U.S. Department of Health and Human Services

Office of Inspector General

Medicaid Fraud Control Units Fiscal Year 2022 Annual Report

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March 2023, OEI-09-23-00190

U.S. Department of Health and Human Services
Office of Inspector General
Report in Brief
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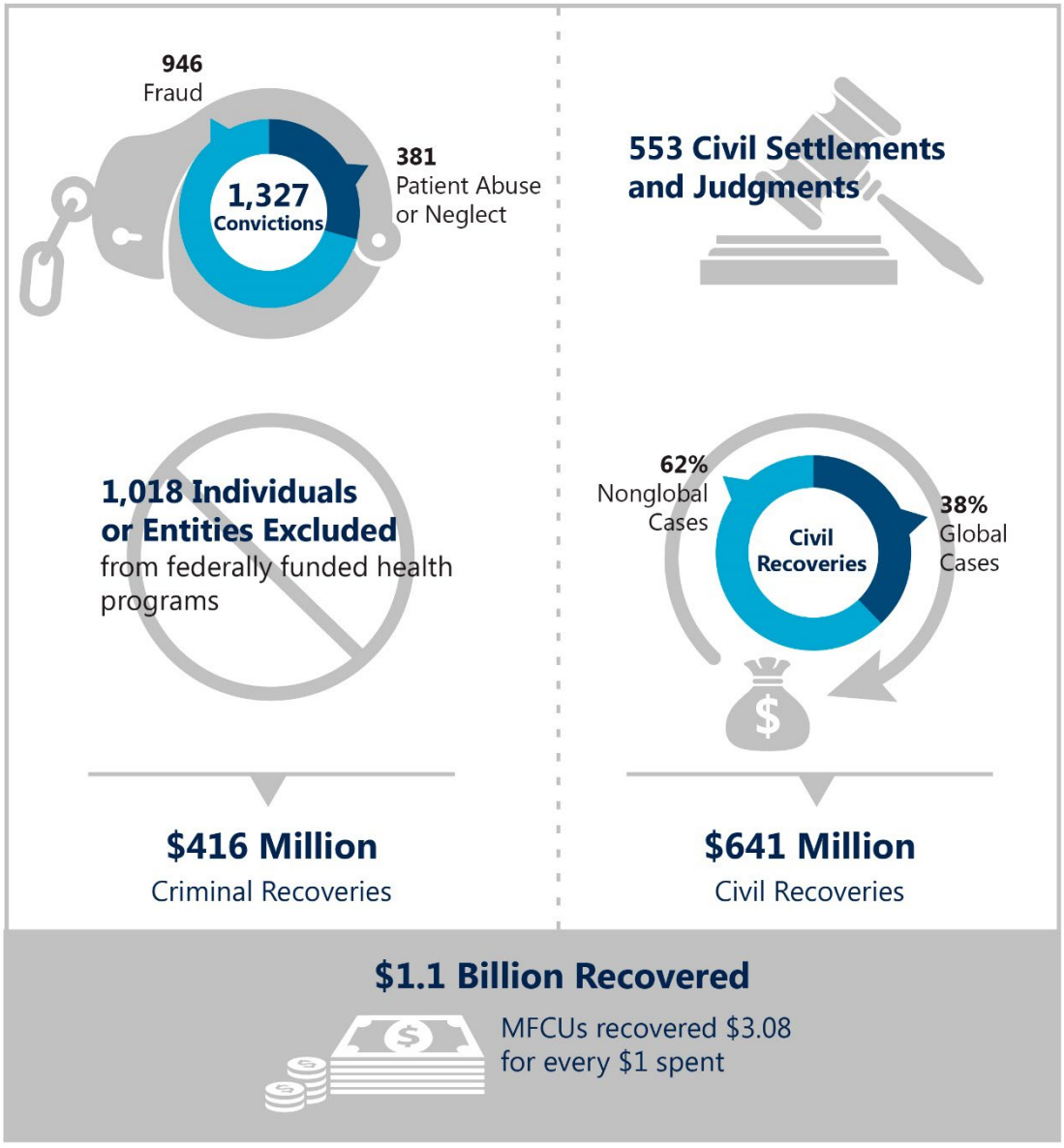

Medicaid Fraud Control Units (MFCUs) investigate and prosecute Medicaid provider fraud and patient abuse or neglect. The Department of Health and Human Services Office of Inspector General (OIG) is the designated Federal agency that oversees and annually recertifies and approves Federal funding for each MFCU. For this report, OIG analyzed the annual statistical data on case outcomes (such as convictions; civil settlements and judgments; and recoveries) that 53 MFCUs submitted to OIG for fiscal year 2022. Those MFCUs operated in all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

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BACKGROUND

Medicaid Fraud Control Units (MFCUs or Units) investigate and prosecute Medicaid provider fraud and patient abuse or neglect.[1] The Social Security Act (SSA) requires each State to effectively operate a MFCU, unless the Secretary of Health and Human Services (HHS) determines that (1) the operation of a Unit would not be cost-effective because minimal Medicaid fraud exists in a particular State; and (2) the State has other adequate safeguards to protect enrollees from abuse or neglect.[2] In fiscal year (FY) 2022, all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operated MFCUs.[3, 4]

MFCUs are funded jointly by the 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.[5] In FY 2022, combined Federal and State expenditures for the Units totaled approximately $343 million, of which approximately $257 million represented Federal funds.[6]

As illustrated in Exhibit 1, MFCU cases typically begin as referrals from external sources or are generated internally from data mining.[7] MFCU staff review referrals of possible fraud and patient abuse or neglect to determine the potential for criminal prosecution and/or civil action. If the Unit accepts a referral for investigation, the case may result in various possible outcomes. Criminal prosecutions may result in convictions; civil actions may result in civil settlements or judgments. Both criminal prosecutions and civil actions may include the assessment of monetary recoveries. The Office of Inspector General (OIG) has the authority to exclude convicted individuals and entities from any federally funded health care program on the basis of convictions referred from MFCUs.[8] In addition to achieving these case outcomes, Units may also make programmatic recommendations to their respective State Governments to help strengthen program integrity and efforts to fight patient abuse or neglect.

Exhibit 1: The typical life cycle of a MFCU case

Oversight of the MFCU Program

Reducing Medicaid fraud is a top priority for OIG, and its role in overseeing MFCUs helps achieve that priority. OIG oversees the MFCU grant program by recertifying Units; conducting reviews and inspections (hereinafter referred to as inspections) of Units; providing technical assistance to Units; and monitoring key statistical data about Unit caseloads and outcomes.[9]

Annually, OIG reviews each Unit's application for recertification; approval of this application is necessary for the Unit to receive Federal reimbursement.[10] To recertify a Unit, OIG performs a desk review to assess the Unit's compliance with the Federal requirements for MFCUs contained in statute, regulations, and OIG policy transmittals. OIG also examines the Unit's adherence to 12 performance standards, such as those regarding staffing, maintaining adequate referrals, and cooperating with Federal authorities.[11]

OIG further assesses a Unit's performance by conducting inspections of Units that may identify findings and lead to OIG making recommendations for improvement. During an inspection, OIG also makes observations regarding Unit operations and practices, and may identify beneficial practices that could be useful to other Units. Finally, OIG provides training and technical assistance to Units, as appropriate.

OIG also provides ongoing technical assistance and guidance to Units. These activities may include outreach, responding to questions from the Units, providing training to Units, and issuing policy transmittals to all Units. OIG also collects and presents statistical data reported by each MFCU annually, such as the numbers of open cases, indictments, and convictions and amounts of recoveries. These data can be accessed on the OIG website in two formats: a statistical chart and an interactive map.

Methodology

For this report, we analyzed information from the FY 2022 Annual Statistical Reports that the 53 MFCUs submitted to OIG, the recertification materials that the MFCUs submitted to OIG, and OIG exclusions data.

We aggregated case outcomes across all Units for FY 2022 and for each of the preceding 4 years—FYs 2018 through 2021. These outcomes include convictions; civil settlements and judgments; and recoveries. We also calculated the return on investment (ROI) for MFCUs.[12] We identified the provider types with the highest numbers of criminal and civil outcomes in FY 2022 and the numbers of exclusions that OIG imposed in FY 2022 on individuals and entities as a result of conviction referrals from MFCUs. We also analyzed MFCU drug diversion cases using data for FYs 2018 through 2022. Additionally, we include the beneficial practices described in previous Unit inspection reports, as described in Appendix A.

Standards

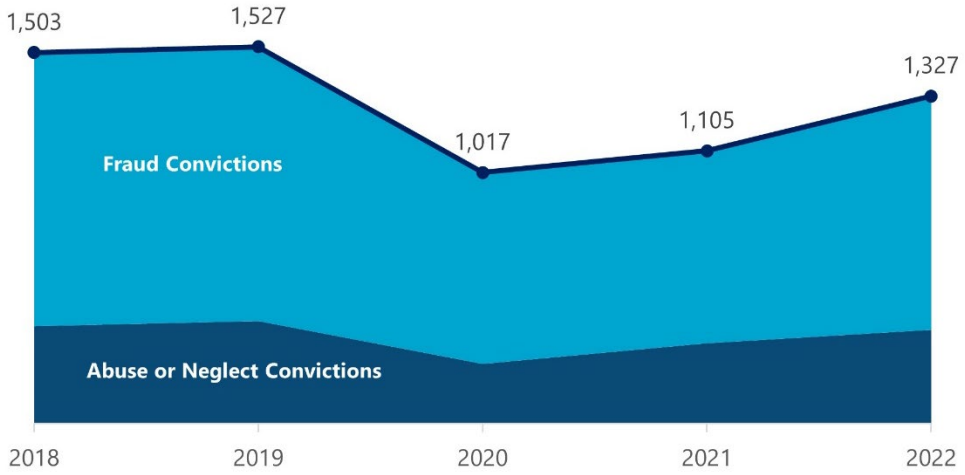
We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency. OIG inspections of the MFCUs and this annual report differ from other OIG evaluations in that they support OIG's direct administration 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

MFCUs reported 1,327 convictions in FY 2022, an increase over the previous 2 years

Total convictions resulting from MFCU cases continued to increase from the FY 2020 level, but remained lower than in FY 2019. In FY 2022, MFCU cases resulted in 946 convictions for fraud and 381 convictions for patient abuse or neglect. Exhibit 2 shows the total number of convictions during FYs 2018 through 2022. Although the proportion of patient abuse or neglect convictions to fraud convictions was similar to that in previous years, the total number of patient abuse or neglect convictions also continued to increase from the FY 2020 level.

Exhibit 2: Convictions both for fraud and for patient abuse or neglect have increased since FY 2020.



Source: OIG analysis of Annual Statistical Reports for FYs 2018 through 2022.

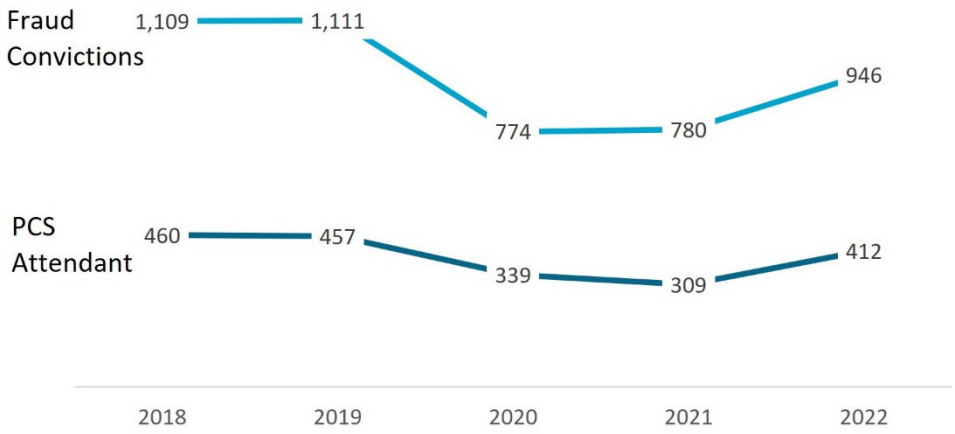
MFCU convictions lead to the exclusion of individuals and entities from participation in federally funded health care programs, broadening the impact of those convictions. When MFCUs make referrals to OIG regarding convictions for fraud and patient abuse or neglect in their respective States, OIG has the authority to exclude those convicted individuals and entities from federally funded health care programs. Through these referrals, MFCUs help ensure that individuals and entities convicted in one State are excluded from Medicaid programs in other States, as well as from other Federal programs related to health care.[13]

In FY 2022, OIG imposed a total of 2,332 exclusions on individuals and entities. MFCU cases were responsible for 1,018 (44 percent) of those exclusions. In addition to these 1,018 MFCU-generated exclusions, MFCUs participated in joint cases with the OIG Office of Investigations that also may have resulted in exclusions.

As in previous years, significantly more convictions for fraud involved Personal Care Services (PCS) attendants than any other provider type

Compared to other provider types, PCS attendants had the highest number of fraud convictions each year during FYs 2018 through 2022. Exhibit 3 shows the number of fraud convictions for PCS attendants, as compared to total fraud convictions, for FYs 2018 through 2022.

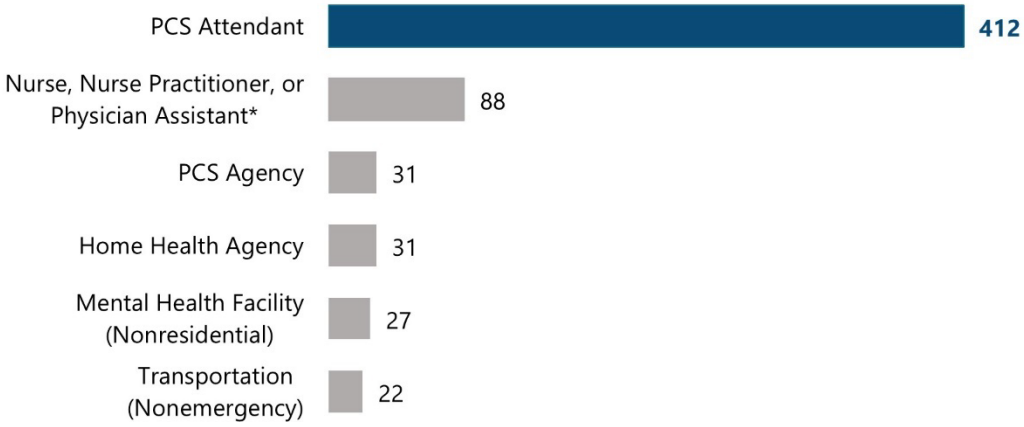
Exhibit 3: Fraud convictions involving PCS attendants accounted for a significant portion of total fraud convictions during FYs 2018 through 2022.



Source: OIG analysis of Annual Statistical Reports for FYs 2018 through 2022.

In FY 2022, fraud convictions involving PCS attendants accounted for 412 of the total 946 fraud convictions (44 percent). Exhibit 4 shows the provider types with the most fraud convictions in FY 2022.

Exhibit 4: Convictions of PCS attendants for fraud were significantly higher than for any other provider type in FY 2022.



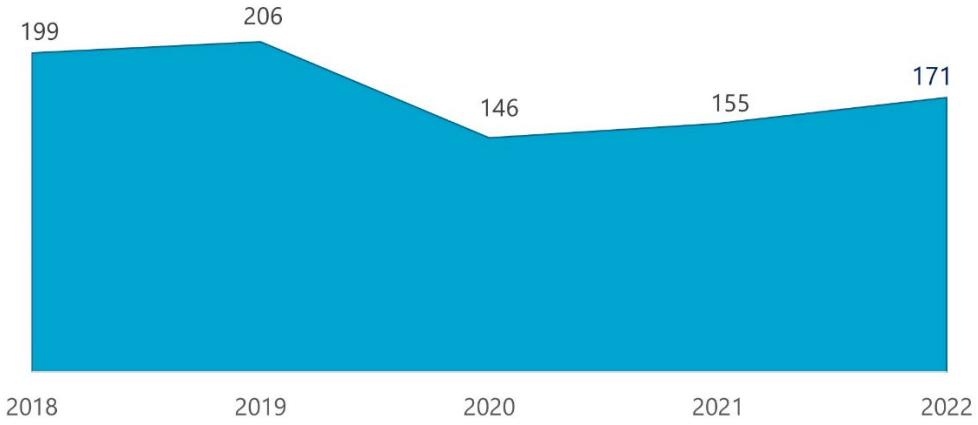
* Licensed Practical Nurse (LPN), Registered Nurse (RN), Nurse Practitioner (NP), or Physician Assistant.
This chart shows the top six provider types based on the number of fraud convictions in FY 2022.
Source: OIG analysis of FY 2022 Annual Statistical Reports.

See Appendix B for detailed statistics, by provider type, on the number of criminal convictions; civil settlements or judgments; and recovery amounts, as well as the number of open investigations.

MFCUs reported 171 convictions related to drug diversion cases in FY 2022, an increase over the previous 2 years

MFCU convictions related to drug diversion cases continued to increase from the FY 2020 level. Exhibit 5 shows the number of convictions associated with drug diversion cases during FYs 2018 through 2022. Associated criminal recoveries from drug diversion cases totaled $18 million in FY 2022. Two States, Pennsylvania and Kentucky, accounted for 79 percent of this total and those States recovered $9 million and $6 million, respectively. In Medicaid, drug diversion cases generally involve (a) the fraudulent billing of Medicaid, or (b) fraudulent activities of Medicaid providers involving drugs diverted from legal and medically necessary uses, regardless of whether Medicaid itself was billed. MFCUs may conduct drug diversion investigations jointly with other State or Federal agencies, such as OIG or the U.S. Attorney's Office.[14]

Exhibit 5: Convictions from drug diversion cases continued to increase in FY 2022.

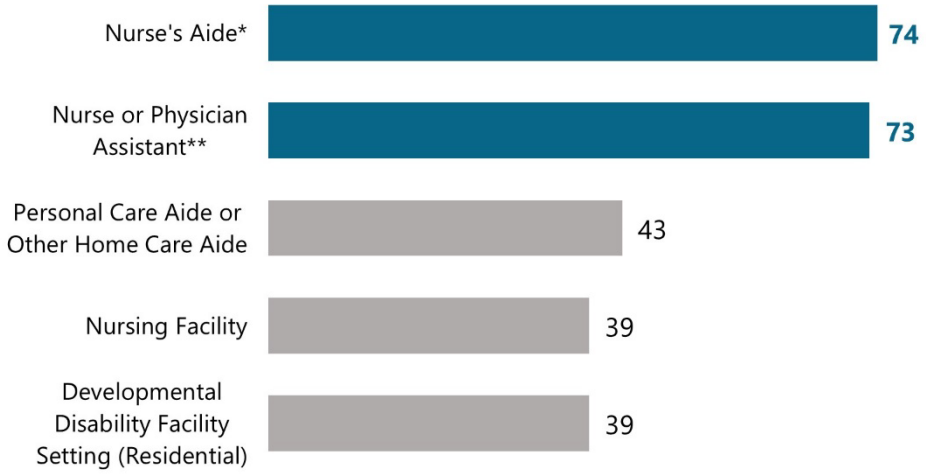


Source: OIG analysis of Annual Statistical Reports for FYs 2018 through 2022.

In FY 2022, convictions for patient abuse or neglect involved two provider types more than any others: nurse's aides and nurses or physician assistants

In FY 2022, convictions of nurse's aides and of nurses or physician assistants accounted for 147 of the total 381 convictions for patient abuse or neglect (39 percent). Exhibit 6 on the next page shows the provider types with the most convictions for patient abuse or neglect.

Exhibit 6: In FY 2022, convictions of nurse's aides and of nurses or physician assistants for patient abuse and neglect were significantly higher than for any other provider types.

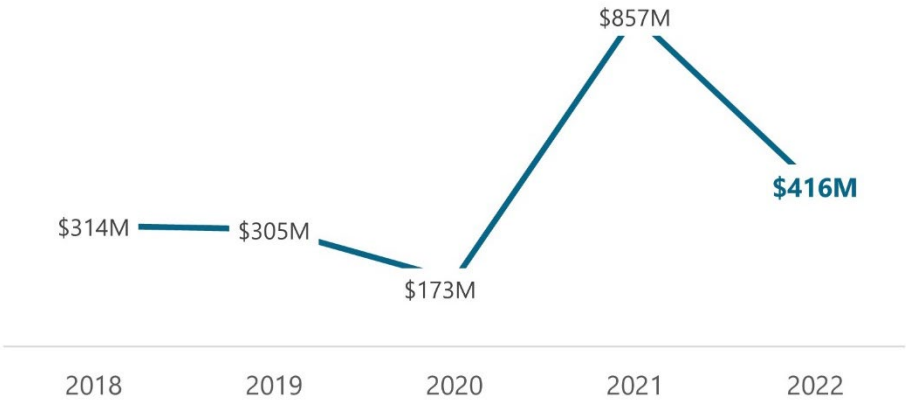


*Certified Nurse Assistant or other.
** LPN, RN, NP, or Physician Assistant.
This chart shows the top five provider types based on the number of convictions for patient abuse and neglect in FY 2022.
Source: OIG analysis of FY 2022 Annual Statistical Reports.

MFCUs reported criminal recoveries of $416 million in FY 2022

Although MFCU criminal recoveries decreased in FY 2022, they remained significantly higher than the totals reported during FYs 2018 through 2020 (see Exhibit 7). MFCU criminal recoveries decreased from $857 million in FY 2021 to $416 million in FY 2022. The large criminal recovery amounts in FY 2021 were primarily the result of cases prosecuted by MFCUs in Virginia and Texas. These two MFCUs reported a combined $714 million in criminal recoveries, 83 percent of the total reported criminal recoveries in FY 2021.

Exhibit 7: Criminal recoveries varied during FYs 2018 through 2022.



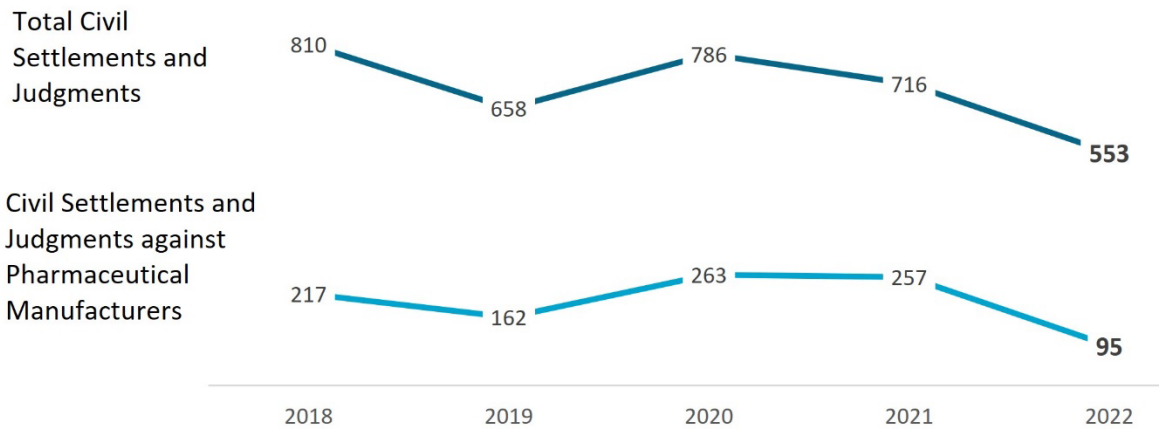
Source: OIG analysis of Annual Statistical Reports for FYs 2018 through 2022.

One case that significantly contributed to the total criminal recoveries in FY 2022 involved an investigation by the Texas MFCU. In that case, the MFCU investigated a Chief Executive Officer of a hospice facility for defrauding the Medicare and Medicaid programs.[15] Among other actions, the defendant billed Medicare and Medicaid for hospice services that were (1) not provided, (2) not directed by a medical professional, and (3) provided to patients not eligible for hospice care. In addition, the defendant used blank, pre-signed controlled substance prescriptions to distribute drugs without physician input. The case involved co-defendants, some of whom pleaded guilty, and others who were found guilty at trial. The total combined restitution ordered to be paid by four of the defendants totaled about $82 million and each was sentenced to at least 5 years in Federal prison.

MFCUs reported 553 civil settlements and judgments in FY 2022

The total number of civil settlements and judgments reported by MFCUs decreased in FY 2022, as did the total number of civil settlements and judgments associated with pharmaceutical manufacturers. As shown in Exhibit 8, during FY 2021 to FY 2022, civil settlements and judgments involving pharmaceutical manufacturers decreased at a significantly higher rate (63 percent) compared to the decrease in the total number of civil settlements and judgments (23 percent).

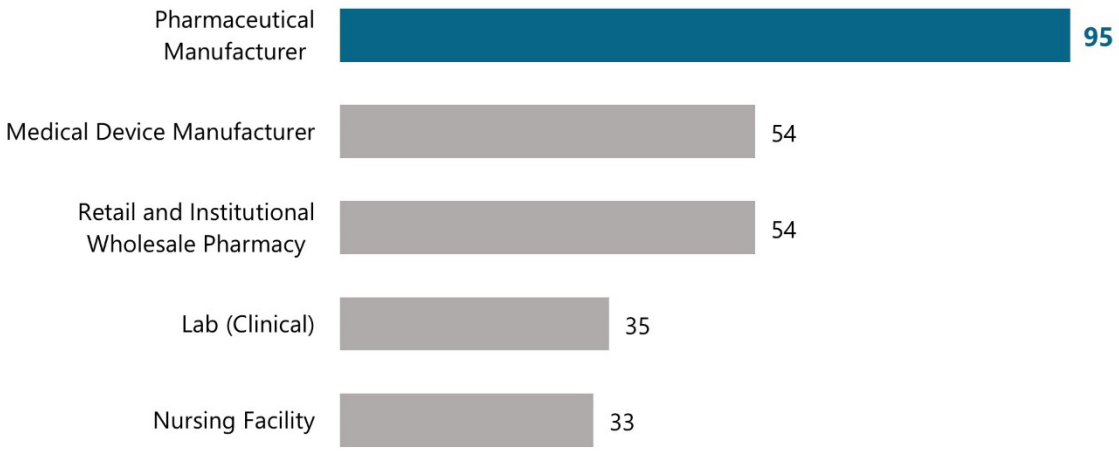
Exhibit 8: The total number of civil settlements and judgments decreased in FY 2022, as did the total attributed to pharmaceutical manufacturers.



Source: OIG analysis of Annual Statistical Reports for FYs 2018 through 2022.

Despite the significant decrease in civil settlements and judgments involving pharmaceutical manufacturers, this provider type continued to account for more civil settlements and judgments than any other provider type. Following pharmaceutical manufacturers, medical device manufactures and retail and institutional wholesale pharmacies had the next highest number of civil settlements and judgments (see Exhibit 9).

Exhibit 9: Pharmaceutical manufacturers had the highest number of civil settlements and judgments in FY 2022.

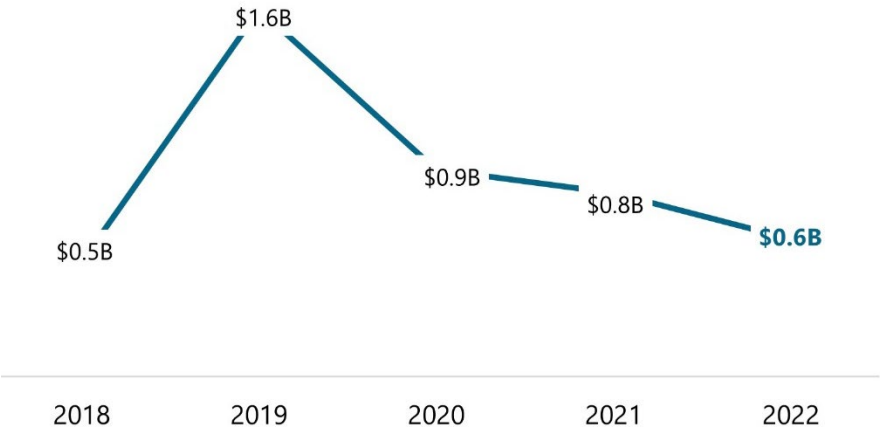


This chart shows the top five provider types based on the number of civil settlements and judgments in FY 2022.
Source: OIG analysis of FY 2022 Annual Statistical Reports.

MFCUs reported civil recoveries of $641 million in FY 2022

Civil recoveries continued a 3-year decrease. As shown in Exhibit 10, civil recoveries were substantially higher in FY 2019 relative to other years. In FY 2019, two global cases accounted for a significant portion of the civil recoveries and totaled more than $1.3 billion.

Exhibit 10: Total civil recovery amounts decreased over the last 3 years.



Source: OIG analysis of Annual Statistical Reports for FYs 2018 through 2022.

In FY 2022, $395 million (62 percent) of the $641 million in civil recoveries derived from nonglobal cases. The remaining $246 million (38 percent) derived from global cases.[16]

In one global case that was resolved in FY 2022, all 50 States, Washington D.C., and Puerto Rico partnered with Federal agencies to pursue allegations that a pharmaceutical manufacturer knowingly underpaid Medicaid drug rebates. As a result of the investigation, the pharmaceutical manufacturer agreed to pay a total of $234 million.[17]

Types of Civil Cases

A **global case** involves both the Federal Government and a group of States and is coordinated by the National Association of Medicaid Fraud Control Units.

A **nonglobal case** is conducted by a Unit—individually or with other law enforcement partners—and is not coordinated by the National Association of Medicaid Fraud Control Units.

CONCLUSION

MFCUs play a vital role in holding wrongdoers accountable for Medicaid provider fraud and protecting patients from abuse or neglect. Medicaid, as a Federal-State partnership that provides health insurance for over 80 million individuals, requires skilled and effective oversight from both the Federal and State governments. MFCUs, which report to, or work closely with, the State Attorney General, and which receive funding and oversight from OIG, are uniquely positioned to investigate and prosecute provider fraud and patient abuse or neglect in coordination with Federal and State law enforcement and oversight agencies.

This report outlines the criminal and civil outcomes achieved by MFCUs in FY 2022, including total recoveries of $1.1 billion with an ROI of $3.08 for every $1 spent. Notably in FY 2022, MFCUs continued to achieve increased criminal outcomes after encountering pandemic-related challenges that we described in the FY 2020 and FY 2021 MFCU annual reports.

As in past MFCU annual reports, OIG has identified beneficial practices implemented by the MFCUs, included in Appendix A, which other MFCUs may want to consider for adoption.

OIG annually recognizes the efforts of one MFCU with the Inspector General's Award for Excellence in Fighting Fraud, Waste, and Abuse. In 2023, the Utah MFCU received this award for achieving strong case outcomes and maintaining outstanding partnerships with OIG's Office of Investigations and other Federal and State partners, as well as managed care entities.

APPENDICES

Appendix A: Beneficial Practices Described in Office of Inspector General Inspection Reports

This appendix summarizes MFCU practices that OIG has highlighted as beneficial to Unit operations, which other Units may wish to consider adopting in their States.

All of OIG's MFCU reports are available at https://oig.hhs.gov/reports-and-publications/oei/m.asp#mfcu.

STANDARD 4	A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.
Kansas OEI-12-18-00210 July 2019	**Supplementing reviews of referrals of patient abuse or neglect and enhancing referral coordination:** The Unit's nurse investigator reviewed complaints about patient abuse or neglect that had been previously closed by the State's survey and certification agency to determine whether the complaints warranted further investigation. In addition, the nurse investigator arranged for the Unit to receive complaints of patient abuse or neglect at the same time the State's survey and certification agency sent the complaints to local law enforcement agencies. After reviewing the complaints, the nurse investigator contacted local law enforcement agencies. If those agencies did not plan to take any action on the complaints, the Unit's Special Agent in Charge reviewed the complaints to determine whether to open a formal investigation.
Louisiana OEI-12-20-00650 August 2021	**Hiring an outreach coordinator to promote the Unit's mission among its stakeholders:** The outreach coordinator's responsibilities were to promote the Unit's mission among nursing homes, rehabilitation facilities, local law enforcement agencies, and other State agencies. The outreach coordinator was responsible for (1) developing training regarding the Unit's mission and presenting that training to Unit stakeholders; (2) coordinating with the Louisiana Department of Justice on press releases; and (3) acting as a liaison to receive referrals from stakeholders.
Montana OEI-12-19-00170 March 2020	**Participating in an Elder Abuse Task Force to provide training to law enforcement and first responders:** To encourage referrals, the Unit regularly trained cadets at the Montana Law Enforcement Academy and trained other law enforcement and first responder personnel through its participation in the Montana Elder Abuse Task Force. The training focused on the Unit's mission and how the Unit can assist with crimes that law enforcement personnel and first responders may encounter.

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Beneficial Practices Described in Office of Inspector General Inspection Reports

STANDARD 4	A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.
New York OEI-12-17-00340 September 2018	**Establishing data analytics working groups to improve the Unit's ability to data mine to find potential cases:** The Unit established data analytics working groups to provide guidance, training, and an assessment of the Unit's data mining efforts. The groups include the Data Analytics Tool group, the Data Sources group, the Fraud and Abuse group, and the Governance group.
Ohio OEI-07-14-00290 April 2015	**Establishing a program integrity group composed of personnel from other Medicaid program integrity entities:** To improve the quantity and quality of referrals, the Unit established the Ohio Program Integrity Group, which combines the knowledge and resources of all of the State agencies that are responsible for Medicaid program integrity. In addition, the Unit spearheaded the Managed Care Program Integrity Group, which meets quarterly.
South Carolina OEI-12-20-00610 September 2021	**Notifying referral sources of the Unit's decision whether to open formal investigations of incoming referrals:** Through secure electronic channels, the Unit communicated with the State Medicaid agency and other referral sources regarding the Unit's decision to accept or decline referrals. In response, State officials lauded the responsiveness of the Unit's communications. The Unit followed a similar practice, where appropriate, regarding referrals received from private citizens.
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.**
Arkansas OEI-12-19-00450 September 2020	**Designating staff as subject matter experts:** The Unit director designated Unit investigators as subject matter experts on specific, common provider types for efficient assignment and improved investigation of cases.
New York OEI-12-17-00340 September 2018	**Developing a strategic plan to optimize and prioritize resources:** The Unit developed a written strategic plan to help Unit staff make informed decisions regarding the optimal use of resources. The plan provides guidance to prioritize certain types of investigations, such as criminal investigations that are related to systematic patient abuse and neglect; fraud allegations against managed care companies; and fraud investigations of large providers. The plan also establishes a priority for false claims investigations with higher potential for monetary recoveries or risk of patient harm.

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Beneficial Practices Described in Office of Inspector General Inspection Reports

STANDARD 8	A Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health care fraud.
California OEI-09-15-00070 February 2016	**Co-locating Unit and OIG staff to facilitate referrals and communication:** Unit investigators have workstations at an OIG field office—this facilitated the mutual referral of cases and improved communication and cooperation with OIG on joint cases.
Florida OEI-07-15-00340 June 2016	**Co-locating Unit and OIG staff to improve cooperation on joint cases:** Unit staff have workstations at an OIG field office—this improved communication and cooperation with OIG on joint cases, including fraud cases generated through the U.S. Department of Justice Medicare Strike Force.
Idaho OEI-12-18-00320 August 2019	**Monitoring media sources to report convictions of providers to OIG:** The Unit's legal secretary monitored media sources for convictions in patient abuse and neglect cases. Although the convictions were a result of investigations by local authorities and not the Unit, the legal secretary obtained the conviction information, and after the Unit Director's review and approval, the legal secretary submitted the police reports and court documents to OIG. As a result of those efforts, OIG has excluded individuals from federally funded health programs.

STANDARD 9	A Unit makes statutory or programmatic recommendations, when warranted, to the State government.
Minnesota OEI-06-13-00200 March 2014	**Developing legislation to protect Medicaid enrollees from abuse:** The Unit helped develop legislation to protect Medicaid enrollees by strengthening background checks for individuals who serve as guardians and conservators of Medicaid enrollees.
Washington OEI-09-16-00010 September 2016	**Using information from a case closure form to make program integrity recommendations to State agencies:** The Unit used a case closure form to make numerous program integrity recommendations to State agencies and tracked the responses to these recommendations in a database.

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Beneficial Practices Described in Office of Inspector General Inspection Reports

STANDARD 12	A Unit conducts training that aids in the mission of the Unit.
Kentucky OEI-06-17-00030 September 2017	**Implementing a mentoring program to develop Unit attorneys:** The Unit created an executive advisor position to help Unit attorneys develop litigation skills. The executive advisor also mentored new attorneys and served as a co-chair on Unit prosecutions.
Louisiana OEI-12-20-00650 August 2021	**Sponsoring combined training events with a neighboring Unit:** The Unit and a neighboring Unit alternated hosting a combined training for employees of both Units. Training events included case studies, statistical trends, and roundtable discussions.
Maryland OEI-07-16-00140 September 2016	**Developing an internal boot camp to train new staff:** The Unit developed an internal "boot camp" training program that helped new staff develop a full understanding of the Unit's work. Experienced MFCU staff gave 1- to 2-hour lectures on topics such as civil and criminal investigation procedures; interviewing techniques; and understanding medical codes.
Missouri OEI-12-18-00490 January 2020	**Creating in-house training videos:** The Unit's Chief Auditor created in-house training videos for Unit investigators and attorneys. The videos contained step-by-step tutorials for creating and using investigative and trial tools.
New York OEI-12-17-00340 September 2018	**Using a moot-court approach for training attorneys:** The Unit used moot-court training to train Unit attorneys. This training helped the Unit attorneys practice opening arguments to prepare for trial.

OTHER	Beneficial practices not relating directly to a specific performance standard.
South Dakota OEI-07-16-00170 September 2016	**Having providers teach their peers about implications of Medicaid fraud:** The Unit used providers who had previously been investigated for Medicaid fraud to educate their peers. These providers gave presentations alongside Unit staff at training conferences—this helped to highlight Medicaid billing issues and the implications of Medicaid fraud.
Virginia OEI-07-15-00290 August 2016	**Using specialty software to better analyze, maintain, and share documentary evidence:** The Unit used specialty software designed to read the text in a document, analyze it for keywords, and systematically code it according to criteria established by an analyst. This improved the Unit's abilities to process and track evidence collected during investigations and to share that evidence with Federal and State partners working on joint cases.

Appendix B: Medicaid Fraud Control Unit Case Outcomes and Open Investigations by Provider Type and Case Type for Fiscal Year 2022

Exhibit B1: Number of convictions; settlements and judgments; and recoveries by provider type and case type

PROVIDER TYPE	CRIMINAL		CIVIL	
	Convictions	Amount of Recoveries	Settlements and Judgments	Amount of Recoveries
Patient Abuse or Neglect				
Assisted Living Facility	16	$264,782	0	$0
Developmental Disability Facility (Residential)	39	$41,562	1	$300,000
Hospice	1	$792	0	$0
Nondirect Care Staff	6	$127,120	0	$0
Nurse's Aide (Certified Nurse Assistant or Other)	74	$55,158	0	$0
Nurse (LPN, RN, or NP) or Physician Assistant	73	$127,400	0	$0
Nursing Facility	39	$209,438	14	$412,669
Personal Care Aide or Other Home Care Aide	43	$155,146	2	$0
Other	90	$4,781,278	2	$554,250
Fraud—Facility-Based Medicaid Providers and Programs—Inpatient and/or Residential				
Assisted Living Facility	1	$258	1	$2,575
Developmental Disability Facility (Residential)	3	$37,447	3	$1,350,000
Hospice	9	$84,210,632	0	$0
Hospital	2	$2,022,305	15	$14,312,030
Inpatient Psychiatric Services for Individuals Under Age 21	0	$0	0	$0
Nursing Facility	8	$9,448	33	$2,181,860
Other Inpatient Mental Health Facility	1	$15,496	0	$0
Other Long-Term Care Facility	0	$0	0	$0

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Exhibit B1: Number of convictions; settlements and judgments; and recoveries by provider type and case type (continued)

PROVIDER TYPE	CRIMINAL		CIVIL	
	Convictions	Amount of Recoveries	Settlements and Judgments	Amount of Recoveries
Fraud—Facility-Based Medicaid Providers and Programs—Outpatient and/or Day Services				
Adult Day Center	1	$1,799,673	3	$687,038
Ambulatory Surgical Center	0	$0	1	$200,000
Developmental Disability Facility (Nonresidential)	4	$1,088,305	4	$365,865
Dialysis Center	0	$0	0	$0
Mental Health Facility (Nonresidential)	27	$16,641,719	12	$30,616,202
Substance Abuse Treatment Center	6	$6,745,046	7	$6,379,578
Other Facility (Nonresidential)	6	$36,315	6	$30,439,207
Fraud—Licensed Practitioners				
Audiologist	0	$0	0	$0
Chiropractor	3	$53,191	3	$189,465
Clinical Social Worker	5	$766,777	3	$130,776
Dental Hygienist	3	$7,131	2	$667,319
Dentist	7	$1,714,597	10	$5,587,265
Nurse (LPN, RN, or Other Licensed)	67	$1,732,990	1	$989
Nurse Practitioner	16	$171,265	3	$126,665
Optometrist	2	$859,610	4	$993,343
Pharmacist	7	$2,359,411	1	$10,000
Physician Assistant	5	$575,411	0	$0
Podiatrist	1	$4,937	0	$0
Psychologist	8	$1,496,870	7	$1,071,374
Therapist (Non-Mental Health, Physical Therapist (PT), Speech Therapist (ST), Occupational Therapist (OT), or Radiation Therapist (RT))	7	$1,192,346	1	$3,092
Other Practitioner	12	$917,685	4	$205,916
Fraud—Medical Services				
Ambulance	5	$1,103,467	2	$382,938
Billing Services	4	$272	0	$0

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Exhibit B1: Number of convictions; settlements and judgments; and recoveries by provider type and case type (continued)

PROVIDER TYPE	CRIMINAL		CIVIL	
	Convictions	Amount of Recoveries	Settlements and Judgments	Amount of Recoveries
Fraud—Medical Services (continued)				
Home Health Agency	31	$69,131,435	27	$18,001,631
Lab (Clinical)	3	$123,952	35	$16,185,292
Lab (Radiology and Physiology)	2	$1,246,877	1	$5,631
Lab (Other)	1	$40,000	9	$1,598,710
Medical Device Manufacturer	0	$0	54	$10,055,268
Pain Management Clinic	2	$877,691	4	$1,081,168
Personal Care Services Agency	31	$38,204,270	2	$184,857
Pharmaceutical Manufacturer	0	$0	95	$253,806,011
Pharmacy (Hospital)	0	$0	0	$0
Pharmacy (Institutional Wholesale)	4	$3,446,704	24	$4,028,132
Pharmacy (Retail)	19	$4,937,818	30	$78,602,932
Supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	17	$43,110,892	18	$2,628,742
Transportation (Nonemergency)	22	$4,733,527	6	$824,741
Other	5	$351,517	8	$3,886,663
Fraud—Other Individual Providers				
Emergency Medical Technician or Paramedic	0	$0	0	$0
Nurse's Aide (CNA or Other)	19	$242,302	0	$0
Optician	1	$74,084	1	$9,230
Personal Care Services Attendant	412	$7,639,555	22	$198,625
Pharmacy Technician	1	$2,189	0	$0
Unlicensed Counselor (Mental Health)	20	$5,945,499	0	$0
Unlicensed Therapist (Non-Mental Health)	1	$10,452	0	$0
Other	54	$24,679,580	3	$262,450

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Exhibit B1: Number of convictions; settlements and judgments; and recoveries by provider type and case type (continued)

PROVIDER TYPE	CRIMINAL		CIVIL	
	Convictions	Amount of Recoveries	Settlements and Judgments	Amount of Recoveries
Fraud—Physicians (Doctor of Medicine (MD) /Doctor of Osteopathic Medicine (DO)) by Medical Specialty				
Allergist/Immunologist	0	$0	0	$0
Cardiologist	0	$0	1	$184,314
Emergency Medicine	1	$25	1	$14,982,081
Family Practice	11	$11,332,998	12	$2,420,432
Geriatrician	0	$0	0	$0
Internal Medicine	12	$3,597,292	9	$1,777,643
Neurologist	1	$310,799	0	$0
Obstetrician/Gynecologist	0	$0	3	$639,221
Ophthalmologist	2	$1,025	0	$0
Pediatrician	3	$23,336	4	$1,496,761
Physical Medicine and Rehabilitation	1	$214,367	1	$9,617,679
Psychiatrist	2	$1,620,191	2	$349,159
Radiologist	0	$0	1	$76,230
Surgeon	2	$8,368	7	$13,392,111
Urologist	2	$20,400	0	$0
Other Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO)	16	$59,090,801	15	$4,738,596
Fraud—Program-Related				
Managed Care Organization (MCO)	1	$100	8	$89,612,479
Medicaid Program Administration	8	$5,000	0	$0
Other	19	$3,304,754	5	$13,646,658
TOTAL	**1,327**	**$415,653,075**	**553**	**$641,463,864**

Note: Criminal and civil recovery amounts do not add up to the totals shown because of rounding.

Exhibit B2: Number of open investigations at the end of FY 2022 by provider type and case type

PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Patient Abuse or Neglect			
Assisted Living Facility	250	12	262
Developmental Disability Facility (Residential)	245	7	252
Hospice	8	0	8
Nondirect Care Staff	123	0	123
Nurse's Aide (CNA or Other)	316	1	317
Nurse (RN, LPN, or NP) or Physician Assistant	305	1	306
Nursing Facility	945	80	1,025
Personal Care Aide or Other Home Care Aide	307	6	313
Other	660	9	669
Fraud—Facility-Based Medicaid Providers and Programs—Inpatient and/or Residential			
Assisted Living Facility	34	19	53
Developmental Disability Facility (Residential)	39	11	50
Hospice	57	45	102
Hospital	59	189	248
Inpatient Psychiatric Services for Individuals Under Age 21	5	11	16
Nursing Facility	128	183	311
Other Inpatient Mental Health Facility	24	25	49
Other Long-Term Care Facility	15	16	31
Fraud—Facility-Based Medicaid Providers and Programs—Outpatient and/or Day Services			
Adult Day Center	73	7	80
Ambulatory Surgical Center	2	16	18
Developmental Disability Facility (Nonresidential)	29	10	39
Dialysis Center	0	33	33
Mental Health Facility (Nonresidential)	396	78	474
Substance Abuse Treatment Center	163	70	233
Other Facility (Nonresidential)	65	66	131

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Exhibit B2: Number of open investigations at the end of FY 2022 by provider type and case type (continued)

PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Fraud—Licensed Practitioners			
Audiologist	5	3	8
Chiropractor	22	4	26
Clinical Social Worker	77	3	80
Dental Hygienist	0	1	1
Dentist	241	49	290
Nurse (LPN, RN, or Other Licensed)	503	7	510
Nurse Practitioner	77	10	87
Optometrist	17	6	23
Pharmacist	58	23	81
Physician Assistant	26	0	26
Podiatrist	25	13	38
Psychologist	72	13	85
Therapist (Non-Mental Health, PT, ST, OT, or RT)	98	26	124
Other Practitioner	78	16	94
Fraud—Medical Services			
Ambulance	36	41	77
Billing Services	50	84	134
Home Health Agency	525	80	605
Lab (Clinical)	131	550	681
Lab (Radiology and Physiology)	16	55	71
Lab (Other)	42	162	204
Medical Device Manufacturer	2	724	726
Pain Management Clinic	47	20	67
Personal Care Services Agency	190	10	200
Pharmaceutical Manufacturer	78	1,893	1,971
Pharmacy (Hospital)	23	3	26
Pharmacy (Institutional Wholesale)	9	175	184
Pharmacy (Retail)	293	871	1,164
Supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	159	593	752
Transportation (Nonemergency)	254	26	280
Other	72	309	381

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Exhibit B2: Number of open investigations at the end of FY 2022 by provider type and case type (continued)

PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Fraud—Other Individual Providers			
Emergency Medical Technician or Paramedic	0	1	1
Nurse's Aide (CNA or Other)	75	0	75
Optician	2	1	3
Personal Care Services Attendant	1,621	20	1,641
Pharmacy Technician	19	0	19
Unlicensed Counselor (Mental Health)	59	0	59
Unlicensed Therapist (Non-Mental Health)	8	3	11
Other	391	43	434
Fraud—Physicians (MD/DO) by Medical Specialty			
Allergist/Immunologist	7	2	9
Cardiologist	15	16	31
Emergency Medicine	23	28	51
Family Practice	228	38	266
Geriatrician	3	1	4
Internal Medicine	130	28	158
Neurologist	16	5	21
Obstetrician/Gynecologist	27	5	32
Ophthalmologist	14	14	28
Pediatrician	44	13	57
Physical Medicine and Rehabilitation	20	6	26
Psychiatrist	67	16	83
Radiologist	6	23	29
Surgeon	33	17	50
Urologist	4	3	7
Other MD/DO	164	89	253
Fraud—Program-Related			
Managed Care Organization (MCO)	10	62	72
Medicaid Program Administration	9	13	22
Other	135	90	225
TOTAL	**10,604**	**7,202**	**17,806**

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

Christina Lester served as the team leader for this study, and Linda Min served as the lead analyst. Office of Evaluation and Inspections (OEI) staff who provided support include Susan Burbach, Robert Gibbons, Petra Nealy, and Keith Peters.

We would also like to acknowledge the contributions of other Office of Inspector General (OIG) staff, including Alexis Crowley, Lonie Kim, Jessica Swanstrom, and Sara Swisher.

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ABOUT THE OFFICE OF INSPECTOR GENERAL

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ENDNOTES

[1] Social Security Act (SSA) § 1903(q)(3)–(4). Regulations at 42 CFR § 1007.11(b)(1) add that a Unit's responsibilities may include reviewing complaints of misappropriation of patients' private funds in residential health care facilities. Units may investigate patient abuse and neglect incidents occurring in (1) health care facilities that receive Medicaid payments; and (2) board and care facilities, which are residential settings that receive payments on behalf of two or more unrelated adults who reside in the facility and receive nursing care services or a substantial amount of personal care services (PCS). SSA § 1903(q)(4). 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, P.L. No. 116-260, Division CC § 207.

[2] SSA § 1902(a)(61).

[3] The SSA authorizes the Secretary of HHS to award grants (SSA § 1903(a)(6)) and to certify and annually recertify Units (SSA § 1903(q)). The Secretary delegated this authority to OIG. See also 42 CFR § 1007.15. Units must meet several requirements established by the SSA and Federal regulations. For example, each Unit must (1) be a single, identifiable entity of State Government, separate and distinct from the State Medicaid agency (SSA § 1903(q)(2); 42 CFR §§ 1007.5(a) and 1007.9(a)); (2) employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney (SSA § 1903(q)(6); 42 CFR § 1007.13); (3) develop a formal agreement, such as a memorandum of understanding, describing the Unit's relationship with the State Medicaid agency (42 CFR § 1007.9(d)); and (4) have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority (SSA § 1903(q)(1); 42 CFR § 1007.7).

[4] The territories of American Samoa, Guam, and the Northern Mariana Islands have not established Units. Puerto Rico and the U.S. Virgin Islands received certification to operate in FY 2019 and North Dakota received certification to operate in FY 2020.

[5] 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.

[6] OIG's analysis of MFCU Annual Statistical Reports for FY 2022.

[7] 42 CFR § 1007.20. MFCUs must receive approval from OIG to conduct data mining. As of January 2023, 22 MFCUs were approved for data mining. OIG, *Data Mining Applications*, https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/data-mining.asp. Accessed on January 17, 2023.

[8] SSA § 1128; 42 U.S.C. § 1320a-7. See also OIG, *Background Information*, https://oig.hhs.gov/exclusions/background.asp. Accessed on March 6, 2023.

[9] 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 investigators and prosecutors should apply professional judgment and discretion in determining what criminal and civil cases to pursue.

[10] 42 CFR § 1007.15.

[11] MFCU performance standards are published at 77 Fed. Reg. 32645 (June 1, 2012).

[12] To calculate the ROI for MFCUs, we first calculated the total recoveries by adding the $416 million in criminal case recoveries to the $641 million in civil case recoveries. We then divided the $1.1 billion in total recoveries by the total MFCU grant expenditures of $343 million, resulting in the overall ROI of $3.08 for every $1 spent.

[13] OIG, *LEIE Downloadable Databases*, https://oig.hhs.gov/exclusions/exclusions_list.asp. Accessed on January 3, 2023. The list of OIG-excluded individuals or entities can be found on the OIG website.

[14] MFCUs may receive Federal financial participation for investigating Medicaid providers for alleged fraudulent activities related to drug diversion regardless of whether the Medicaid program was billed. OIG, *State Fraud Policy Transmittal 2020-3*, *MFCU Authority to Receive Federal Funding to Investigate and Prosecute Diversion and Misuse of Pharmaceuticals*, October 28, 2020. This transmittal describes the situations in which Units may receive Federal financial participation to investigate and prosecute drug diversion cases.

[15] U.S. Attorney's Office Northern District of Texas, *Novus Hospice CEO Sentenced to 13+ Years for Healthcare Fraud*, https://www.justice.gov/usao-ndtx/pr/novus-hospice-ceo-sentenced-13-years-healthcare-fraud. Accessed on January 26, 2023.

[16] To calculate the percentages for civil global and nonglobal recoveries, we used the total civil recoveries of $641,463,864 and rounded the dollar value to the nearest tenth.

[17] Wisconsin Department of Justice, *Wisconsin Department of Justice Announces Mallinckrodt to Pay $230 Million Agreement in Underpayment of Medicaid Drug Rebates Lawsuit*. https://www.doj.state.wi.us/news-releases/wisconsin-department-justice-announces-mallinckrodt-pay-230-million-agreement. Accessed on January 26, 2023.