U.S. Department of Health & Human Services

Office of Inspector General

Medicaid Fraud Control Units Fiscal Year 2017 Annual Report

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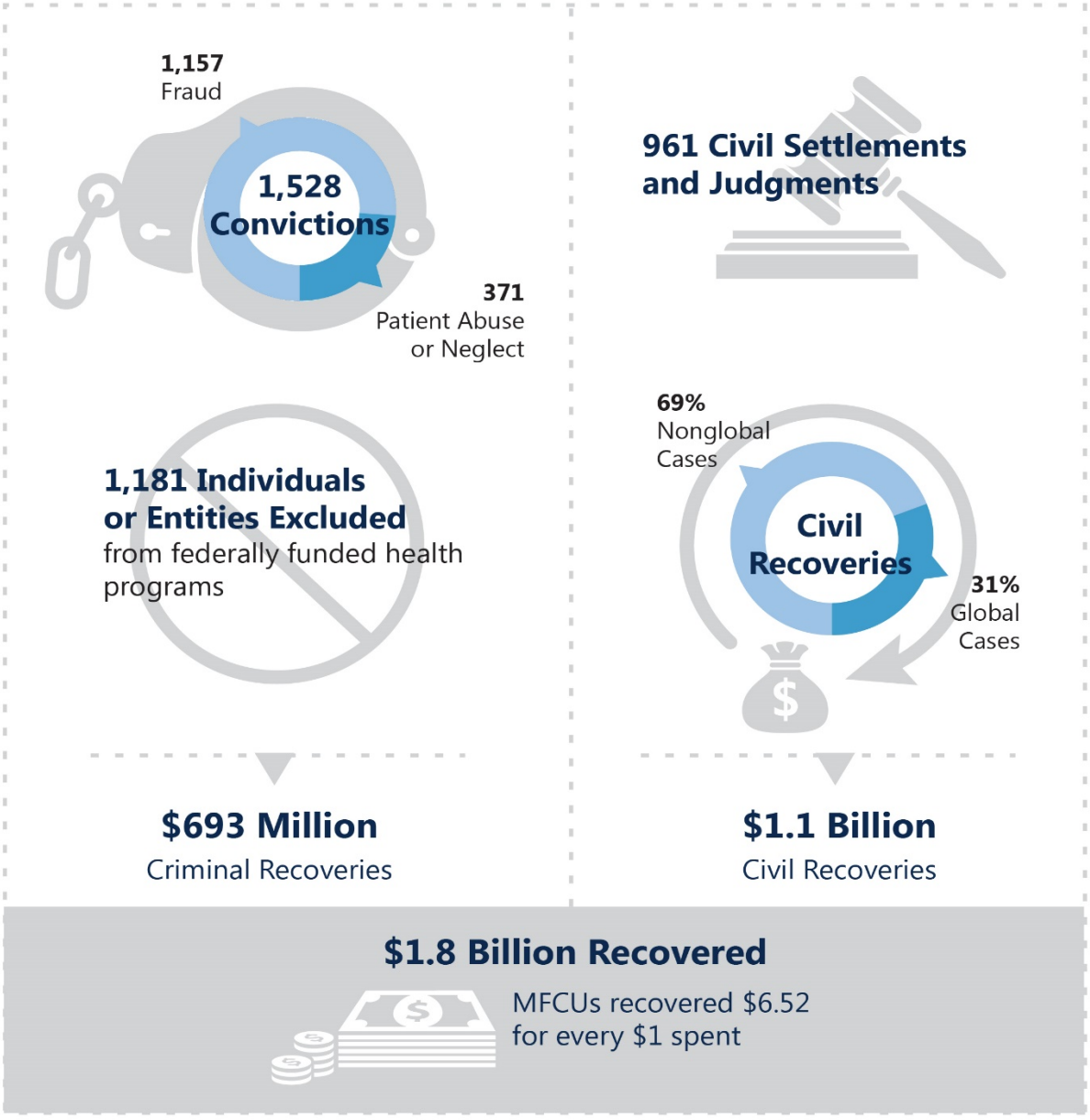
At a Glance

Medicaid Fraud Control Units Fiscal Year 2017 Annual Report



Medicaid Fraud Control Units (MFCUs or Units) investigate and prosecute Medicaid provider fraud and patient abuse or neglect. They operate in 49 States and the District of Columbia. The Department of Health and Human Services Office of Inspector General is the designated Federal agency that oversees and annually approves Federal funding for MFCUs through a recertification process. For this report we analyzed the annual statistical data on case outcomes—such as convictions; civil settlements and judgments; and recoveries—that the 50 MFCUs submitted for fiscal year 2017.

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BACKGROUND

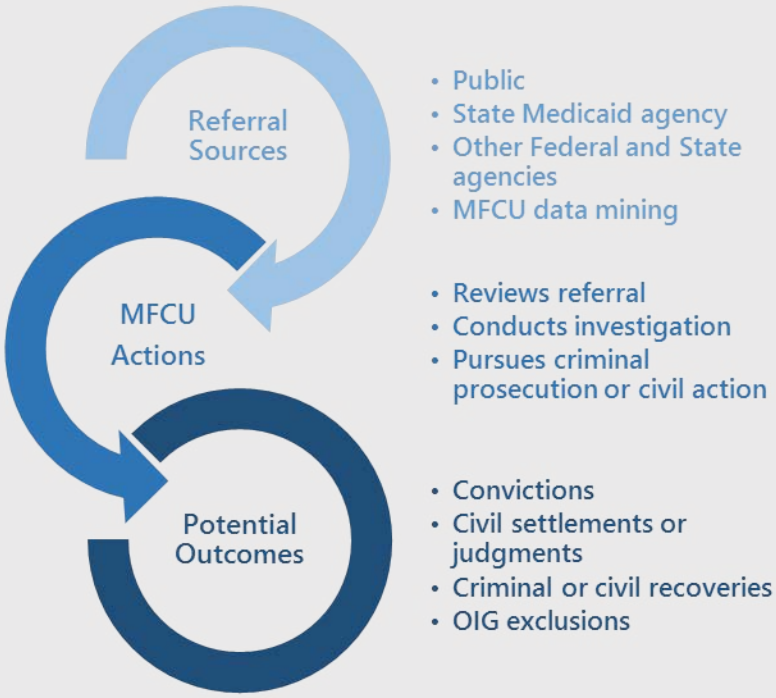
The function of Medicaid Fraud Control Units (MFCUs or Units) is to investigate and prosecute Medicaid provider fraud and patient abuse or neglect.[1] The Social Security Act (SSA) requires each State to effectively operate a MFCU, unless the Secretary of Health and Human Services determines that (1) 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 beneficiaries from abuse or neglect.[2] Currently, 49 States and the District of Columbia (States) operate MFCUs.[3]

MFCUs are funded jointly by Federal and State Governments. Each of the 50 MFCUs receives Federal reimbursement equivalent to 75 percent of its total expenditures, with State funds contributing the remaining 25 percent.[4] In fiscal year (FY) 2017, combined Federal and State expenditures for the Units totaled approximately $276 million, $207 million of which represented Federal funds.[5]

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

- be a single, identifiable entity of State Government, separate and distinct from the State Medicaid agency;[6]
- employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney;[7]
- develop a formal agreement, such as a memorandum of understanding, describing the Unit's relationship with the State Medicaid agency;[8] and
- have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority.[9]

Exhibit 1: The typical lifecycle of a MFCU case.



As illustrated in Exhibit 1, MFCU cases typically begin as referrals from external sources or are generated internally from data mining.[10] MFCU staff review referrals of possible fraud and patient abuse or neglect to determine their potential for criminal prosecution and/or civil action. If the Unit accepts a referral for investigation, the case may result in various possible outcomes, such as convictions; civil settlements or judgments; and monetary recoveries. The Office of Inspector General (OIG) has the authority to exclude convicted individuals and entities from any federally funded health care programs on the basis of convictions referred from MFCUs.[11] Units may also make program recommendations to their respective State Governments that help strengthen program integrity and efforts to fight patient abuse or neglect.

OIG Oversight of the MFCU Program

It is a top OIG priority to continually strengthen and support the effectiveness of MFCUs as key partners in combating fraud and abuse. OIG oversees the MFCU grant program by recertifying Units, conducting onsite reviews of Units, providing technical assistance to Units, and maintaining key statistical data about Unit caseloads and outcomes.[12] Further, OIG has identified enhancing Medicaid program integrity—including efforts to maximize the effectiveness of MFCUs—as an OIG Priority Outcome. (See Appendix A for details.)

Annually, OIG approves each Unit's application for recertification, which is necessary for the Unit to receive Federal reimbursement.[13] To recertify a Unit, OIG assesses 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.[14]

OIG conducts periodic onsite reviews of Units. These reviews allow OIG to evaluate a Unit's outcomes, operations, and compliance with Federal laws, regulations, policies and performance standards. On the basis of these reviews, OIG issues public reports that contain findings and recommendations for improvement or corrective actions. These reports may also note Unit practices that OIG identifies as particularly beneficial and

that may be useful to other MFCUs. Appendix B contains a list of beneficial practices that OIG cited in MFCU reports published in recent years.

OIG also provides ongoing technical assistance and guidance to Units. These activities may include responding to questions from the Units, providing training to Units, and issuing policy transmittals to all Units.

Annually, OIG collects and presents statistical data reported by each MFCU, such as the number of open cases, indictments, 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

We based the information in this report on the FY 2017 Annual Statistical Reports submitted to OIG by all 50 MFCUs, recertification materials submitted annually by the MFCUs, and OIG exclusions data.

We aggregated case outcomes across all Units for FY 2017 and for each of the preceding 4 years—FYs 2013 through 2016. These outcomes include convictions; civil settlements and judgments; and recoveries. For each of these outcomes, we also calculated an average across the 5-year period of FYs 2013 through 2017. Additionally, we identified the provider types with the highest number of criminal and civil outcomes in FY 2017 and the number of FY 2017 exclusions that OIG imposed on individuals and entities as a result of conviction referrals from MFCUs. We also conducted analysis of MFCU drug diversion cases, using data for FYs 2015 through 2017, the only years for which these data were available.

Standards

OIG inspections of the MFCUs, and this annual report, differ from other OIG evaluations as they support OIG's direct administration of the MFCU grant program, but are subject to the same internal quality controls as other OIG evaluations, including internal peer review.

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of Inspectors General on Integrity and Efficiency.

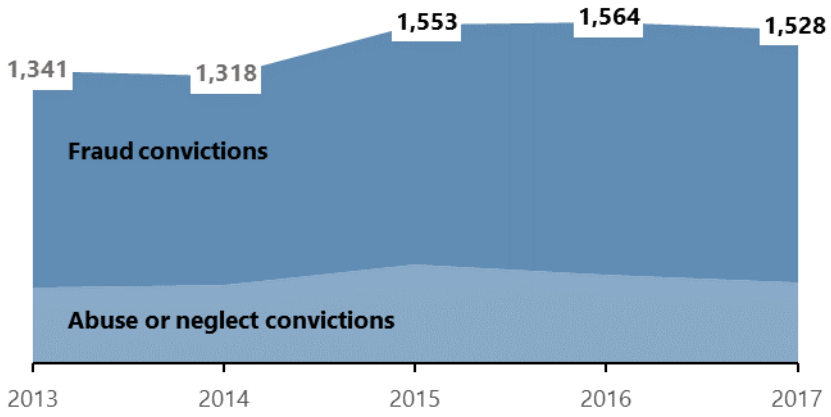
CASE OUTCOMES

The number of convictions in FY 2017 remained similar to those in recent years

In FY 2017, MFCU convictions totaled 1,528, similar to the number of convictions for recent years. This total included 1,157 convictions of fraud and 371 convictions of patient abuse or neglect. Exhibit 2 shows the number of convictions in each of the last 5 years.

Exhibit 2: FY 2017 convictions remained similar to those in FYs 2015 and 2016.

Fraud convictions accounted for 73 percent of all convictions for the last 5 years.

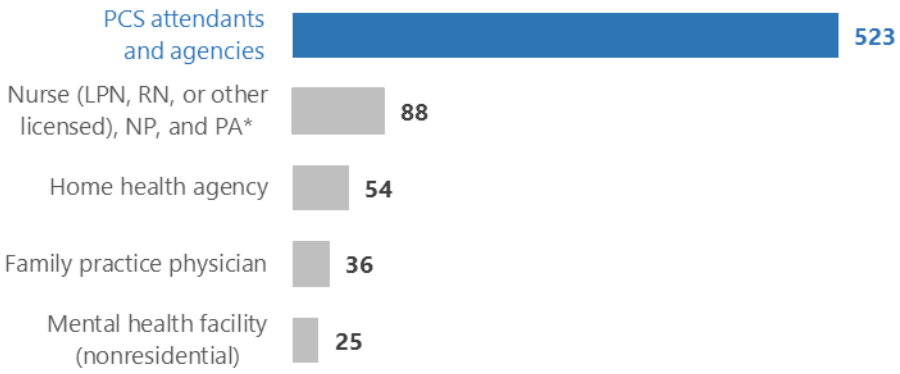


Source: OIG analysis of Quarterly Statistical Reports for FYs 2013–2014 and Annual Statistical Reports for FYs 2015–2017.

Significantly more convictions for fraud involved personal care services (PCS) attendants and agencies than any other provider type in FY 2017

Of the 1,157 fraud convictions in FY 2017, 523 (45 percent) involved PCS attendants and agencies. For additional information on the prevalence of fraud involving PCS, see OIG's December 2017 issue brief and October 2016 investigative advisory. On the next page, Exhibit 3 shows the provider types with the most fraud convictions in FY 2017.

Exhibit 3: Convictions of PCS attendants and agencies for fraud were significantly higher than for any other provider type in FY 2017.

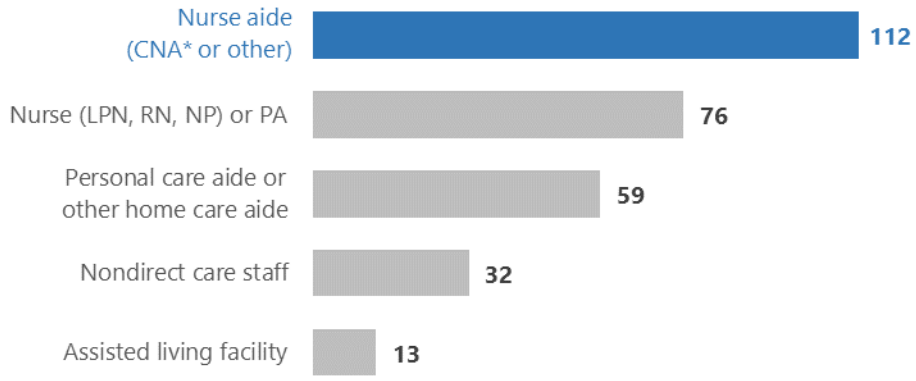


*LPN = Licensed Practical Nurse; RN = Registered Nurse; NP = Nurse Practitioner; PA = Physician Assistant
Source: OIG analysis of FY 2017 Annual Statistical Reports.

More convictions for patient abuse or neglect involved nurse aides than any other provider type in FY 2017

In FY 2017, nurse aides accounted for 112 of the total 371 patient abuse or neglect convictions (30 percent). Exhibit 4 shows the provider types with the most convictions for patient abuse or neglect.

Exhibit 4: Convictions of nurse aides for patient abuse or neglect were higher than for any other provider type in FY 2017.



*CNA = Certified Nurse Aide
Source: OIG analysis of FY 2017 Annual Statistical Reports.

Appendix C shows the number of convictions and recovery amounts for patient abuse or neglect cases, by provider type.

MFCU convictions led to the exclusion of individuals and entities from Federal health care programs, broadening the impact of convictions

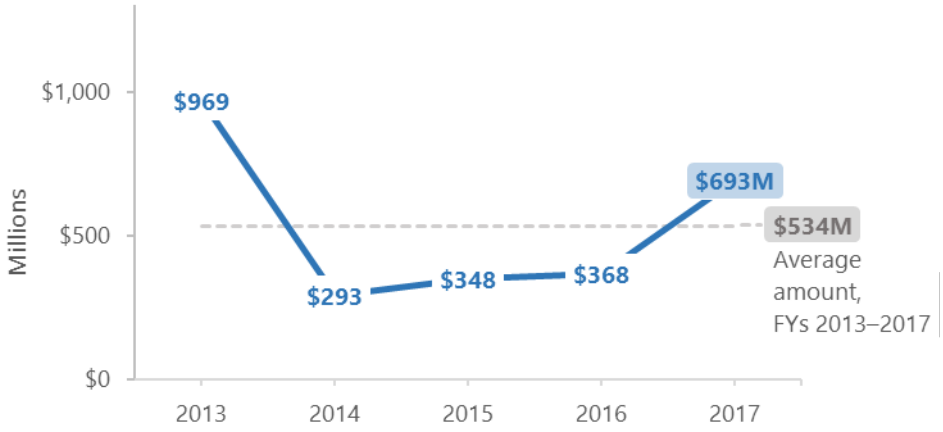
In FY 2017, OIG excluded 1,181 individuals and entities from participating in Federal health care programs as a result of conviction referrals from MFCUs. When MFCUs refer convictions for fraud and patient abuse or neglect in their respective States to OIG, OIG has the authority to exclude convicted individuals and entities from federally funded health care programs. Through these referrals, MFCUs help ensure that convicted individuals and entities are excluded from Medicaid programs in other States, as well as other Federal programs related to health care. On its website, OIG maintains the List of Excluded Individuals/Entities.

Criminal recoveries nearly doubled in 2017

Criminal recoveries of $693 million in FY 2017 were almost double those from FY 2016. The majority of this amount—about $519 million—came from the Texas MFCU, which prosecuted a large case involving a doctor and other codefendants who defrauded Medicaid and Medicare by improperly recruiting individuals and falsifying medical documents.

Exhibit 5 shows the amounts of criminal recoveries for FYs 2013 through 2017 in relation to the 5-year average.

Exhibit 5: In FY 2017, criminal recoveries increased above the average for FYs 2013–2017.



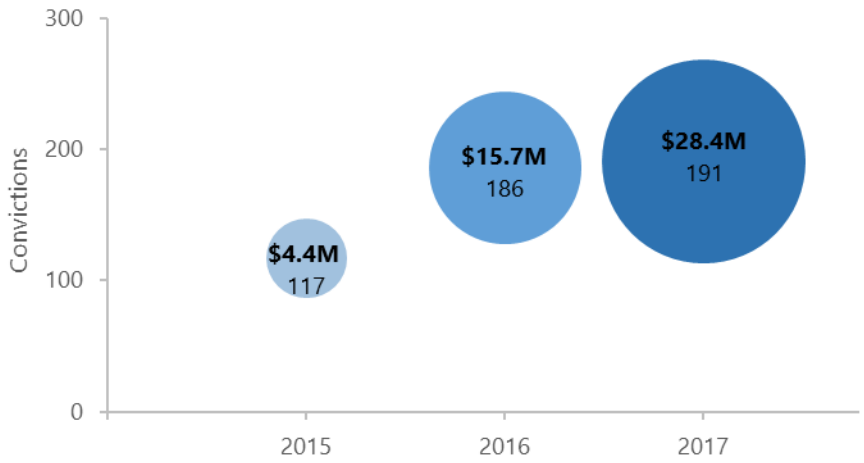
Source: OIG analysis of Quarterly Statistical Reports for FYs 2013–2014 and Annual Statistical Reports for FYs 2015–2017.

Appendix C shows the number of convictions and recovery amounts for criminal cases, by provider type. Appendix C also provides a variety of other statistics about MFCU caseloads and outcomes, by provider type.

Recoveries from drug diversion cases increased in FY 2017

In FY 2017, recoveries from drug diversion cases increased considerably, from $15.7 million to $28.4 million. Exhibit 6 shows the number of convictions and recovery amounts associated with drug diversion cases during FYs 2015 through 2017.

Exhibit 6: In FY 2017, drug diversion recoveries and convictions continued to increase.



Source: OIG analysis of FYs 2015–2017 Annual Statistical Reports. Data available only since 2015.

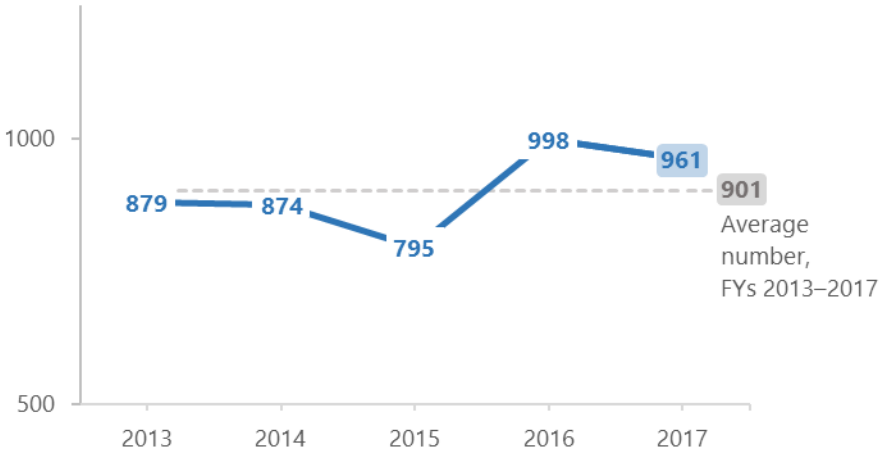
Drug diversion cases involve investigating fraudulent billing of Medicaid for drugs diverted from legal and medically necessary uses. MFCUs may conduct drug diversion investigations jointly with other State or Federal agencies, such as OIG or the U.S. Drug Enforcement Administration.

In FY 2017, a single case in New York was responsible for $25.2 million of the $28.4 million in drug diversion recoveries. This case involved a pharmacist who illegally purchased HIV drugs from patients and then resold them at the full Medicaid reimbursement amount. Another pharmacist knowingly purchased these diverted drugs and dispensed them to thousands of patients, including many Medicaid beneficiaries. Both pharmacists received prison sentences and were ordered to pay restitution.[15]

The number of civil settlements and judgments declined slightly in 2017

In FY 2017, MFCUs were responsible for 961 civil settlements and judgments, slightly less than the number for FY 2016. Exhibit 7 shows the numbers of civil settlements and judgments for FYs 2013 through 2017 in relation to the 5-year average.

Exhibit 7: Civil settlements and judgments in FY 2017 were higher than the average for FYs 2013–2017.



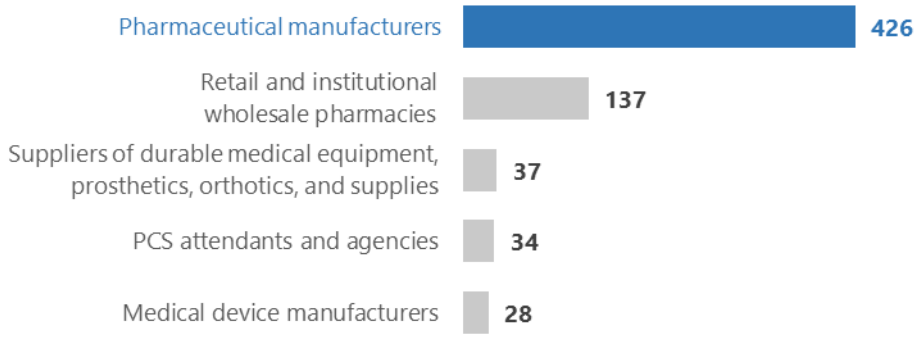
Source: OIG analysis of Quarterly Statistical Reports for FYs 2013–2014 and Annual Statistical Reports for FYs 2015–2017.

Significantly more civil settlements and judgments involved pharmaceutical manufacturers than any other provider type in FY 2017

Of the 961 civil settlements and judgements in FY 2017, 426 (44 percent) involved pharmaceutical manufacturers. In one example, a pharmaceutical manufacturer entered into a settlement for knowingly misclassifying its drug as a generic drug to avoid paying rebates owed to Medicaid, in violation of the Federal False Claims Act. This pharmaceutical manufacturer entered into a $465 million settlement and a Corporate Integrity Agreement with OIG that requires an annual review of the company's practices related to the Medicaid drug rebate program.[16]

On the next page, Exhibit 8 shows the provider types with the most civil settlements and judgments in FY 2017.

Exhibit 8: Civil settlements and judgments of pharmaceutical manufacturers was significantly higher than for any other provider type in FY 2017.

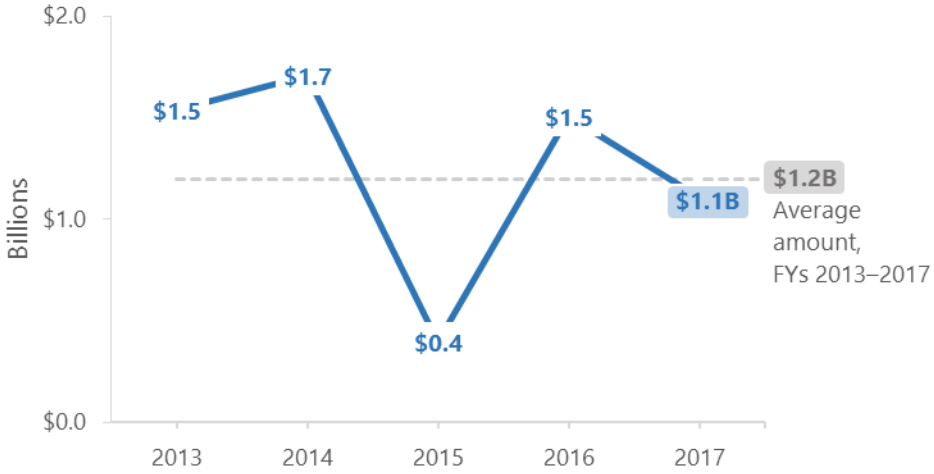


Source: OIG analysis of FY 2017 Annual Statistical Reports.

Civil recoveries declined in 2017

Civil recoveries decreased to $1.1 billion in FY 2017 from $1.5 billion in FY 2016. Exhibit 9 shows the amounts of civil recoveries for FYs 2013 through 2017 in relation to the 5-year average. The occurrence of large monetary settlements in certain years and the timing of these settlements (e.g., just before or after the end of the annual reporting period) contributes to this variability.

Exhibit 9: In FY 2017, civil recoveries decreased to slightly below the average for FYs 2013–2017.
Large monetary settlements contribute to the variability.



Source: OIG analysis of Quarterly Statistical Reports for FYs 2013–2014 and Annual Statistical Reports for FYs 2015–2017.

Of the $1.1 billion in civil recoveries in FY 2017, $765 million (69 percent) derive from "nonglobal" cases (see sidebar).[17] The remaining $343 million (31 percent) derive from "global" cases.[18]

Two 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 (NAMFCU).

A **nonglobal** case is conducted by a Unit individually or with other law enforcement partners, and is not coordinated by the NAMFCU.

The majority of nonglobal recoveries—more than $513 million—came from the Georgia MFCU's settlement with a large health care corporation regarding allegations that the corporation had paid kickbacks to an obstetric clinic in return for referrals of patients to the corporation's hospitals, which billed both Medicaid and Medicare.

Appendix C shows the number of settlements and judgments and recovery amounts for civil cases, by provider type.

APPENDIX A: OIG Priority Outcome to Maximize MFCU Effectiveness

It is a top OIG priority to strengthen the effectiveness of Medicaid Fraud Control Units (MFCUs) as key partners in combating fraud and abuse. As part of its oversight, OIG constantly strives to support the MFCUs in ways that maximize their effectiveness. Over the past year, the OIG has engaged in numerous actions to help drive MFCU effectiveness. These include activities in five categories: (1) enhancing OIG oversight, (2) increasing the use of data, (3) expanding the MFCU program to better align with a growing and evolving Medicaid program, (4) targeting MFCU training where it can be of greatest assistance to MFCUs, and (5) increasing collaboration between MFCUs and OIG.

To assess the impact of these efforts, the OIG has established two key performance indicators: (1) indictment rate and (2) conviction rate. The table below shows these rates for FYs 2015–2017 and the targets that OIG aims to achieve in FYs 2018–2019.

KEY PERFORMANCE INDICATORS	FY 2015 (ACTUAL)	FY 2016 (ACTUAL)	FY 2017 (ACTUAL)	FY 2018 TARGET	FY 2019 TARGET
Indictment rate	17.8%	17.2%	18.4%	18.5%	19.0%
Conviction rate	91.2%	89.7%	88.6%	91.0%	91.0%

Calculations:

Indictment rate = Total number of criminal cases with indictments or charges
plus number of nonglobal civil cases open, filed, or referred for filing
divided by
total number of open cases.

Conviction rate = Total number of criminal cases resulting in a defendant convicted
divided by
total number of cases resulting in a defendant acquitted, dismissed, or convicted.

To calculate these measures, OIG aggregates data submitted by Units through Annual Statistical Reports. The data used in calculating the measures can be accessed on the MFCU section of the OIG website.

APPENDIX B: Beneficial Practices From OIG Onsite Reports Published in FYs 2012–2017

This appendix summarizes MFCU practices that OIG highlighted in prior reports as beneficial to Unit operations. Other Units should consider whether adopting similar practices in their States may yield additional benefits.

All prior OIG reports on MFCUs are available at https://oig.hhs.gov/reports-and-publications/oei/m.asp#mfcu.

STATE REPORT NUMBER	PRACTICE CATEGORY	DESCRIPTION
Alaska OEI-09-16-00430	Successful partnerships	Unit stakeholders reported that the MFCU director made efforts to improve communication with agencies such as OIG and the State Medicaid agency. As a result, the number of joint OIG-MFCU cases tripled from FY 2012 to FY 2015.
	Successful partnerships and program integrity improvements	Unit collaboration with Federal and State partners to investigate allegations of PCS fraud led to convictions and significant monetary recoveries. Further, the Unit made program integrity recommendations to safeguard against PCS provider fraud, and the State Medicaid agency implemented these recommendations.
Arizona OEI-07-15-00280	Focus on managed care	MFCU staff attended quarterly meetings with the State Medicaid agency and managed care organizations (MCOs). These meetings provided guidance to MCOs about what constitutes a quality referral and the types of referrals that will result in the MFCU's opening a case for investigation.
Arkansas OEI-06-12-00720	Outreach activities	Outreach by the Unit built relationships with stakeholders and aided the Unit's mission. For example, Unit investigators led training for staff of the State Office of Long Term Care, about how to develop a potential referral to the MFCU.

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Beneficial Practices From OIG Onsite Reports Published in FYs 2012–2017 (continued)

STATE REPORT NUMBER	PRACTICE CATEGORY	DESCRIPTION
California OEI-09-15-00070	Focus on managed care	The Unit provided quarterly training for MCO representatives that resulted in increased fraud referrals from MCOs to the Unit.
	Outreach activities	The Unit hired a field representative to provide outreach and increase the number of fraud referrals sent to the Unit. The field representative acted as a liaison between the Unit and other State agencies and also trained staff from these agencies about Medicaid fraud and the Unit's role in combating provider fraud and patient abuse or neglect.
	Co-location of Unit and OIG staff	Unit investigators have workstations at an OIG field office, which facilitated the mutual referral of cases and improved communication and cooperation with OIG on joint cases.
Florida OEI-07-15-00340	Co-location of Unit and OIG staff	Unit staff have workstations in an OIG field office, which improved communication and cooperation with OIG on joint cases, including fraud cases generated through the U.S. Department of Justice's Medicare Strike Force.
Idaho OEI-09-12-00220	Case management tools	The Unit implemented an investigative checklist that improved the Unit's case flow. This Unit also used an investigative case plan for each case, which the case investigator discussed with Unit attorneys prior to monthly staff meetings.
Kentucky OEI-06-17-00030	Successful partnerships	The Unit regularly met with the State Medicaid agency, other State agencies, and MCOs to encourage fraud referrals and improve communication and collaboration. The results included improved quality, completeness, and timeliness of fraud referrals.
	Improved staff skills	The Unit created an executive advisor position. The executive advisor helped Unit attorneys develop litigation skills, mentored new attorneys, and served as a co-chair on Unit prosecutions.

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Beneficial Practices From OIG Onsite Reports Published in FYs 2012–2017 (continued)

STATE REPORT NUMBER	PRACTICE CATEGORY	DESCRIPTION
Maryland OEI-07-16-00140	Improved staff skills	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.
Massachusetts OEI-07-15-00390	Successful partnerships	The Unit developed partnerships with other State and Federal agencies and used clinical experts to facilitate the investigation and prosecution of drug diversion and other pharmacy cases.
	Case management tools	The Unit used its Intranet system to streamline its administrative processes, such as periodic supervisory case file reviews. The Unit found that this helped improve case management and the effectiveness of investigations and prosecutions.
Michigan OEI-09-13-00070	Co-location of Unit and OIG staff	The Unit made workspace available to an OIG agent within the Unit offices. Co-location facilitated communication between the MFCU and OIG in assessing potential fraud referrals and working joint cases.
	Case management tools	Unit management and the Michigan Department of Licensing and Regulatory Affairs (LARA) developed a streamlined process for referring cases of patient abuse or neglect. This process helped to ensure that referrals from LARA were consistent with the Unit's statutory functions, thereby promoting Unit efficiency and case flow.
Minnesota OEI-06-13-02000	Program integrity improvements	The Unit helped develop legislation to protect Medicaid beneficiaries by strengthening background checks for individuals who serve as guardians and conservators of adult Medicaid beneficiaries.

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Beneficial Practices From OIG Onsite Reports Published in FYs 2012–2017 (continued)

STATE REPORT NUMBER	PRACTICE CATEGORY	DESCRIPTION
Nevada OEI-09-12-00450	Outreach activities	The Unit's outreach program consisted of educational classes taught by Unit presenters who describe various types of fraud and abuse or neglect; discuss Federal and State laws regarding fraud and abuse or neglect; and provide Unit contact information for reporting Medicaid-related crime. The Unit's "Train the Trainer" program was instrumental in the success of the provider outreach program.
New Hampshire OEI-02-12-00180	Outreach activities	The Unit sent a letter to nursing facilities and assisted living facilities explaining drug diversion. This led to an increase in the number of drug diversion referrals from these types of facilities.
New Jersey OEI-02-13-00020	Case management tools	The Unit developed a document containing case tasks, deadlines, and descriptions of significant investigative and legal issues, which helped to facilitate case management.
New Mexico OEI-09-14-00240	Focus on managed care	Unit management and the State Medicaid agency worked closely to develop and implement an improved referral process that ensures that the Unit receives all appropriate fraud referrals generated by MCOs.
	Program integrity improvements	The Unit consistently provided program integrity recommendations to the State Medicaid agency during quarterly joint protocol meetings. One of these recommendations resulted in the inclusion of language into MCO contracts that clarified the State Medicaid agency role in referring all "verified" allegations of fraud, waste, or abuse in a managed care setting to the MFCU.

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Beneficial Practices From OIG Onsite Reports Published in FYs 2012–2017 (continued)

STATE REPORT NUMBER	PRACTICE CATEGORY	DESCRIPTION
New York OEI-02-11-00440	Focus on patient abuse or neglect	The Unit established a separate Patient Protection Unit. This resulted in the allocation of additional resources and expertise to cases of patient abuse or neglect.
	Successful partnerships	The Unit developed a list of individuals and entities associated with ongoing investigations and by sharing it with the State Office of the Medicaid Inspector General, facilitated communication.
	Use of technology	The Unit established an Electronic Investigative Support Group composed of staff dedicated to providing technical expertise as needed throughout cases. For example, the group provided data analysis and tools for conducting undercover surveillance activities, which helped to improve the efficiency of investigations.
North Carolina OEI-07-16-00070	Improved staff skills	The Unit partnered with another State agency to create the North Carolina Financial Investigators Academy. The academy provided instruction to financial investigators on topics such as elements of criminal law; search and seizure procedures; interviewing; and testifying. The Unit required all of its newly hired financial investigators to attend the academy, regardless of previous experience.
Ohio OEI-07-14-00290	Successful partnerships	The Unit helped to establish the Ohio Program Integrity Group, which combines the knowledge and resources of all the State agencies that are responsible for Medicaid program integrity. In addition, the Unit spearheaded the Managed Care Program Integrity Group which meets quarterly.
	Use of technology	The Unit employed a special projects team to provide technical support to all of its investigative teams.
Oregon OEI-09-16-00200	Outreach activities	The Unit created a group that provided outreach to help increase referrals of patient abuse or neglect and facilitate Unit work in remote areas of the State. This group provided outreach about the Unit's mission and legal authorities by establishing Unit liaisons for each county in Oregon and attending multidisciplinary team meetings at the county level.

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Beneficial Practices From OIG Onsite Reports Published in FYs 2012–2017 (continued)

STATE REPORT NUMBER	PRACTICE CATEGORY	DESCRIPTION
South Dakota OEI-07-16-00170	Outreach activities	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, which helped to highlight Medicaid billing issues and the implications of Medicaid fraud.
Tennessee OEI-06-12-00370	Successful partnerships	Unit staff and stakeholders formed relationships with partners through participation on task forces, such as the Provider Fraud Task Force and the Federal Health Care Fraud Task Force, which was key to the Unit's productivity.
Texas OEI-06-13-00300	Outreach activities	To help increase the number of referrals, the Unit instituted outreach to heighten public awareness of the Unit and its mission. The Unit required each investigator and investigative auditor to make 12 outreach contacts per year.
Utah OEI-09-13-00490	Improved staff skills	The Unit required all Unit auditors and investigators to become trained as Certified Fraud Examiners. This training helped the Unit improve the efficiency and effectiveness of its provider fraud investigations.
	Case management tools	The Unit used a spreadsheet to track investigator workloads, which helped the Unit ensure the timely completion of investigations. The spreadsheet tracked the number of cases assigned to each investigator, hours spent on each case, and case complexity. The information was also helpful in making decisions about assigning new cases to investigators.
	Focus on managed care	Unit management worked with the State Medicaid agency and MCOs to add provisions in MCO contracts to help ensure that MCOs send fraud referrals to the Unit.

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Beneficial Practices From OIG Onsite Reports Published in FYs 2012–2017 (continued)

STATE REPORT NUMBER	PRACTICE CATEGORY	DESCRIPTION
Vermont OEI-02-13-00360	Successful partnerships	The Unit director created Provider Focus Teams in collaboration with the State Medicaid agency. These teams facilitated existing cases, developed provider training, and made program recommendations. The Unit Director helped create the Vermont Elder Justice Working Group, which consisted of representatives from State and Federal advocacy groups, regulatory agencies, and law enforcement agencies. The group's mission was to improve health care for the elderly living in long-term care facilities by improving communication among stakeholders and law enforcement agencies.
Virginia OEI-07-15-00290	Successful partnerships	The Unit's partnerships with the Food and Drug Administration, the Internal Revenue Service, and the Social Security Administration led to successful Medicaid fraud prosecutions, particularly with regard to pharmaceutical manufacturers, and increased Unit recoveries.
	Use of technology	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 ability to process and track evidence collected during investigations and to share that evidence with Federal and State partners working on joint cases.
Washington OEI-09-16-00010	Focus on managed care	The Unit worked with the State Medicaid agency to revise both the MOU between the Unit and the agency and the agency's contracts with MCOs to ensure that the Unit received copies of all MCO fraud referrals.
	Program integrity improvements	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 From OIG Onsite Reports Published in FYs 2012–2017 (continued)

STATE REPORT NUMBER	PRACTICE CATEGORY	DESCRIPTION
West Virginia OEI-07-13-00080	Improved staff skills	Unit staff learned new skills and obtained certifications as Certified Fraud Examiners and Certified Coding Professionals.
	Focus on managed care	The Unit focused on managed care by holding meetings with MCO administrators to obtain referrals.
Wyoming OEI-09-16-00530	Improved staff skills	The Unit used a MFCU investigator from a neighboring State to help train its newly hired investigator. As part of the training, the investigator from the neighboring State observed work on active Medicaid fraud cases and met with the new investigator, Unit management, and attorneys to discuss progress. This was a cost-effective training option for the Unit and furthered a positive working relationship with the neighboring MFCU.

APPENDIX C: FY 2017 MFCU Case Outcomes and Open Investigations by Provider Type and Case Type

Exhibit C1: 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	13	$157,249	1	$8,450
Developmental Disability Facility	3	$2,903	0	$0
Hospice	0	$0	0	$0
Nondirect Care Staff	32	$369,413	0	$0
Nurse Aide (CNA or Other)	112	$72,077	3	$6,190
Nursing Facilities	8	$7,453	10	$368,203
Nurse (LPN, RN, NP) or Physician Assistant	76	$47,623	0	$0
Personal Care Aide or Other Home Care Aide	59	$128,878	1	$2,000
Other	68	$12,437,547	1	$7,355
Fraud—Facility-Based Medicaid Providers and Programs—Inpatient and/or Residential				
Assisted Living Facility	9	$123,880	14	$962,541
Developmental Disability Facility (Residential)	0	$0	2	$73,095
Hospice	2	$7,361,559	1	$30,229
Hospital	4	$4,727,897	15	$570,937,362
Inpatient Psychiatric Services for Individuals Under Age 21	0	$0	0	$0
Nursing Facility	10	$179,507	11	$1,244,577
Other Inpatient Mental Health Facility	0	$0	3	$749,986
Other Long-Term Care Facility	1	$85,879	0	$0

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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	2	$13,754	6	$8,823
Ambulatory Surgical Center	0	$0	1	$25,836
Developmental Disability Facility (Nonresidential)	1	$500	4	$270,222
Dialysis Center	0	$0	0	$0
Mental Health Facility (Nonresidential)	25	$11,376,668	7	$7,286,193
Substance Abuse Treatment Center	24	$1,187,813	4	$1,785,759
Other Facility (Nonresidential)	8	$109,752	7	$6,824,645
Fraud—Licensed Practitioners				
Audiologist	1	$800	1	$30,000
Chiropractor	1	$3,113	2	$250,533
Clinical Social Worker	10	$2,402,458	4	$175,648
Dental Hygienist	1	$0	0	$0
Dentist	10	$1,960,914	25	$16,195,746
Nurse (LPN, RN, or Other Licensed)	87	$8,073,391	5	$16,994
Nurse Practitioner	0	$0	1	$230,000
Optometrist	0	$0	0	$0
Pharmacist	10	$5,330,942	6	$12,242,387
Physician Assistant	1	$0	0	$0
Podiatrist	5	$5,117,606	0	$0
Psychologist	13	$2,745,128	3	$166,817
Therapist (Non-Mental Health, PT, ST, OT, RT)	5	$88,705	3	$453,656
Other Practitioner	48	$8,976,725	9	$1,472,028
Fraud—Medical Services				
Ambulance	13	$5,521,817	4	$2,693,171
Billing Services	4	$3,073,411	7	$6,227,021

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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	54	$62,468,019	12	$7,391,059
Lab (Clinical)	8	$3,396,067	8	$6,268,310
Lab (Radiology and Physiology)	4	$2,046,870	2	$6,750,480
Lab (Other)	0	$0	3	$84,576
Medical Device Manufacturer	0	$0	28	$6,134,391
Pain Management Clinic	2	$1,494,699	4	$21,106,889
Personal Care Services Agency	49	$2,772,302	14	$3,564,307
Pharmaceutical Manufacturer	0	$0	426	$289,740,635
Pharmacy (Hospital)	0	$0	0	$0
Pharmacy (Institutional Wholesale)	1	$567	67	$27,809,268
Pharmacy (Retail)	12	$34,712,565	70	$31,737,553
Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)	21	$28,333,624	37	$2,284,941
Transportation (Nonemergency)	18	$4,814,919	6	$850,747
Other	17	$1,142,751	21	$6,537,870
Fraud—Other Individual Providers				
Emergency Medical Technician or Paramedic	0	$0	0	$0
Nurse's Aide (CNA or Other)	24	$42,175	0	$0
Optician	1	$0	1	$25,000
Personal Care Services Attendant	474	$5,797,716	20	$219,082
Pharmacy Technician	5	$609,301	0	$0
Unlicensed Counselor (Mental Health)	22	$3,937,398	1	$3,525
Unlicensed Therapist (Non-Mental Health)	5	$124,380	0	$0
Other	58	$5,982,816	5	$99,613
Fraud—Physicians (MD/DO) by Medical Specialty				
Allergist/Immunologist	0	$0	3	$931,554
Cardiologist	4	$108,003,909	2	$131,370

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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 (MD/DO) by Medical Specialty (continued)				
Emergency Medicine	0	$0	0	$0
Family Practice	36	$333,734,767	7	$1,546,877
Geriatrician	0	$0	1	$31,435
Internal Medicine	7	$466,045	9	$5,397,157
Neurologist	1	$0	1	$16,989
Obstetrician/Gynecologist	1	$0	2	$1,152,623
Ophthalmologist	1	$2,519,945	1	$49,255
Pediatrician	3	$238,968	4	$403,554
Physical Medicine and Rehabilitation	4	$148,716	0	$0
Psychiatrist	2	$50,079	4	$704,061
Radiologist	0	$0	3	$3,056,677
Surgeon	0	$0	0	$0
Urologist	0	$0	0	$0
Other MD/DO	14	$8,006,716	17	$4,485,956
Fraud—Program Related				
Managed Care Organization (MCO)	0	$0	2	$31,777,258
Medicaid Program Administration	6	$760,957	5	$8,174,986
Other	8	$80,689	14	$8,740,722
Total	**1,528**	**$693,372,320**	**961**	**$1,107,954,185**

Exhibit C2: Number of open investigations at the end of FY 2017 by provider type and case type

PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Patient Abuse or Neglect			
Assisted Living Facility	167	2	169
Developmental Disability Facility	120	1	121
Hospice	7	5	12
Nondirect Care Staff	171	1	172
Nurse Aide (CNA or Other)	521	0	521
Nursing Facilities	867	75	942
Nurse (RN, LPN, NP) or Physician Assistant	548	0	548
Personal Care Aide or Other Home Care Aide	294	0	294
Other	623	2	625
Fraud—Facility-Based Medicaid Providers and Programs—Inpatient and/or Residential			
Assisted Living Facility	38	11	49
Developmental Disability Facility (Residential)	36	5	41
Hospice	69	54	123
Hospital	117	215	332
Inpatient Psychiatric Services for Individuals Under Age 21	17	6	23
Nursing Facility	119	236	355
Other Inpatient Mental Health Facility	23	38	61
Other Long-Term Care Facility	16	8	24
Fraud—Facility-Based Medicaid Providers and Programs—Outpatient and/or Day Services			
Adult Day Center	77	8	85
Ambulatory Surgical Center	0	11	11
Developmental Disability Facility (Nonresidential)	21	9	30
Dialysis Center	1	49	50
Mental Health Facility (Nonresidential)	218	46	264
Substance Abuse Treatment Center	96	33	129
Other Facility (Nonresidential)	105	52	157

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Number of open investigations at the end of FY 2017 by provider type and case type (continued)

PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Fraud—Licensed Practitioners			
Audiologist	6	3	9
Chiropractor	23	7	30
Clinical Social Worker	95	4	99
Dental Hygienist	4	2	6
Dentist	357	80	437
Nurse (LPN, RN, or Other Licensed)	406	9	415
Nurse Practitioner	63	1	64
Optometrist	25	6	31
Pharmacist	51	36	87
Physician Assistant	31	0	31
Podiatrist	21	5	26
Psychologist	83	6	89
Therapist (Non-Mental Health, PT, ST, OT, RT)	93	30	123
Other Practitioner	152	19	171
Fraud—Medical Services			
Ambulance	106	19	125
Billing Services	36	24	60
Home Health Agency	635	78	713
Lab (Clinical)	59	411	470
Lab (Radiology and Physiology)	10	30	40
Lab (Other)	18	120	138
Medical Device Manufacturer	2	563	565
Pain Management Clinic	58	13	71
Personal Care Services Agency	266	17	283
Pharmaceutical Manufacturer	148	3,226	3,374
Pharmacy (Hospital)	0	4	4
Pharmacy (Institutional Wholesale)	15	238	253
Pharmacy (Retail)	179	577	756
Transportation (Nonemergency)	196	13	209
Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	191	499	690

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Number of open investigations at the end of FY 2017 by provider type and case type (continued)

PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Fraud—Medical Services			
Other	115	176	291
Fraud—Other Individual Providers			
Emergency Medical Technician or Paramedic	2	0	2
Nurse Aide (CNA or Other)	59	1	60
Optician	2	5	7
Personal Care Services Attendant	1,855	13	1,868
Pharmacy Technician	10	0	10
Unlicensed Counselor (Mental Health)	109	6	115
Unlicensed Therapist (Non-Mental Health)	8	0	8
Other	257	38	295
Fraud—Physicians (MD/DO) by Medical Specialty			
Allergist/Immunologist	8	3	11
Cardiologist	22	18	40
Emergency Medicine	11	8	19
Family Practice	279	16	295
Geriatrician	5	0	5
Internal Medicine	172	16	188
Neurologist	32	2	34
Obstetrician/Gynecologist	29	6	35
Ophthalmologist	12	8	20
Pediatrician	29	4	33
Physical Medicine and Rehabilitation	26	8	34
Psychiatrist	87	8	95
Radiologist	8	6	14
Surgeon	37	6	43
Urologist	4	1	5
Other MD/DO	283	75	358

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Number of open investigations at the end of FY 2017 by provider type and case type (continued)

PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Fraud—Program Related			
Managed Care Organization (MCO)	14	86	100
Medicaid Program Administration	15	14	29
Other	67	125	192
TOTAL	11,157	7,556	18,713

ENDNOTES

[1] 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. Unit investigations of patient abuse and neglect are limited to incidents occurring in: (1) health care facilities that receive Medicaid payments, or (2) board and care facilities, which are residential settings that receive payment on behalf of two or more unrelated adults who reside in the facility and for whom nursing care services or a substantial amount of personal care services are provided. SSA § 1903(q)(4).
[2] SSA § 1902(a)(61).
[3] North Dakota and the territories of American Samoa, Guam, the Northern Marianas Islands, Puerto Rico, and the U.S. Virgin Islands have not established Units.
[4] SSA § 1903(a)(6). Units receive 90 percent Federal reimbursement for their first 3 years of operation.
[5] OIG analysis of FY 2017 MFCU Annual Statistical Reports.
[6] SSA § 1903(q)(2); 42 CFR § 1007.9(a).
[7] SSA § 1903(q)(6); 42 CFR § 1007.13.
[8] 42 CFR § 1007.9(d).
[9] SSA § 1903(q)(1).
[10] 42 CFR § 1007.20. To conduct data mining, MFCUs must receive preapproval from OIG.
[11] SSA § 1128(a), 42 USC § 1320a-7. See also *OIG Exclusions Background Information*. Accessed at http://oig.hhs.gov/exclusions/background.asp on March 13, 2018.
[12] SSA § 1903(a)(6), (q). The SSA authorizes the Secretary of HHS to award grants to the Units; the Secretary delegated this authority to the OIG.
[13] 42 CFR § 1007.15.
[14] MFCU performance standards are published at 77 Fed. Reg. 32645 (June 1, 2012).
[15] New York Attorney General's Press Office, *A.G. Schneiderman Announces Sentencing of Long Island Pharmacist of up to 24 Years in Prison For Selling Black-Market HIV Medications*. Accessed at https://ag.ny.gov/press-release/ag-schneiderman-announces-sentencing-long-island-pharmacist-24-years-prison-selling on February 26, 2018.
[16] District of Massachusetts U.S. Attorney's Office, *Mylan Agrees to Pay $465 Million to Resolve False Claims Act Liability*. Accessed at https://www.justice.gov/usao-ma/pr/mylan-agrees-pay-465-million-resolve-false-claims-act-liability on March 12, 2018.
[17] To calculate the return on investment (ROI) for MFCUs, we first calculated the total recoveries by adding the $693 million in criminal case recoveries to $1.1 billion in civil case recoveries. We then divided the $1.8 billion in total recoveries by the total MFCU grant expenditures of $276 million, resulting in the overall ROI of $6.52.
[18] To calculate the percentages for civil global and nonglobal recoveries, we used the total civil recoveries of $1,108 million.

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