U.S. Department of Health and Human Services

Office of Inspector General

Medicaid Fraud Control Units Fiscal Year 2018 Annual Report

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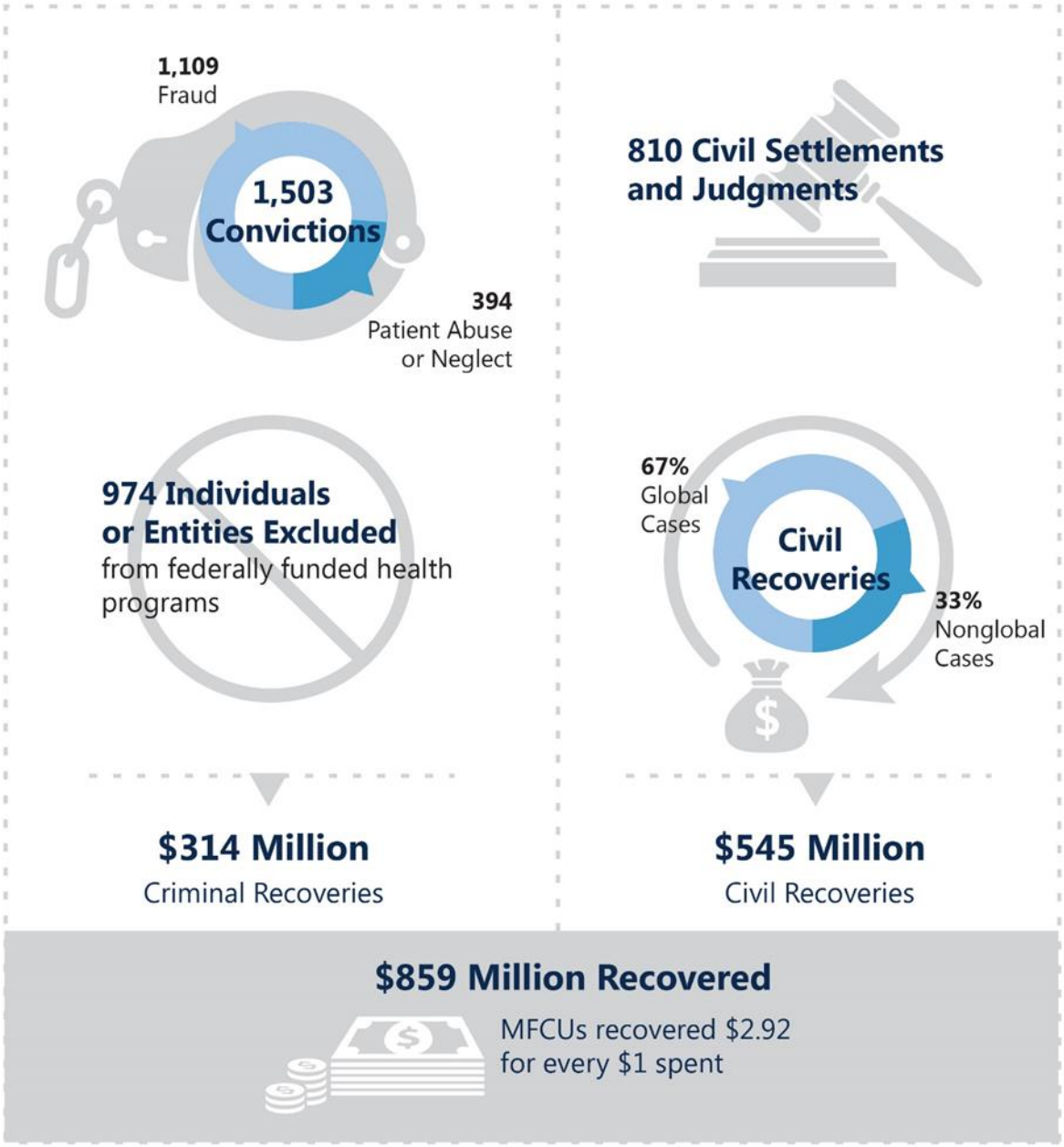
At a Glance

Medicaid Fraud Control Units Fiscal Year 2018 Annual Report



Medicaid Fraud Control Units (MFCUs or Units) investigate and prosecute Medicaid provider fraud and patient abuse or neglect. In 2018, Units operated 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 2018.

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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] Forty-nine States and the District of Columbia (States) operated MFCUs in fiscal year (FY) 2018. In December 2018, OIG certified two additional MFCUs in the territories of Puerto Rico and the U.S. Virgin Islands.[3]

MFCUs are funded jointly by Federal and State Governments. Each of the 50 MFCUs that was operating in FY 2018 received Federal reimbursement equivalent to 75 percent of its total expenditures, with State funds contributing the remaining 25 percent.[4] In FY 2018, combined Federal and State expenditures for the Units totaled approximately $294 million, of which $221 million 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 (MOU), 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 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.[11] In addition to achieving these case outcomes, 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

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 onsite reviews of Units, providing technical assistance to Units, and maintaining key statistical data about Unit caseloads and outcomes. 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 reviews each Unit's application for recertification; approval of this application is necessary for the Unit to receive Federal reimbursement.[12] 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.[13]

OIG conducts periodic onsite reviews of Units. These reviews allow OIG to evaluate a Unit's outcomes; operations; compliance with Federal laws, regulations, and policies; and adherence to 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 has 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 numbers 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 2018 Annual Statistical Reports that all 50 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 2018 and for each of the preceding 4 years—FYs 2014 through 2017. These outcomes include convictions; civil settlements and judgments; and recoveries. For each of these outcomes, we calculated an average across the 5-year period of FYs 2014 through 2018. We also calculated the return on investment (ROI) for MFCUs.[14] Additionally, we identified the provider types with the highest numbers of criminal and civil outcomes in FY 2018 and the numbers of exclusions that OIG imposed in FY 2018 on individuals and entities as a result of conviction referrals from MFCUs. We analyzed MFCU drug diversion cases, using data for FYs 2015 through 2018.

Standards

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. However, they are subject to the same internal quality controls as other OIG evaluations, including internal peer review.

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

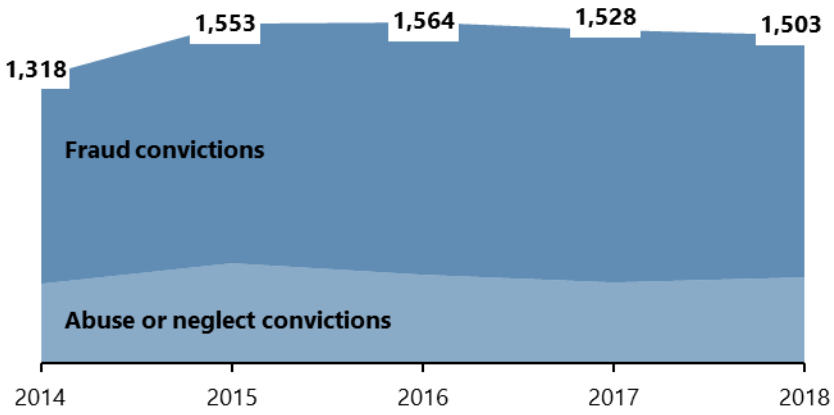
CASE OUTCOMES

The number of convictions remained similar to those in recent years

In FY 2018, MFCU cases resulted in 1,503 convictions, similar to the numbers of convictions in other recent years. This total included 1,109 convictions for fraud and 394 convictions for patient abuse or neglect. The distribution of both types of convictions—convictions of fraud, and convictions of abuse or neglect—remained similar to the distributions in previous years. Exhibit 2 shows the number of convictions for each of the last 5 years.

Exhibit 2: FY 2018 convictions remained similar to those from the past 3 years.

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



Source: OIG analysis of Quarterly Statistical Reports for FY 2014 and Annual Statistical Reports for FYs 2015–2018.

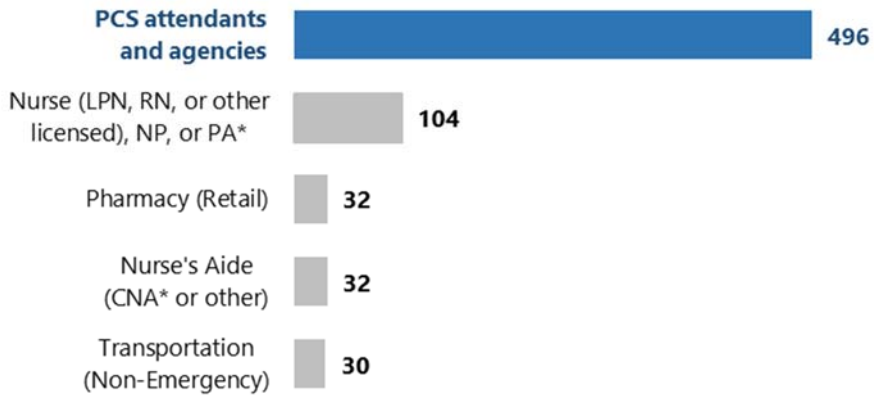
MFCU convictions led to the exclusion of individuals and entities from Federal health care programs, broadening the impact of those convictions. When MFCUs make referrals to OIG regarding convictions for fraud and patient abuse or neglect in their respective States, OIG has the authority to exclude those 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. On its website, OIG maintains the List of Excluded Individuals/Entities. In FY 2018, OIG excluded 974 individuals and entities from participating in Federal health care programs as a result of conviction referrals from MFCUs.

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

Of the 1,109 fraud convictions in FY 2018, 496 (45 percent) involved PCS attendants and agencies. For additional information on the prevalence of Medicaid fraud involving personal care services and efforts to combat such fraud, see OIG's December 2018 *Top Management and Performance Challenges Facing HHS* (p. 27).

Exhibit 3 shows the provider types with the most fraud convictions in FY 2018.

Exhibit 3: Convictions of PCS attendants and agencies for fraud were significantly higher than for any other provider type in FY 2018.

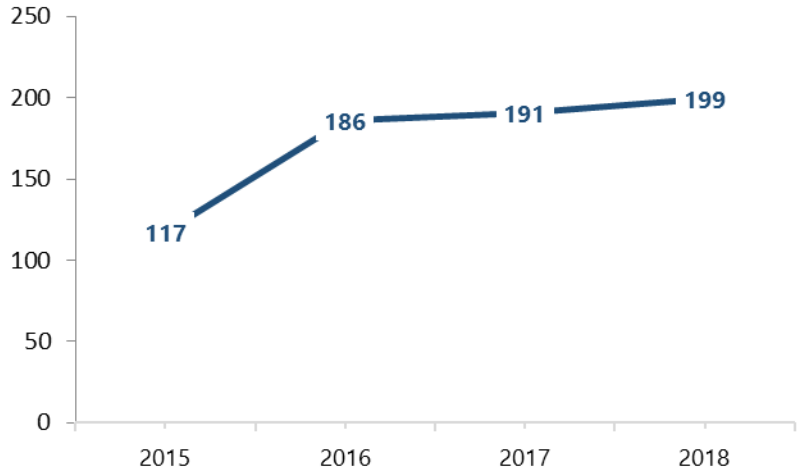


*LPN = Licensed Practical Nurse; RN = Registered Nurse; NP = Nurse Practitioner; PA = Physician Assistant; CNA = Certified Nurse Aide
Source: OIG analysis of FY 2018 Annual Statistical Reports.

Convictions from drug diversion cases continued to increase in FY 2018

Convictions from drug diversion cases increased from 191 in FY 2017 to 199 in FY 2018, with associated recoveries of $7.7 million in FY 2018. In a Medicaid context, drug diversion cases involve investigating the 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. On the next page, Exhibit 4 shows the number of convictions associated with drug diversion cases during FYs 2015 through 2018.

Exhibit 4: In FY 2018, convictions from drug diversion cases continued to increase.

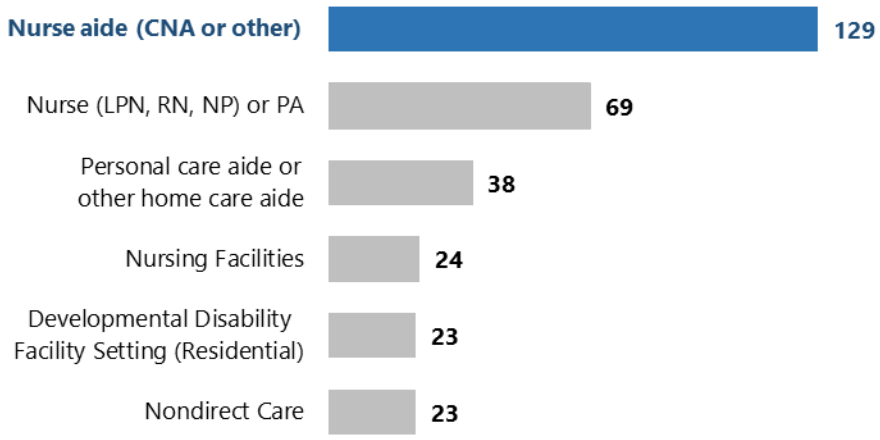


Source: OIG analysis of Annual Statistical Reports from FYs 2015-2017. Data available only since 2015.

In FY 2018, more convictions for patient abuse or neglect involved nurse aides than any other provider type

In FY 2018, nurse aides accounted for 129 of the total 394 convictions for patient abuse or neglect (33 percent). Exhibit 5 shows the provider types with the most convictions for patient abuse or neglect.

Exhibit 5: In FY 2018, convictions of nurse aides for patient abuse or neglect were significantly higher than for any other provider type.



Source: OIG analysis of FY 2018 Annual Statistical Reports.

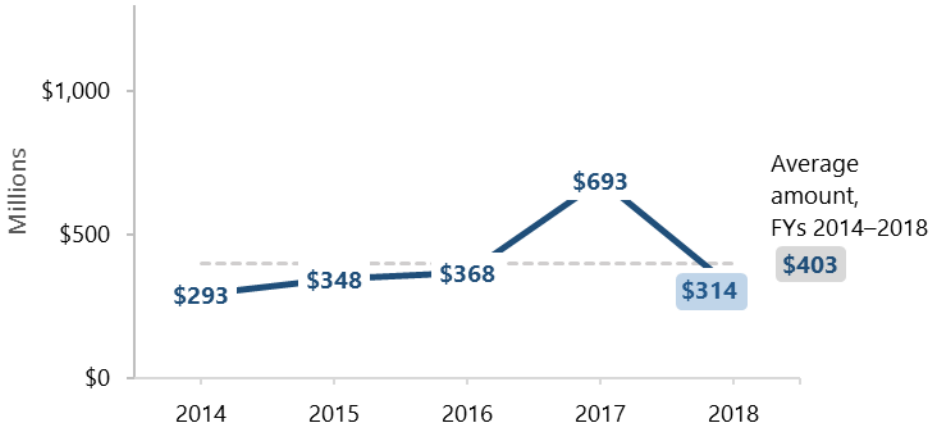
Appendix C shows—by provider type—the number of convictions and recovery amounts for cases of patient abuse or neglect.

Criminal recoveries returned to the same general level that existed prior to a spike last year

Criminal recoveries of $314 million in FY 2018 were less than half of the amount in FY 2017 but at the same general level as the amounts from FYs 2014 through 2016. As shown in Exhibit 6, criminal recovery amounts per year during the 5-year period of FYs 2014 through 2018 averaged over $400 million, whereas recoveries in FY 2017 were close to $700 million. The spike in the criminal recovery amount in FY 2017 was (in part) the result of a single large fraud case with a recovery amount totaling $268 million.[15]

In FY 2018, one case that resulted in significant criminal recoveries was prosecuted by the Florida Unit. The case involved two operators of a behavioral health clinic who were ordered to pay about $1.37 million in restitution. The two individuals participated in a conspiracy to commit health care fraud by not disclosing that one of them had been excluded from participating in Medicaid.[16]

Exhibit 6: In FY 2018, criminal recoveries decreased below the average for FYs 2014–2018.



Source: OIG analysis of Quarterly Statistical Reports for FY 2014 and Annual Statistical Reports for FYs 2015–2018.

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

The number of civil settlements and judgments declined for the second year in a row

In FY 2018, MFCUs were responsible for 810 civil settlements and judgments, which represents the second year of decline in a row and is slightly below the 5-year average. Exhibit 7 shows the number of civil settlements and judgments for FYs 2014 through 2018 in relation to the 5-year average.

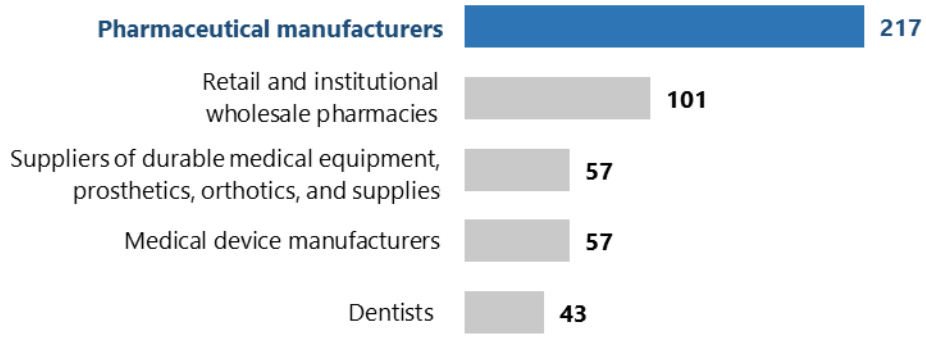
Exhibit 7: Civil settlements and judgments in FY 2018 were slightly less than the average for FYs 2014–2018.

Source: OIG analysis of Quarterly Statistical Reports for FY 2014 and Annual Statistical Reports for FYs 2015–2018.

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

Of the 810 civil settlements and judgments in FY 2018, 217 (27 percent) involved pharmaceutical manufacturers. Exhibit 8 shows the provider types with the most civil settlements and judgments in FY 2018.

Exhibit 8: In FY 2018, civil settlements and judgments for pharmaceutical manufacturers were significantly higher than for any other provider type.



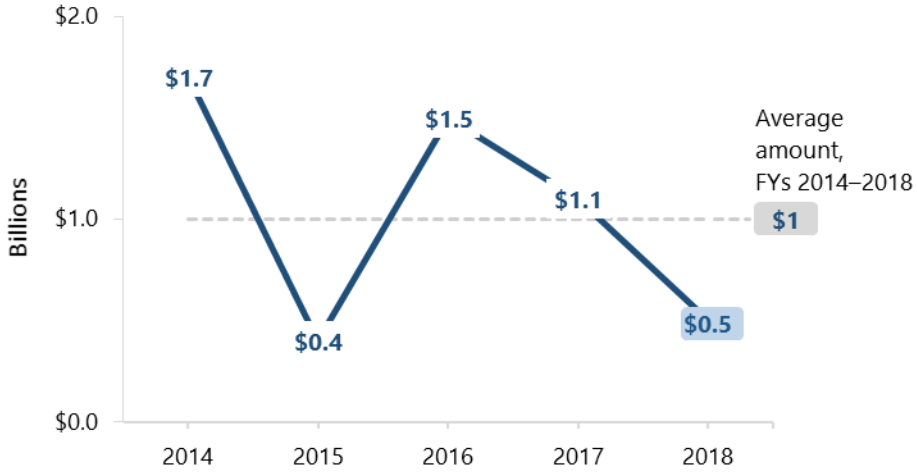
Source: OIG analysis of FY 2018 Annual Statistical Reports.

Civil recoveries declined for the second straight year

Civil recoveries decreased to $545 million in FY 2018, which represents a decrease from FYs 2016 and 2017. Exhibit 9 shows the amounts of civil recoveries for FYs 2014 through 2018 in relation to the 5-year average. The occurrence of large monetary settlements in certain years and the timing of these settlements contributes to this variability.

Exhibit 9: In FY 2018, civil recoveries decreased below the average for FYs 2014–2018.

Large monetary settlements contribute to the variability.



Source: OIG analysis of Quarterly Statistical Reports for FY 2014 and Annual Statistical Reports for FYs 2015–2018.

Of FY 2018's civil recoveries of $545 million, $367 million (67 percent) were derived from "global" cases.[17] (See sidebar.) The remaining $178 million (33 percent) derived from "nonglobal" cases.

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.

As the result of one global case, a dental management company and its affiliated dental clinics were ordered to pay the United States and participating States a total of $23.9 million. This was to resolve allegations that the company and its affiliated clinics had knowingly submitted false claims for payment to State Medicaid programs for medically unnecessary dental services performed on children insured by Medicaid.[18]

As a result of a nonglobal case that the Alaska Unit investigated, a health care agency that provides services to persons with intellectual or

developmental disabilities agreed to pay $2.3 million to resolve allegations that it billed for services not provided. As part of the settlement agreement, the provider was also required to enter into a 5-year Corporate Integrity Agreement with OIG to help prevent future instances of fraud or abuse.[19]

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

APPENDIX A: OIG Priority Outcome: Maximizing 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 few years, 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, OIG has established two key performance indicators: (1) indictment rate and (2) conviction rate. The table below shows these rates for FYs 2015–2018 and the target that OIG aims to achieve in FY 2019.[20]

KEY PERFORMANCE INDICATORS	FY 2015 (ACTUAL)	FY 2016 (ACTUAL)	FY 2017 (ACTUAL)	FY 2018 (ACTUAL)	FY 2019 TARGET	FY 2020 TARGET
Indictment rate	16.1%	16.0%	17.2%	16.4%	17.0%	17.2%
Conviction rate	91.2%	89.6%	88.6%	90.3%	90.7%	90.8%

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 that Units submit through Annual Statistical Reports.

APPENDIX B: Beneficial Practices Described in OIG Onsite Reports

This appendix summarizes MFCU practices that OIG—in its more recent onsite-review reports—has highlighted as being beneficial to Unit operations. Other Units should consider whether adopting similar practices in their States may yield similar benefits.

All of OIG's reports on its onsite reviews of 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 Described in OIG Onsite Reports (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 Described in OIG Onsite Reports (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 reviews of case files. 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 Described in OIG Onsite Reports (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 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 to the MFCU all "verified" allegations of fraud, waste, or abuse in a managed care setting.
New York OEI-12-17-00340	Strategic Plan	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.
	Successful partnerships	The Unit established data-analytics working groups to provide guidance, training, and 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.
	Improved staff skills	The Unit used moot-court training to train Unit attorneys. This training helped the Unit attorneys practice opening arguments to prepare for trial.

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Beneficial Practices Described in OIG Onsite Reports (continued)

STATE REPORT NUMBER	PRACTICE CATEGORY	DESCRIPTION
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.
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.
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.

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Beneficial Practices Described in OIG Onsite Reports (continued)

STATE REPORT NUMBER	PRACTICE CATEGORY	DESCRIPTION
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.
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.

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Beneficial Practices Described in OIG Onsite Reports (continued)

STATE REPORT NUMBER	PRACTICE CATEGORY	DESCRIPTION
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.
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 2018: 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	11	$104,691	0	$0
Developmental Disability Facility	23	$25,619	1	$5,960
Hospice	0	$0	0	$0
Nondirect Care Staff	23	$572,385	1	$83,000
Nurse Aide (CNA or Other)	129	$206,954	1	$4,500
Nursing Facilities	24	$68,168	21	$1,343,000
Nurse (LPN, RN, NP) or Physician Assistant	69	$50,815	0	$0
Personal Care Aide or Other Home Care Aide	38	$108,804	1	$20,000
Other	77	$1,241,449	2	$15,000
Fraud—Facility-Based Medicaid Providers and Programs—Inpatient and/or Residential				
Assisted Living Facility	5	$20,599	3	$116,508
Developmental Disability Facility (Residential)	1	$61,667	4	$830,000
Hospice	1	$23,925	1	$29,621
Hospital	8	$37,041,364	23	$12,102,234
Inpatient Psychiatric Services for Individuals Under Age 21	0	$0	1	$232,117
Nursing Facility	8	$12,301,622	15	$36,351,638
Other Inpatient Mental Health Facility	1	$77,106	0	$0
Other Long-Term Care Facility	1	$667,103	1	$82,233

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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	1	$24,962	3	$192,625
Ambulatory Surgical Center	0	$0	0	$0
Developmental Disability Facility (Nonresidential)	4	$136,703	3	$2,295,373
Dialysis Center	0	$0	2	$57,876
Mental Health Facility (Nonresidential)	20	$10,684,901	8	$13,178,517
Substance Abuse Treatment Center	14	$189,419	6	$5,236,675
Other Facility (Nonresidential)	10	$4,145,686	21	$4,870,292
Fraud—Licensed Practitioners				
Audiologist	3	$14,263,893	1	$51,546
Chiropractor	1	$1,960	5	$1,635,320
Clinical Social Worker	10	$4,124,692	6	$519,470
Dental Hygienist	0	$0	0	$0
Dentist	16	$11,303,329	43	$27,829,264
Nurse (LPN, RN, or Other Licensed)	88	$1,961,017	7	$331,336
Nurse Practitioner	11	$267,999	1	$4,457
Optometrist	1	$3,401	2	$87,447
Pharmacist	4	$3,184,775	0	$0
Physician Assistant	5	$2,929	0	$0
Podiatrist	1	$83,653	1	$80,677
Psychologist	15	$3,097,639	1	$126,760
Therapist (Non-Mental Health, PT, ST, OT, RT)	9	$776,174	3	$90,795
Other Practitioner	29	$1,275,871	4	$9,737,935
Fraud—Medical Services				
Ambulance	3	$866,500	4	$205,435
Billing Services	5	$2,674,345	2	$903,555

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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	27	$17,831,658	17	$25,867,737
Lab (Clinical)	0	$53,313	22	$5,646,144
Lab (Radiology and Physiology)	2	$25,310	1	$72,106
Lab (Other)	0	$0	11	$1,206,484
Medical Device Manufacturer	0	$0	57	$6,964,707
Pain Management Clinic	5	$13,640,377	0	$0
Personal Care Services Agency	36	$5,239,144	14	$777,787
Pharmaceutical Manufacturer	0	$0	217	$311,330,073
Pharmacy (Hospital)	0	$0	2	$309,555
Pharmacy (Institutional Wholesale)	2	$47,417	23	$4,560,858
Pharmacy (Retail)	32	$5,506,057	78	$32,425,607
Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)	22	$14,828,695	57	$5,235,133
Transportation (Nonemergency)	30	$1,279,772	14	$1,801,522
Other	8	$293,163	19	$1,285,221
Fraud—Other Individual Providers				
Emergency Medical Technician or Paramedic	0	$0	0	$0
Nurse's Aide (CNA or Other)	32	$222,997	1	$618,768
Optician	0	$0	0	$0
Personal Care Services Attendant	460	$5,415,614	16	$207,045
Pharmacy Technician	5	$9,629	0	$0
Unlicensed Counselor (Mental Health)	22	$2,950,522	2	$1,115,022
Unlicensed Therapist (Non-Mental Health)	4	$41,964	0	$0
Other	69	$2,611,250	5	$1,002,162
Fraud—Physicians (MD/DO) by Medical Specialty				
Allergist/Immunologist	0	$0	1	$128,695
Cardiologist	3	$16,158,755	3	$394,180

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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	7	$187,893
Family Practice	17	$36,088,772	3	$1,017,947
Geriatrician	0	$0	0	$0
Internal Medicine	9	$2,276,677	5	$1,586,744
Neurologist	4	$2,789,941	3	$644,145
Obstetrician/Gynecologist	0	$0	1	$33,544
Ophthalmologist	1	$607,348	0	$0
Pediatrician	3	$318,979	2	$1,161,188
Physical Medicine and Rehabilitation	2	$400,200	0	$0
Psychiatrist	0	$10,000	6	$820,176
Radiologist	0	$0	0	$0
Surgeon	4	$790,461	1	$26,114
Urologist	2	$182,747	1	$47,436
Other MD/DO	17	$71,568,097	17	$6,645,449
Fraud—Program Related				
Managed Care Organization (MCO)	2	$58,073	2	$12,036,324
Medicaid Program Administration	0	$0	0	$0
Other	14	$1,456,048	4	$1,020,345
Total	**1,503**	**$314,345,099**	**810**	**$544,827,273**

Exhibit C2: Number of open investigations at the end of FY 2018 by provider type and case type

PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Patient Abuse or Neglect			
Assisted Living Facility	221	2	223
Developmental Disability Facility	135	0	135
Hospice	8	0	8
Nondirect Care Staff	144	0	144
Nurse Aide (CNA or Other)	479	0	479
Nursing Facilities	1,071	61	1,132
Nurse (RN, LPN, NP) or Physician Assistant	433	2	435
Personal Care Aide or Other Home Care Aide	329	0	329
Other	692	3	695
Fraud—Facility-Based Medicaid Providers and Programs—Inpatient and/or Residential			
Assisted Living Facility	34	9	43
Developmental Disability Facility (Residential)	36	6	42
Hospice	78	42	120
Hospital	84	244	328
Inpatient Psychiatric Services for Individuals Under Age 21	16	12	28
Nursing Facility	118	211	329
Other Inpatient Mental Health Facility	21	40	61
Other Long-Term Care Facility	16	15	31
Fraud—Facility-Based Medicaid Providers and Programs—Outpatient and/or Day Services			
Adult Day Center	76	5	81
Ambulatory Surgical Center	1	8	9
Developmental Disability Facility (Nonresidential)	22	5	27
Dialysis Center	2	50	52
Mental Health Facility (Nonresidential)	245	39	284
Substance Abuse Treatment Center	112	36	148
Other Facility (Nonresidential)	91	43	134

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Number of open investigations at the end of FY 2018 by provider type and case type (continued)

PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Fraud—Licensed Practitioners			
Audiologist	3	1	4
Chiropractor	21	5	26
Clinical Social Worker	90	4	94
Dental Hygienist	5	2	7
Dentist	320	56	376
Nurse (LPN, RN, or Other Licensed)	528	4	532
Nurse Practitioner	69	1	70
Optometrist	21	4	25
Pharmacist	47	28	75
Physician Assistant	33	1	34
Podiatrist	20	8	28
Psychologist	94	6	100
Therapist (Non-Mental Health, PT, ST, OT, RT)	80	26	106
Other Practitioner	138	18	156
Fraud—Medical Services			
Ambulance	93	20	113
Billing Services	28	46	74
Home Health Agency	652	68	720
Lab (Clinical)	73	364	437
Lab (Radiology and Physiology)	12	27	39
Lab (Other)	34	130	164
Medical Device Manufacturer	1	584	585
Pain Management Clinic	55	18	73
Personal Care Services Agency	263	13	276
Pharmaceutical Manufacturer	150	3,046	3,196
Pharmacy (Hospital)	1	3	4
Pharmacy (Institutional Wholesale)	14	200	214
Pharmacy (Retail)	217	553	770
Transportation (Nonemergency)	207	10	217
Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	170	548	718

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Number of open investigations at the end of FY 2018 by provider type and case type (continued)

PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Fraud—Medical Services (continued)			
Other	85	208	293
Fraud—Other Individual Providers			
Emergency Medical Technician or Paramedic	2	0	2
Nurse Aide (CNA or Other)	54	0	54
Optician	3	4	7
Personal Care Services Attendant	1,810	11	1,821
Pharmacy Technician	13	0	13
Unlicensed Counselor (Mental Health)	96	7	103
Unlicensed Therapist (Non-Mental Health)	3	0	3
Other	359	34	393
Fraud—Physicians (MD/DO) by Medical Specialty			
Allergist/Immunologist	8	2	10
Cardiologist	18	16	34
Emergency Medicine	12	11	23
Family Practice	251	15	266
Geriatrician	2	0	2
Internal Medicine	167	20	187
Neurologist	37	2	39
Obstetrician/Gynecologist	26	8	34
Ophthalmologist	16	9	25
Pediatrician	50	3	53
Physical Medicine and Rehabilitation	26	14	40
Psychiatrist	85	8	93
Radiologist	7	6	13
Surgeon	24	6	30
Urologist	1	1	2
Other MD/DO	340	89	429

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Number of open investigations at the end of FY 2018 by provider type and case type (continued)

PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Fraud—Program Related			
Managed Care Organization (MCO)	16	53	69
Medicaid Program Administration	16	10	26
Other	72	119	191
TOTAL	**11,502**	**7,283**	**18,785**

ENDNOTES

[1] Social Security Act § 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] 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 this authority to OIG. Also see 42 CFR § 1007.15. North Dakota and the territories of American Samoa, Guam, and the Northern Marianas 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 2018 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 February 7, 2019.

[12] 42 CFR § 1007.15.

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

[14] To calculate the ROI for MFCUs, we first calculated the total recoveries by adding the $314 million in criminal case recoveries to $545 million in civil case recoveries. We then divided the $859 million in total recoveries by the total MFCU grant expenditures of $294 million, resulting in the overall ROI of $2.92.

[15] One large $268 million-dollar case was prosecuted in FY 2017 that accounted for about 39 percent of all criminal recoveries in FY 2017. This case came from the Texas MFCU, which prosecuted the case involving a doctor and other codefendants who defrauded Medicaid and Medicare by improperly recruiting individuals and falsifying medical documents.

[16] Middle District of Florida, U.S. Attorney's Office, *Two Behavioral Health Clinic Operators Sentenced To Prison In Healthcare Fraud Conspiracy*. Accessed at https://www.justice.gov/usao-mdfl/pr/two-behavioral-health-clinic-operators-sentenced-prison-health-care-fraud-conspiracy on February 7, 2019.

[17] To calculate the percentages for civil global and nonglobal recoveries, we used the total civil recoveries of $544,827,273 million.

[18] U.S. Department of Justice, *Dental Management Company Benevis and Its Affiliated Kool Smiles Dental Clinics to Pay $23.9 Million to Settle False Claims Act Allegations Relating to Medically Unnecessary Pediatric Dental Services.* Accessed at https://www.justice.gov/opa/pr/dental-management-company-benevis-and-its-affiliated-kool-smiles-dental-clinics-pay-239 on February 7, 2019.

[19] State of Alaska, Department of Law, *The ARC of Anchorage to Pay Nearly $2.3 Million Dollars to Settle Medicaid False Claims Act Allegations*. Accessed at http://law.alaska.gov/press/releases/2018/042418-MFCU.html on February 21, 2019.

[20] Since publication of *Medicaid Fraud Control Units Fiscal Year 2017 Annual Report*, we have amended the indictment rates for FYs 2015-2017 to reflect the most current data as revised by the Units.

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