 42 CFR § 1007.11(f) requires Units to guard the privacy rights of all enrollees and other individuals whose data are under the Unit's control, and to provide adequate safeguards to protect sensitive information and data under the Unit's control.

Forensic Accountant used the electronic case management system to generate case lists for supervisory review meetings.[24] However, much of the Unit's referral and case information, including many pending referrals that were not entered in the electronic case management system and many cases that were pending closure for extended periods, was not entered or updated in this system. In OIG's judgment, it is important for Unit managers to have accurate data on the Unit's entire caseload to monitor and evaluate the Unit's overall performance.

Further, the case management challenges caused the Unit to report some of its data inaccurately to OIG. Federal regulation requires Units to report statistical information, including data on cases and referrals, annually to OIG.[25] The Unit's Forensic Accountant completed this task using data from the electronic case management system. However, because the Unit did not enter all case information timely in the electronic case management system, she acknowledged that some of the Unit's data reported to OIG were inaccurate.[26] For example, data on case openings and closings did not reliably reflect the actual status of cases, and the Unit typically did not report referrals that were not opened as cases in the electronic case management system.

Unit staff did not follow consistent practices for maintaining case files, which contributed to difficulties accessing case information

Performance Standard 7(b): Case files include all relevant facts and information and justify the opening and closing of the cases.

We found that the Unit's practices for maintaining case files did not ensure that case files were organized in an effective manner. From interviews with Unit staff and our review of Unit case files, we found that the case files lacked consistent structure and organization and lacked standardized formatting for routine case information. Specifically, we found that investigators did not follow a consistent system for organizing case information. One investigator said that "there's no rhyme or reason how [the Unit's case files are] set up," and "there's not a real structure." Multiple investigators said that they would prefer a more consistent method for organizing case information.

The Unit's inconsistent practices for maintaining case files led to difficulties in accessing case information and in determining the progression of cases. One of the Unit's attorneys said that reviewing a case "takes longer than it should because there is no roadmap and no clear indication of when we got this, what happened, and who did what." We experienced similar difficulties during our onsite review of the Unit's case files, and we were unable to locate some of the relevant case information. Specifically, we found that 48 percent of case files contained little or no

[24] Unit managers noted that they were kept apprised of significant case activities through frequent ad hoc communication within the Unit.

[25] 42 CFR § 1007.17(a)(2).

[26] Our findings in this report related to case flow and referrals were made on the basis of multiple sources of information; we did not rely exclusively on data provided in the Unit's annual statistical reporting to OIG.

documentation of investigative activities. In some instances, we were unable to locate case documents because of the Unit's inconsistent case file organization. For example, we could not easily match some of the case numbers provided from the electronic case management system with case files stored on the shared drive because of the drive's inconsistent folder names.[27, 28]

The Unit did not maintain adequate staffing for its administrative functions

Performance Standard 2(d): The Unit employs a number of support staff in relation to its overall size that allows the Unit to operate effectively.

We found that the Unit experienced difficulties hiring and retaining a qualified Law Office Assistant (LOA), which resulted in turnover and vacancies in this position during the review period. Specifically, two LOAs left the Unit during this period, and the LOA position remained vacant from May 2022 until May 2024, despite the Unit's efforts to fill the vacancy. Managers primarily attributed the difficulties with hiring and retaining a qualified LOA to the relatively low rate of pay for this position.

As a result of the Unit's difficulties hiring and retaining a qualified LOA, the Unit experienced challenges maintaining adequate staffing for administrative tasks. These tasks included answering phone calls, conducting the initial intake of referrals, and entering and updating case information in the Unit's electronic case management system. The Unit's LOA was responsible for completing these duties when the Unit employed an LOA. Because of the obstacles presented by the Unit's electronic case management system, the Unit relied heavily on its LOA to complete administrative tasks in this system. Unit managers explained that efficiently opening a case in the Unit's electronic case management system required a high level of competence to gather and enter an extensive amount of preliminary case data.

In the absence of a qualified LOA, the Unit assigned significant administrative responsibilities to the Chief Investigator, who lacked experience with these tasks in the electronic case management system.[29] Although Unit staff and stakeholders consistently praised the Chief Investigator's supervisory and managerial skills, the additional administrative tasks placed a significant burden on him, which contributed to case delays.

[27] In these instances, we consulted with Unit staff to help us locate the case information on the shared drive, but we were not always able to find all case information within a reasonable timeframe.

[28] The Unit's policies and procedures manual specified that folder names for case files on the shared drive should include the case number from the electronic case management system, but in practice, folder names were inconsistent.

[29] Some of the LOA's administrative tasks were also reassigned to the Unit's paralegal and Forensic Accountant.

The Unit took steps to encourage referrals but could expand these efforts

Performance Standard 4: A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.

We found that the Unit took some steps to ensure that pertinent agencies refer potential cases of patient abuse and neglect and provider fraud to the Unit, but the Unit could expand these efforts. The Unit conducted some outreach efforts during the review period, including giving presentations to local police departments and presenting at an Alaska District Attorney's convention. However, multiple Unit staff maintained that the Unit missed opportunities to conduct additional outreach to potential referral sources, which could improve referrals of patient abuse and neglect to the Unit (see Exhibit 2 for a summary of pertinent agencies). We also found that the Unit maintained a positive working relationship and ad hoc communication with the Department of Health's Program Integrity office, but the frequency of meetings between the Program Integrity office and the Unit declined during the review period.

Exhibit 2: Potential Sources of Patient Abuse or Neglect Referrals

Adult Protective Services: Responsible for helping to prevent or stop harm from occurring to vulnerable adults. Receives mandated reports of maltreatment from health care providers.

Senior and Disability Services, Quality Assurance division: Responsible for conducting reviews, investigations, and quality assurance reporting for services, programs, and providers administered or certified by Senior and Disability Services. Receives mandated reports of maltreatment from health care providers.

Health Facilities Licensing and Certification: Responsible for surveying health facilities to ensure facilities meet Federal and State standards and for investigating complaints made against health facilities.

Source: OIG analysis of information from agency websites, 2023.

Patient abuse and neglect. Although Adult Protective Services (APS) and Senior and Disability Services (SDS) referred potential cases of patient abuse or neglect to the Unit during the review period, both agencies reported that they would like more training from the Unit. An APS staff member reported that APS had a positive working relationship with the Unit and that the Chief Investigator was responsive to APS's requests. However, the APS employee also reported that many APS staff needed training regarding the Unit's role and responsibilities due to turnover within APS. She suggested that a yearly training with the Unit could benefit both agencies. Additionally, SDS staff reported that communication with the Unit had improved recently and that they had begun meeting quarterly with the Unit. They also noted that the Unit Director provided a training on corporate investigations during the review period but said that they would

like additional trainings and feedback from the Unit to improve the quality of referrals.

We found that the Unit did not communicate with Health Facilities Licensing and Certification (HFLC) during the review period, and it did not receive any referrals from HFLC. An HFLC staff member reported that HFLC would be open to working more closely with the Unit but would benefit from training to better understand the Unit's mission. In OIG's experience, State licensing and certification agencies can serve as significant sources of patient abuse or neglect referrals for Units. However, HFLC reported that it referred incidents of potential criminal patient abuse or neglect to local police departments. In addition to preventing the Unit from identifying appropriate referrals of patient abuse or neglect for investigation, this arrangement could impact the Unit's ability to submit convicted providers to OIG for exclusion from Federal health care programs. If local law enforcement agencies have convicted providers of patient abuse or neglect in connection with a health care item or service, they may not know to inform OIG to exclude these providers from Federal health care programs.[30]

Provider fraud. We found that the Unit took steps to encourage referrals of suspected fraud to the Unit but could improve its communication with the Program Integrity office through regularly scheduled meetings. The Unit's Chief Investigator maintained a positive working relationship with the Program Integrity office through frequent ad hoc communication with Program Integrity staff. Nonetheless, the Program Integrity office reported sending only 10 fraud referrals to the Unit during the review period.[31] Prior to the COVID-19 pandemic, the Unit and the Program Integrity office reported engaging in quarterly meetings, but these meetings became less frequent during and after the pandemic. At the time of our inspection, the Chief Investigator reported that the Unit had engaged in two meetings with the Program Integrity office in the last year. The Chief Investigator said that these meetings provided the Unit with valuable information on fraud trends, and he said he believed that the Unit's communication with the Program Integrity office could be improved with regularly scheduled meetings.

[30] 42 U.S.C. § 1320a-7(a)(2).

[31] Because the Unit's case management challenges caused it to inaccurately report referral information to OIG, we did not have reliable data on referrals to the Unit from most sources. However, the Program Integrity office directly reported to us the number of referrals it made to the Unit during the review period.

The Unit maintained positive working relationships with its Federal partners but lacked procedures to communicate and coordinate regularly with them

Performance Standard 8: A Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health care fraud.

Performance Standard 8(a) 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 Federal partners.[32] We found that the Unit maintained positive working relationships with OIG's Office of Investigations (OI) and the Federal Bureau of Investigations (FBI), but the Unit did not have regularly scheduled meetings with OI or written policies regarding cooperation and coordination with Federal partners. The Unit Director reported that the Unit worked closely with the FBI and OI, and that FBI staff visited the Unit's office twice per month. Although OI does not have a field office in Alaska, we found that the Unit worked 21 joint cases with OI during the review period. The Unit engaged in frequent ad hoc communication with OI staff, but an OI manager said he believed that communication between the two entities could be improved with more consistent meetings.
We also found that the Chief Investigator maintained a positive working relationship with the criminal division of the U.S. Attorney's Office (USAO), but staff from the Unit and the USAO reported that there were opportunities to strengthen the relationships at the leadership level through more consistent communication.

Further, we found that the Unit did not have procedures for regularly coordinating, or "deconflicting," its cases with OI or the USAO.[33] The Chief Investigator stated he believed that the Unit could improve its deconfliction practices with OI, and a manager from OI said that he and the Unit could both improve their deconfliction processes. The Unit Director stated he believed that the lack of regular deconfliction processes with other Federal entities did not pose problems because the small population and isolated nature of Alaska enabled law enforcement entities to engage in frequent ad hoc communication, and an individual from the USAO said that case conflicts "don't come up often." However, in OIG's judgment, regularly scheduled meetings and processes to deconflict cases could improve the Unit's communication and coordination with its Federal partners, as required by 42 CFR § 1007.11(e)(2)–(e)(5).

[32] 42 CFR § 1007.11(e)(2)–(e)(5).

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

The Unit did not maintain an accurate, regularly updated equipment inventory, and one inventory item was not properly secured

Performance Standard 11(b): The Unit maintains an equipment inventory that is updated regularly to reflect all property under the Unit's control.

During our onsite inspection, we could not locate 10 of the 30 items in our sample from the Unit's inventory list, including several computers and other electronic devices. Unit staff said that the Unit had either disposed of several of these missing items or returned them to the DOL's Information Technology department. The Unit's Forensic Accountant was responsible for maintaining the Unit's inventory list, but the Unit did not have policies to ensure that the inventory list was accurate and updated regularly. We also found that one of the Unit's smartphones in our inventory sample was not properly secured.[34]

Some aspects of the Unit's supervisory review policies were ineffective and the Unit did not consistently follow other aspects of these policies

Performance Standard 7(a): Reviews by supervisors are conducted periodically, consistent with MFCU policies and procedures, and are noted in the case file.

We found that the Unit's policies and procedures for conducting supervisory reviews of case files were ineffective for supporting a continuous case flow and for ensuring documentation of these reviews. Further, the Unit did not consistently follow its policies pertaining to the frequency of these reviews. We also found that 54 percent of Unit case files lacked documentation of periodic supervisory reviews.

The Unit conducted two types of supervisory review meetings, as described in the next two paragraphs: one type which involved the Unit's attorneys, Forensic Accountant, Chief Investigator, and paralegal; and one type which involved the Chief Investigator and each investigator.

The Unit's policies and procedures manual stated that the Unit's attorneys (including the Director and Deputy Director), Chief Investigator, and Forensic Accountant should meet "monthly, as available, to quickly review the status of active investigations and pending cases."[35] The manual also specified that these reviews should be documented in the electronic case management system, although it did not specify

[34] Federal regulations require Units to safeguard personally identifiable information and other sensitive data to prevent misuse. See 45 CFR § 75.303(e) and 42 CFR § 1007.11(f).

[35] In practice, the Unit's paralegal also attended these meetings.

who was responsible for recording this documentation. We found that the Unit did not conduct the meetings monthly. Instead, the Unit held these supervisory review meetings every 2–3 months, and we found that the meetings were not consistently documented. We also found that the meetings were ineffective in facilitating a continuous case flow, as attendees of these meetings reported that the group quickly reviewed five cases at a time without detailed discussions of case progression. Attendees said that they tried to limit these meetings to 1 hour and that cases often did not progress between the meetings. Further, case investigators were not included in these meetings, which may have resulted in missing critical information about case progression.

The Unit's policies and procedures manual during the review period also stated that each investigator should schedule supervisory review meetings with the Chief Investigator every 3 months to evaluate progress on cases and to establish investigative priorities and expectations. The manual specified that these reviews should be documented in case files, although it did not specify who was responsible for recording this documentation.[36] In practice, the Chief Investigator typically recorded the reviews in a separate spreadsheet. Investigators reported that supervisory review meetings with the Chief Investigator became ad hoc during and after the COVID-19 pandemic, and we found that these reviews were not consistently documented. Nonetheless, we found that the Chief Investigator continued to communicate frequently with investigators regarding their cases. In OIG's judgment, regular and documented supervisory review meetings are important for ensuring that every case is periodically reviewed by a supervisor and that investigators have clear priorities and guidance for the next steps in their investigations.

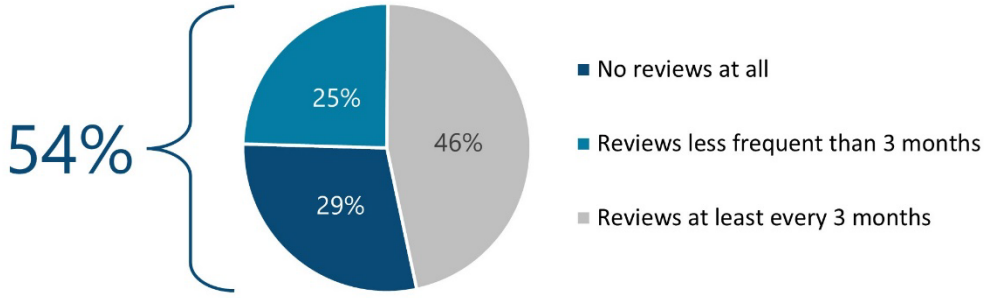
As a result of the Unit's ineffective supervisory review procedures, we found, 54 percent of the Unit's case files were missing documentation of periodic supervisory reviews, which should be conducted at least every 3 months according to Unit policy.[37, 38] Specifically, 29 percent of applicable cases lacked documentation of any supervisory reviews, and an additional 25 percent of applicable cases had documentation of at least one supervisory review but not for every 3-month period (see Exhibit 3). OIG's 2016 review of the Alaska Unit identified similar concerns, finding that 88 percent of the Unit's case files lacked documentation of periodic supervisory reviews during FYs 2013–2015.

[36] In March 2023, the Unit updated its policies and procedures manual and removed the requirement to document supervisory review meetings between the Chief Investigator and each investigator.

[37] We evaluated the Unit's documentation of supervisory reviews based on a 3-month timeframe and accepted documentation of either type of supervisory review described above.

[38] The Director attributed the missing supervisory review documentation to the Unit's LOA vacancies during the review period. However, nearly all cases missing documentation of supervisory reviews lacked documentation of these reviews during periods in which the Unit employed an LOA, and the Unit's policies and procedures manual did not indicate that the LOA was responsible for documenting these reviews.

Exhibit 3: More than half of the Unit's case files were missing documentation of periodic supervisory reviews.



Source: OIG analysis of Unit case files, FYs 2020–2022.

The Unit did not conform with two Federal grant requirements

We found that the Unit lacked supervisory authority over the Unit's LOA position and that the Unit did not acknowledge Federal funding in press releases.

Performance Standard 1: A Unit conforms with all applicable statutes, regulations, and policy directives.

The Unit Director lacked supervisory authority over the Unit's LOA position

Federal regulation states that administrative and support staff must report to the Unit director or another Unit supervisor.[39] However, the Unit's LOA (when the LOA position was occupied during the review period) reported to a DOL supervisor outside of the Unit. Although Unit staff directed the LOA's daily activities, the Director did not formally supervise the LOA and lacked authority to complete supervisory responsibilities such as conducting performance evaluations. The Director also reported that the DOL planned to extend this supervisory model to the Unit's paralegal position.

The Unit did not acknowledge Federal funding in press releases, as required

Federal law requires that when issuing statements, press releases, and other documents describing projects or programs supported by Federal funds, a grantee must clearly state the percentage and dollar amount financed with Federal funds and State or nongovernmental sources.[40] In addition, OIG issued a policy transmittal containing guidance for implementing this provision, known as the Stevens Amendment, and incorporated this requirement in the terms and conditions of the

[39] 42 CFR § 1007.13(e). The expectation that all staff report to a single director reflects a longstanding MFCU practice and was added to the regulation in 2019.

[40] Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1990, Pub. L. No. 101-166, § 511.

MFCU grants beginning in FY 2021.[41] We found that the Unit did not acknowledge its Federal funding in its press releases during FYs 2021–2022. Unit managers said that these omissions were due to a lack of Unit oversight over the press releases, and that the Unit would include the required statement in future press releases.

[41] OIG, *Guidance on Acknowledgement of Federal Funding in Accordance with Stevens Amendment*, May 2020, available at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Stevens-Amendment-OIG-Memo.pdf.

CONCLUSION AND RECOMMENDATIONS

The eight findings we identified posed important challenges to the Unit's operations and overall performance during our review period. They involved core Unit functions and practices, including a lack of communication internally and with external partners; a lack of appropriate case management practices; and other instances of noncompliance with applicable Performance Standards, regulations, and policy transmittals. We found that these factors had multiple impacts, including contributing to significant delays in the Unit's case flow.

To address the findings identified in this report, we made the following 13 recommendations to the Alaska Unit.

Maintaining a Continuous Case Flow

1. Revise its procedures for screening referrals to incorporate the expertise of each professional discipline and to reflect current Unit priorities and workloads

The Unit should revise its referral screening procedures to help ensure that it selectively opens cases that make optimal use of Unit resources. The revised screening process should incorporate the expertise of each professional discipline, as appropriate. Further, the revised process should reflect the Unit's current priorities and account for the Unit's existing workload so that opened cases can be investigated in an appropriate timeframe. As one method of accomplishing this, the Unit could consider establishing a case intake committee that regularly meets to review incoming referrals.

2. Take steps to improve communication and collaboration across professional disciplines throughout the investigative phase of cases

The Unit should take steps to improve communication and collaboration between Unit attorneys and investigators throughout investigations. Attorneys should be assigned to, and involved in, cases from the beginning of the investigation. Further, the Unit should take steps, such as revising its procedures for conducting supervisory review meetings, to involve case investigators in all case discussions.

3. Revise its procedures for opening, assigning, and closing cases to better enable cases to be completed in an appropriate timeframe

The Unit should revise its procedures for opening, assigning, and closing cases. This should include specifying achievable timelines for opening and assigning cases and developing a well-defined and routine process for closing cases. The Unit should also reassign the administrative tasks currently assigned to the Chief Investigator to other Unit staff, in the event of continued Law Office Assistant (LOA) turnover or vacancies.

Maintaining Case Information

4. Implement a comprehensive case management system to manage its investigative case information in an efficient and secure manner

The Unit should seek approval from the Department of Law to acquire a new case management system that allows for efficient access to case information and performance data. The Unit should ensure that the new case management system enables the Unit to efficiently maintain investigative information and produce performance data.

5. Take steps to improve the accuracy and completeness of case information and performance data in its electronic case management system

While awaiting implementation of a new case management system, the Unit should take steps to mitigate the shortcomings of its current case management system by improving the accuracy and completeness of its case information and performance data. This should include taking steps to update case information consistently across the Unit's multiple repositories of case documents and case information, to the extent possible while protecting access to sensitive information. The Unit should also take steps to accurately report referral and case information in its annual reports to OIG.

6. Take steps to maintain case files in a consistent and effective manner

The Unit should take steps to implement consistent practices for organizing and updating case information. These steps could include providing additional training to investigators on organizing case information.

Maintaining Adequate Staffing

7. Take steps to improve its ability to staff its administrative functions consistently and appropriately

The Unit should take steps to improve its ability to staff its administrative functions consistently and appropriately because of its challenges with hiring and retaining a qualified LOA. This could be achieved by seeking authority to reclassify the LOA position to a higher paygrade to improve hiring and retention, or by replacing the LOA position with a different staff classification, such as an entry-level investigator. The Unit could also develop a plan to reassign administrative duties to other staff in the event of future LOA turnover to reduce the burden placed on the Chief Investigator.

Maintaining Adequate Referrals

8. Take steps to expand upon the Unit's efforts to encourage referrals to the Unit

The Unit should take steps to expand its outreach efforts to potential sources of referrals of patient abuse and neglect and provider fraud. For patient abuse and neglect referrals, the Unit should increase its communication and training efforts with existing referral sources, including Adult Protective Services and Senior and Disability Services. The Unit should also expand its outreach efforts to other potential referral sources, such as Health Facilities Licensing and Certification, other State regulatory agencies, and local law enforcement agencies. For provider fraud referrals, the Unit should resume its schedule of quarterly meetings with the Program Integrity office.

Cooperating with Federal Authorities

9. Establish procedures for regularly communicating and coordinating with OIG's Office of Investigations and the U.S. Attorney's Office

The Unit should establish a practice of regular meetings or communication with OIG's Office of Investigations (OI) and the U.S. Attorney's Office (USAO), which should include developing procedures for consistently deconflicting cases. The Unit should also develop written procedures for cooperating and coordinating with these Federal partners. To further improve communication, the Unit could consider conducting joint trainings with OI and/or the USAO to help share information and strengthen its relationships with these entities.

Exercising Proper Fiscal Control

10. Develop procedures to improve the accuracy of its inventory list and verify that all Unit property is properly secured

The Unit should develop procedures for conducting physical inventories of its property and periodically reviewing its inventory list to verify that all property on the list is within its possession and properly secured.

Conducting Periodic Supervisory Reviews

11. Revise its policies and procedures for periodic supervisory reviews and conduct and document the reviews in accordance with its updated policies

The Unit should revise its policies and procedures for conducting periodic supervisory reviews of cases and take steps to consistently follow the written policies. The revised policies and procedures should specify who is responsible for documenting the reviews and where they should be recorded. The Unit could also consider whether its needs could be met by a single type of supervisory review meeting.

Complying with Requirements

12. Modify its supervisory structure so that all Unit staff are under the supervision of the Unit Director or another Unit supervisor

The Unit should reorganize its supervisory structure to comply with Federal regulation set forth in 42 CFR § 1007.13(e). All Unit staff, including the LOA position when filled, should be under the supervision of the Unit Director or another Unit supervisor.

13. Include acknowledgments of Federal funding in its press releases and other public documents

The Unit should include the Federal funding statement outlined in OIG's policy transmittal (issued in May 2020) in all future press releases and other public documents.

UNIT COMMENTS AND OIG RESPONSE

The Alaska MFCU concurred with all 13 of our recommendations.

First, the Unit concurred with our three recommendations pertaining to maintaining a continuous case flow. The Unit acknowledged inefficiencies in its case flow and reported that it plans to improve its case tracking capabilities. The Unit also reported that it recognizes the value of attorney involvement in the early stages of cases and that it is committed to establishing successful collaboration between investigators and attorneys in future cases. Further, the Unit reported that it hired an LOA in May 2024, which it believes will alleviate some of the case flow concerns we identified.

Second, the Unit concurred with our three recommendations pertaining to maintaining case information. The Unit reported that it will explore alternatives to its current case management system.

Third, the Unit concurred with our recommendation pertaining to maintaining adequate staffing. The Unit reported that it believes its recently hired LOA will reduce the administrative burden placed on the Chief Investigator. Given the Unit's challenges with hiring and retaining qualified LOAs, we encourage the Unit to take additional steps to improve its ability to staff its administrative functions consistently and appropriately, in the event of future LOA turnover.

Fourth, the Unit concurred with our recommendation pertaining to maintaining adequate referrals. The Unit reported that, following our onsite inspection, it has increased its efforts to meet with State and Federal partners.

Additionally, the Unit concurred with our three recommendations pertaining to cooperating with Federal authorities, exercising proper fiscal control, and conducting periodic supervisory reviews. The Unit reported that it is currently reviewing and revising its procedures for conducting periodic supervisory reviews of cases.

Finally, the Unit concurred with our two recommendations pertaining to compliance with requirements. Regarding the inclusion of a required acknowledgment of Federal funding in its press releases, the Unit reported that it has corrected omissions in its previous press releases and will comply with this requirement in future releases.

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. To close the recommendations in this report, the Unit should submit to OIG documentation of its implementation of each recommendation within 6 months of the issuance of the report.

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

PERFORMANCE ASSESSMENT

We assessed the Alaska Unit's adherence to the 12 MFCU performance standards, including its compliance with applicable laws, regulations, and policy transmittals. We made eight findings that warrant further attention, which are presented here and in the body of the report. We also made eight observations about Unit operations and practices, which are presented here.

Performance Standard 1: Compliance with Requirements

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

Finding: The Unit did not conform with all applicable statutes, regulations, and policy directives.

See page 20.

Observation: The Director and Deputy Director devoted significant time to non-Unit activities during the review period.

Federal regulation and OIG guidance state that professional employees of a Unit may perform non-Unit assignments only to the extent that such duties are of a limited and defined duration.[42, 43] We found that the Director and Deputy Director spent significant amounts of time providing training and guidance to non-Unit DOL employees during the review period,[44] as well as completing trial work they began as part of their previous employment with another DOL division. Specifically, the Director and Deputy Director reported working a total of 147 and 601 hours, respectively, on non-Unit activities during FYs 2020–2022. OIG confirmed that the Unit excluded the attorneys' time spent on non-Unit activities from the Federal grant; however, OIG cautions the Unit to keep non-Unit activities to a limited and defined duration.[45] OIG encourages the Unit to seek guidance from OIG before assigning Unit staff to any future non-MFCU activities.

[42] 42 CFR § 1007.13(d)(3).

[43] OIG, State Fraud Policy Transmittal No. 2014-1, "Employment and Reimbursement of Full- and Part-Time Staff and Performance of Non-MFCU Duties," June 2014, available at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/policy_transmittals/State%20Fraud%20Policy%20Transmittal%20No%20%202014-1.pdf.

[44] The Director and Deputy Director explained that as they were senior attorneys in the DOL with significant institutional knowledge, other DOL employees sought their guidance and expertise.

[45] In OIG's 2016 review of the Alaska Unit, OIG recommended that the Unit develop and implement internal controls to remove costs associated with non-Unit activities from the Federal grant. During our current review period, the Forensic Accountant requested information on the duration of Unit employees' non-Unit activities each month and notified the DOL's fiscal department that this time should be excluded from the Federal grant.

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.

Finding: The Unit did not maintain adequate staffing for its administrative functions.

See page 14.

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 did not reflect all aspects of Unit operations, and staff did not adhere to some of the Unit's policies and procedures.

The Unit maintained a policies and procedures manual, which was last updated in March 2023. However, we found that the Unit's policies and procedures did not reflect all aspects of Unit operations. The Unit lacked effective procedures for ensuring consistent communication and collaboration across professional disciplines during referral screening and investigations (see page 7); for opening, assigning, and closing cases (see page 9); for cooperating and coordinating with Federal partners (see page 17); for maintaining the Unit's equipment inventory (see page 18); and for conducting and documenting periodic supervisory reviews of case files (see page 18).

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.

Finding: The Unit took steps to encourage referrals but could expand these efforts.

See page 15.

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.

Finding: Inconsistent communication and collaboration across professional disciplines and other ineffective Unit practices contributed to significant delays in nearly half of the Unit's cases.

See page 6.

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 shifted its focus during the review period to prioritize larger, more complex cases of provider fraud.

The Director and Deputy Director reported that in FY 2019, the Unit shifted its focus to prioritize larger, more complex cases of provider fraud, such as cases of fraud committed by institutional actors. Prior to our review period, the Unit's caseload contained a relatively high proportion of cases involving personal care attendants (PCAs). During the review period, the Unit's case mix covered a greater range of provider types relative to prior years, which may have been attributable to its prioritization of larger cases.[46, 47]

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 did not maintain case files in an effective manner due to limitations of its case management system and inconsistent practices for maintaining case information.

See page 11.

Finding: Some aspects of the Unit's supervisory review policies were ineffective and the Unit did not consistently follow other aspects of these policies.

See page 18.

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 its Federal partners but lacked procedures to communicate and coordinate regularly with them.

See page 17.

[46] For example, 29 of the Unit's 32 convictions during FYs 2017–2019 were attributable to PCA cases. From FYs 2020–2022, 6 of the Unit's 15 convictions were from PCA cases. In OIG's experience, PCA cases often involve a lower level of complexity relative to other provider types.

[47] While investigation of PCA fraud is important, Performance Standard 6(c) states that the Unit should allocate its resources among provider types on the basis of levels of Medicaid expenditures or other risk factors.

Observation: The Unit reported most of its convictions and adverse actions to Federal partners within appropriate timeframes.

Performance Standard 8(f) and Federal regulation require Units to submit 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.[48] We found that the Unit sent 18 of its 19 submissions to OIG within the appropriate timeframe. The Unit also submitted 15 of its 18 adverse actions to the NPDB within 30 days of the final adverse action, as required by Federal regulations.[49, 50]

Performance Standard 9: Program Recommendations

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

Observation: The Unit did not make programmatic recommendations during the review period.

Performance Standard 10: Agreement with Medicaid Agency

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.

Observation: The Unit's MOU with the State Medicaid agency generally reflected current practice, policy, and legal requirements.

The Unit and the State Medicaid agency had a current MOU, which was last amended in October 2013. In September 2020, the Unit and the State Medicaid agency reviewed the MOU and agreed that it did not require revisions.

Performance Standard 11: Fiscal Control

A Unit exercises proper fiscal control over its resources.

Finding: The Unit did not maintain an accurate, regularly updated equipment inventory, and one inventory item was not properly secured.

See page 18.

[48] 42 CFR § 1007.11(g).

[49] 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).

[50] 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.

Performance Standard 12: Training

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

Observation: Unit staff generally met the Unit's training requirements.

Performance Standards 12(a) and 12(b) state that the Unit should maintain training plans for each professional discipline, ensure that professional staff comply with the training plans, and maintain records of this compliance. We found that the Unit maintained a training plan that included annual training hours for professional staff and that staff generally met those requirements. Professional staff attended several trainings that aided in the Unit's mission, including NAMFCU trainings and conferences.

Other Observation

Observation: Unit managers and investigators expressed concerns that investigators' lack of authority to carry firearms reduced their abilities to investigate cases timely and safely.

As part of its oversight of the MFCU program, OIG evaluates whether Units "effectively carr[y] out the functions and requirements" for the program as established by statute, which includes taking into consideration Units' "effectiveness in…investigating cases of possible fraud."[51] During our inspection, Unit managers and investigators expressed concerns that the Unit's lack of authority from the State for investigators to carry firearms during the performance of Unit duties reduced their abilities to investigate cases timely and safely. Managers and investigators explained that, although the investigators are not authorized to carry firearms as a function of their MFCU positions, they are granted a special commission that permits them to perform certain law enforcement-related duties, including executing search warrants and serving subpoenas. However, investigators reported that they must rely on other entities with full law enforcement authorities, including authorization to carry firearms, to safely perform duties such as conducting high-risk interviews and executing search warrants.

Managers and investigators reported that investigators' lack of authority to carry firearms during the performance of Unit duties presented several concerns for the Unit. First, an investigator reported that relying on other law enforcement entities to conduct essential investigative functions contributed to delays in investigations when those agencies lacked sufficient resources to assist the Unit timely. Additionally, managers and investigators expressed concerns for investigator safety, as they performed routine duties, such as interviewing witnesses and subjects and serving legal process, without firearms to protect themselves or react to dangerous situations. The Director reported that investigators occasionally performed these duties in remote areas of the State, where the nearest State trooper may be hundreds of miles

[51] SSA § 1902(a)(61). See 42 CFR § 1007.17(c)(4).

away. Finally, Unit managers and investigators said they believed that the lack of authority to carry firearms impacted investigator morale and could present challenges for recruiting and retaining investigators. For example, the Chief Investigator reported that applicants for investigative positions sometimes lost interest in joining the Unit when they discovered that the position lacked authority to carry firearms.

OIG encourages the Unit to evaluate the costs and safety risks associated with its lack of authority for investigators to carry firearms during the performance of Unit duties, and to assess whether expanding its statutory law enforcement authority would be effective and prudent. The Unit could share the results of that evaluation with the Department of Law and, if appropriate, seek approval from the State legislature to expand those authorities.

APPENDICES

Appendix A: Detailed Methodology

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 was not operating 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 2020–2022, including (1) the Unit Director's recertification questionnaires, (2) the Unit's MOU with the Department of Health, (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 2020–2022. 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 DOL and the Unit to clarify issues identified in the questionnaire about internal controls. We also selected a purposive sample of 30 items from the Unit's inventory list of 94 items maintained in the Unit's office and verified those items onsite.

Interviews with Key Stakeholders

In April and May 2023, we interviewed key stakeholders, including officials in Alaska's Program Integrity office, SDS, APS, and HFLC 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 June 2023. Of the Unit management, we interviewed the Director, the Deputy Director, and the Chief Investigator. Of the other staff, we interviewed one attorney, five investigators, and the Forensic Accountant. In addition, we interviewed the supervisor of the Unit, the Deputy Chief of the DOL's Office of Special Prosecutions. 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 2020–2022 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 347.

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 58 global cases, leaving 289 case files.

We then selected a simple random sample of 76 cases from the population of 289 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 +/- 11 percent at the 95-percent confidence level.

We reviewed the 76 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 19 convictions submitted to OIG during the review period and all 18 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 all adverse actions to the NPDB for FYs 2020–2022. 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 Anchorage. 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.

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

Exhibit B-1: Estimates for Case File Documentation

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of all cases that had supervisory approval to open	76	84.2%	75.1%	91.0%
Percentage of cases open at least 3 months that contained little or no documentation of investigative activity	73	48.0%	37.4%	58.5%
Percentage of all cases with investigative delays	76	43.4%	33.6%	54.0%
Percentage of all cases for which we could not determine whether there were investigative delays	76	15.8%	9.0%	24.9%
Percentage of all cases closed at the time of our review	76	55.3%	45.0%	65.4%
Percentage of all closed cases that had supervisory approval to close	42	92.9%	81.3%	98.3%

Source: OIG analysis of Alaska MFCU case files, FYs 2020–2022.

Exhibit B-2: Estimates for Periodic Supervisory Reviews

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of cases open at least 3 months that contained documentation of supervisory reviews every 3 months	73	46.6%	36.0%	57.4%
Percentage of cases open at least 3 months that contained documentation of supervisory reviews less frequent than every 3 months	73	24.7%	16.3%	35.0%
Percentage of cases open at least 3 months that contained no documentation of supervisory reviews	73	28.8%	19.7%	39.1%

Source: OIG analysis of Alaska MFCU case files, FYs 2020–2022.

Appendix C: Unit Comments

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

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July 17, 2024

Ann Maxwell
Deputy Inspector General
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Cohen Building; rm 5660
330 Independence Avenue, SW
Washington, D.C. 20201

Dear Ms. Maxwell:

This letter responds to your draft report, *Alaska Medicaid Fraud Control Unit, 2023 Inspection, OEI-07-23-00240,* forwarded to this office on June 17, 2024. You have invited our responses to your recommendations. This letter provides them. It also supplements our more-extensive and detailed responses, which we provided to your staff in May 2024.

General comments

I will begin by reiterating a point I have previously expressed to your staff: that your June 2023 on-site inspection and audit process was fair. Your staff gave us precise advance notice of its methodology, data sources and objectives, and adhered to those commitments.

I will next point out that this is a Covid audit. The review period here spans FY 2020-22 (October 2020 through September 2022). Thus, this audit substantially overlaps with the Covid public health crisis, which challenged **all state agencies'** ability to provide service continuity during a prolonged period of disruption. Against that backdrop, we are proud that your audit found that this MFCU realized "12 felony indictments, 15 convictions, and $6 million in criminal and civil recoveries." *Report*, page 5.

Recommendation responses

Your letter invites responses to ten specific audit recommendations.

Case flow – screening; increase cross-discipline participation in investigative process; reform case management procedure. Page 22.

We generally concur with this recommendation. As your auditors found, this office employs a prosecution case management database which is primarily useful as a repository for

public court documents, but is ill-suited as an investigative resource. Page 11. We acknowledge the inefficiencies noted at pages 11-13 of this audit report. We are committed to improvement in case tracking and database integrity.

Similarly, we recognize the value of attorney staff involvement in early-stage MFCU investigations. We are committed to that principle.

I will take a moment to provide a case-specific example to underscore that point: In a late 2023 case, our attorney staff worked closely with MFCU investigators in the field in an emergent, complex fraud investigation in a remote Alaska community. Our attorney staff assisted investigators in obtaining, and then amending a state court search warrant in real time before an on-duty state court magistrate. The subsequent warrant service yielded a seizure of a large sum of cash in a suspected fraudster's residence. We point to this case as a prime example of productive, proactive, early-stage attorney-investigator collaboration. We are committed to duplication of that success in our future cases.

Acquisition of a MFCU-specific case management system; ensure case management system accuracy. Page 23.

We concur with this recommendation. We share the concerns expressed by your audit staff regarding the **limitations of our agency's** existing case management system. We will explore alternatives internally within our department – including exploration of a MFCU-specific case management system.

Similarly, we concur with the concerns your report notes regarding our staffing vacancies and the over-taxing of the chief investigator. We can report welcome progress in that regard. In May 2024, we on-boarded a clerical assistant – filling a vacancy which had persisted for many months. We are optimistic that this will help alleviate the case flow lapses your team observed.

Adequate staffing; page 23.

We concur with this recommendation. As mentioned above, our office is optimistic that the recent filling of a prolonged vacancy will remediate the burden on the chief investigator.

Increase outreach regarding patient-abuse referrals; page 23.

We concur with this recommendation. In months following the on-site inspection, we have redoubled efforts to formally meet with state Health Department and federal partners.

Ensure regular communications with federal partners, page 24.

We concur with this recommendation.

Ensure accurate inventory procedures; page 25.

We concur with this recommendation.

Revise periodic review procedures, page 25.

We concur with this recommendation. We are reviewing and revising our internal procedures for periodic supervisory review of our open cases.

Compliance with MFCU-specific supervisory regulations, MFCU staff should be supervised by the MFCU Director; page 25.

We concur with this recommendation.

Ensure compliance with press release funding statements; page 25.

We concur. We attribute failure to include a specific funding statement in a few of our press releases to oversight. We have reviewed and corrected the omissions in previous Alaska MFCU press releases. Corrected, compliant **releases now appear on our office's web site.** We will ensure similar compliance with future media releases.

Obtaining law enforcement authority for MFCU investigators; page 31.

We concur with the suggestion that the MFCU should explore and advocate for law enforcement status for its investigative staff.

We agree **with your staff's conclusion** – that **MFCU investigators' work is hazardous**. This is especially true in this state – where field work often places MFCU investigators in remote Alaska communities – occasionally at great distances from traditional state or municipal law enforcement assistance. That said, this issue is a recurring one. It has been raised previously within our department by MFCU staff. Obtaining law enforcement status for MFCU investigators will present a policy decision at higher levels of administration than the MFCU Director.

Suggested timeline for review of remedial steps

For those recommendations which may be addressed internally, we respectfully suggest and welcome review within the next 90 days. These include revisions to our internal case screening and periodic review procedures, and corresponding amendment to our internal policies.

For those remedial measures which require action by our department's policy-makers (case management platform, investigators' law enforcement authority), we respectfully suggest and welcome review at the six-month point.

We appreciate the opportunity to offer these comments. We hope you regard them as responsive.

Respectfully,

James Fayette
Senior Assistant Attorney General
Director, Alaska MFCU

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

Keith Peters of the Medicaid Fraud Policy and Oversight Division served as the team leader for this study, and Sarah Smith served as the lead analyst. Office of Evaluation and Inspections headquarters staff who provided support include Robert Gibbons and Sarah Swisher.

We would also like to acknowledge contributions of two special agents from the Office of Investigations, and a peer reviewer from another State MFCU.

This report was prepared under the direction of Brian Whitley, Regional Inspector General for Evaluations and Inspections in the Kansas City regional office, and Dana Squires and Abbi Warmker, Deputy Regional Inspectors General, as well as in consultation with Richard Stern, then Director of the Medicaid Fraud Policy and Oversight Division.

Contact

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