U.S. Department of Health and Human Services

Office of Inspector General

Medicaid Fraud Control Units Fiscal Year 2019 Annual Report

Suzanne Murrin
Deputy Inspector General for Evaluation and Inspections
March 2020, OEI-09-20-00110

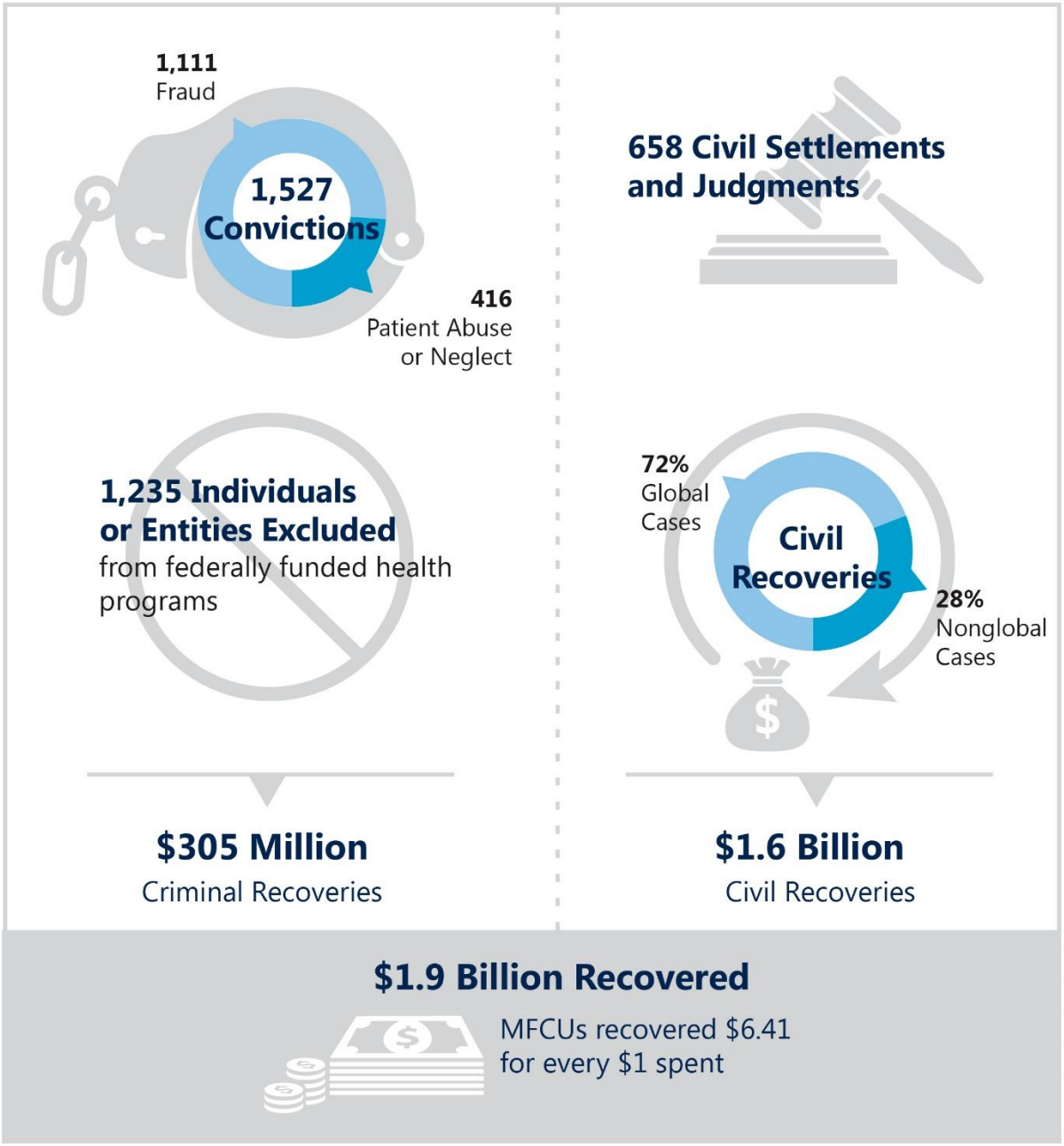
U.S. Department of Health and Human Services

Office of Inspector General

At a Glance

March 2020, OEI-09-20-00110

Medicaid Fraud Control Units Fiscal Year 2019 Annual Report



Medicaid Fraud Control Units (MFCUs or Units) 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 approves Federal funding for MFCUs through a recertification process. For this report, OIG analyzed the annual statistical data on case outcomes (such as convictions; civil settlements and judgments; and recoveries) that 52 MFCUs submitted to OIG for fiscal year 2019. Those MFCUs operated in 49 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

TABLE OF CONTENTS

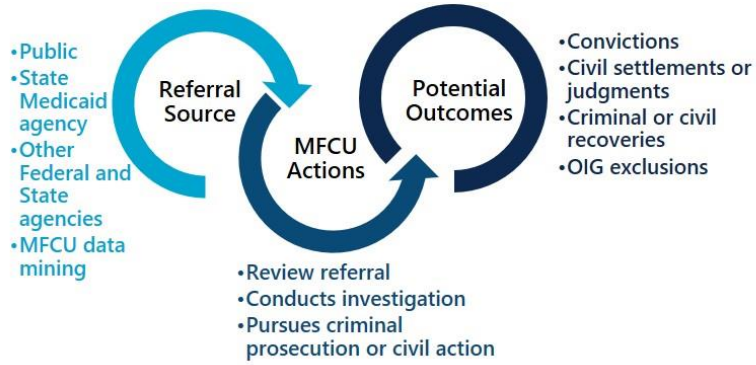
BACKGROUND

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 (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 beneficiaries from abuse or neglect.[2] In fiscal year (FY) 2019, 49 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operated MFCUs. The State of North Dakota was certified to operate a MFCU in FY 2020.[3, 4]

MFCUs are funded jointly by Federal and State Governments. Each Unit receives a Federal grant award equivalent to 90 percent of total expenditures for new Units and 75 percent for all other Units.[5] In FY 2019, combined Federal and State expenditures for the Units totaled approximately $302 million, of which $227 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 onsite reviews of Units, providing technical assistance to Units, and monitoring 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.[9] 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.[10]

OIG further assesses a Unit's performance by conducting onsite Unit reviews that may identify findings and make recommendations for improvement. During an onsite review, OIG also makes observations regarding Unit operations and practices, and may identify beneficial practices that may be useful to other Units. Finally, OIG provides training and technical assistance, as appropriate, to Units while onsite.

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. 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

We based the information in this report on the FY 2019 Annual Statistical Reports that 52 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 2019 and for each of the preceding 4 years—FYs 2015 through 2018. These outcomes include convictions; civil settlements and judgments; and recoveries. For convictions and recoveries, we calculated an average across the 5-year period of FYs 2015 through 2019. We also calculated the return on investment (ROI) for MFCUs.[11] We identified the provider types with the highest numbers of criminal and civil outcomes in FY 2019 and the numbers of exclusions that OIG imposed in FY 2019 on individuals and entities as a result of conviction referrals from MFCUs. We also analyzed MFCU drug diversion cases using data for FYs 2015 through 2019. In addition, we highlight the beneficial practices described in each Unit's more recent onsite review reports, as described in Appendix B.

Standards

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. 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 other OIG evaluations, including internal and external peer review.

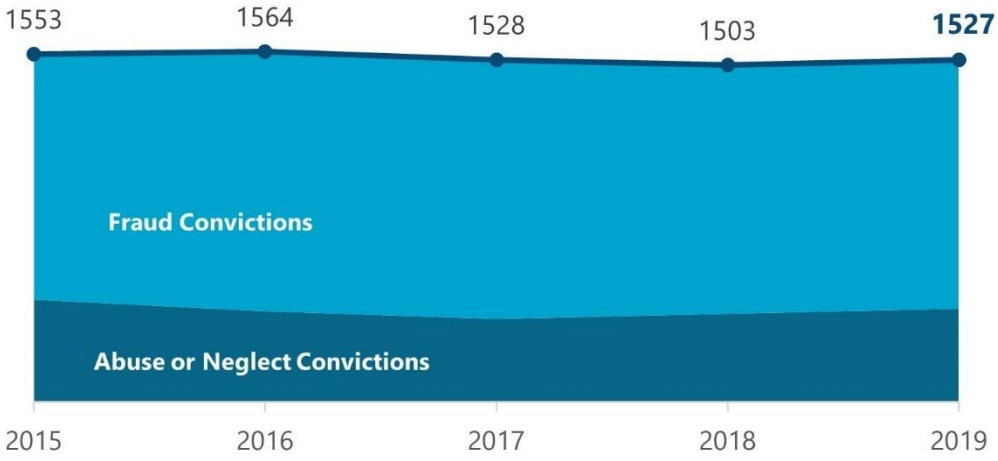
Case Outcomes

The total number of convictions in FY 2019 remained consistent with those of previous years

In FY 2019, MFCU cases resulted in 1,527 convictions, including 1,111 convictions for fraud and 416 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 (see Exhibit 2).

Exhibit 2: FY 2019 convictions remained similar to those from the past 4 years.

Fraud convictions accounted for 73 percent of all convictions in FY 2019.



Source: OIG analysis of Annual Statistical Reports for FYs 2015–2019.

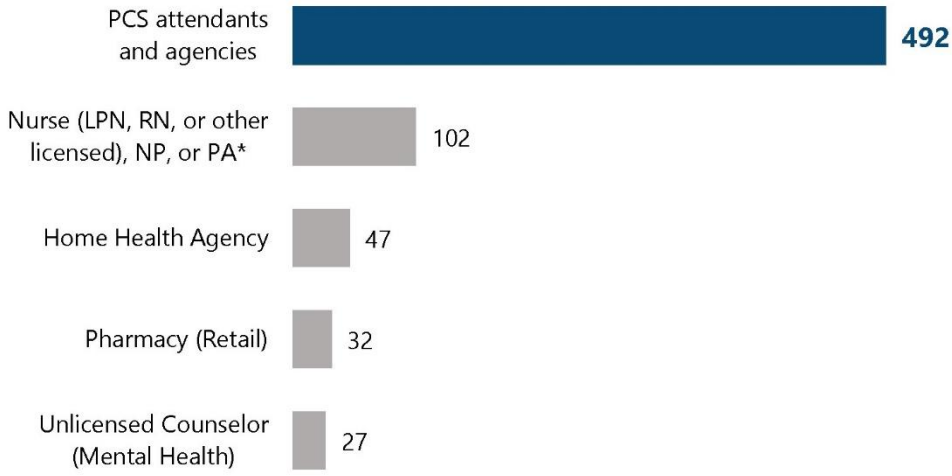
MFCU convictions led to the exclusion of individuals and entities from Federal health care programs, broadening the impact of those convictions. In FY 2019, OIG excluded 1,235 individuals and entities from participating in Federal health care programs as a result of conviction referrals from MFCUs. This is an increase from the 974 excluded as a result of conviction referrals from MFCUs in FY 2018. 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.[12]

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

Compared to other provider types, PCS attendants and agencies had the highest number of fraud convictions in FY 2019. Fraud convictions involving PCS attendants and agencies accounted for 492 of the total 1,111 fraud convictions (44 percent). Additional information on the prevalence of Medicaid fraud involving PCS and efforts to combat such fraud can be found in OIG's December 2019 *Top Management and Performance Challenges Facing HHS* (p.7).

Exhibit 3 shows the provider types with the most fraud convictions in FY 2019. See Appendix C for detailed statistics on the number of convictions and recovery amounts for criminal cases, as well as MFCU caseloads and outcomes by provider type.

Exhibit 3: Convictions of PCS attendants and agencies for fraud were significantly higher than for any other provider type in FY 2019.



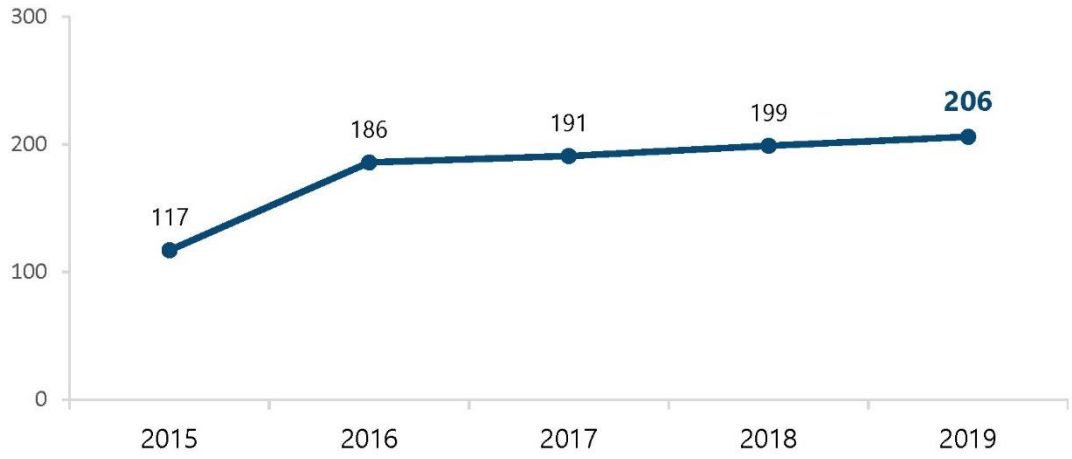
*LPN = Licensed Practical Nurse; RN = Registered Nurse; NP = Nurse Practitioner; PA = Physician Assistant

Source: OIG analysis of FY 2019 Annual Statistical Reports.

Convictions from drug diversion cases continued to increase in FY 2019

Convictions from drug diversion cases increased slightly from 199 in FY 2018 to 206 in FY 2019, with associated criminal recoveries of $3 million in FY 2019. 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. Exhibit 4 on the next page shows the number of convictions associated with drug diversion cases during FYs 2015 through 2019.

Exhibit 4: Convictions from drug diversion cases continued to increase in FY 2019.

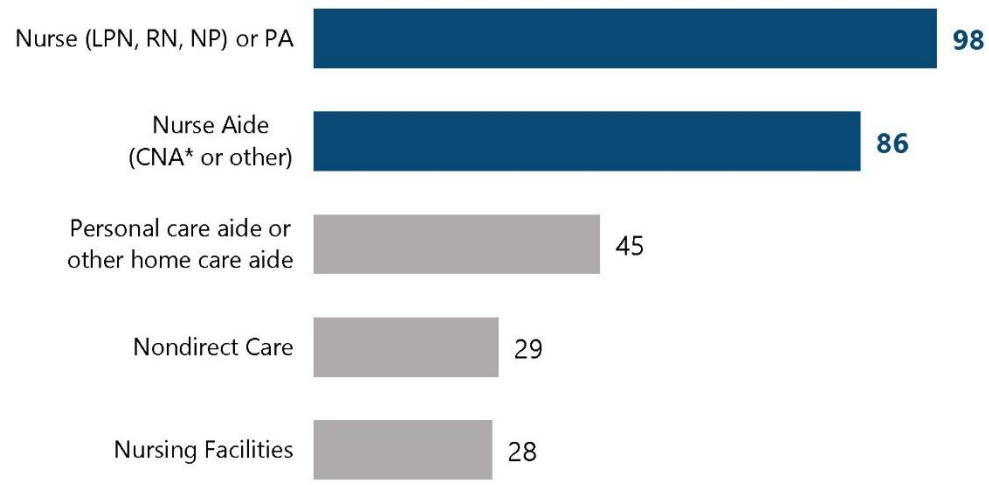


Source: OIG analysis of Annual Statistical Reports for FYs 2015–2019.

In FY 2019, more convictions for patient abuse or neglect involved nurses or nurse aides than any other provider type

In FY 2019, convictions of nurses or nurse aides accounted for 184 of the total 416 convictions for patient abuse or neglect (44 percent). Exhibit 5 shows the provider types with the most convictions for patient abuse or neglect.

Exhibit 5: In FY 2019, convictions of nurses and nurse aides for patient abuse or neglect were significantly higher than any other provider type.



*CNA = Certified Nurse Aide

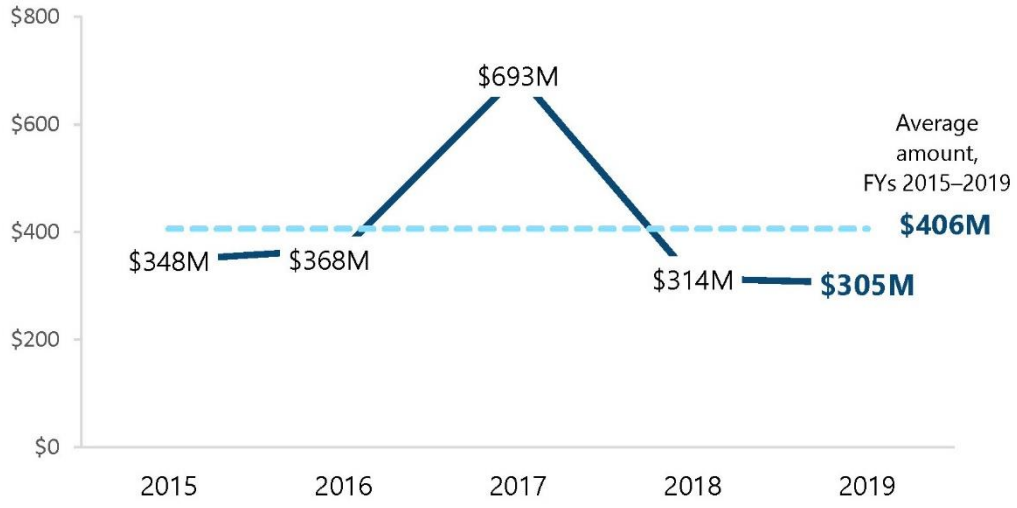
Source: OIG analysis of FY 2019 Annual Statistical Reports.

Criminal recoveries slightly decreased from FY 2018

Criminal recoveries slightly decreased from $314 million in FY 2018 to $305 million in FY 2019, which represents the lowest recovery amount within the 5-year period.[13] As shown in Exhibit 6, there was a significant spike in criminal recoveries during FY 2017. The spike in criminal recovery amounts in FY 2017 was a result of a single, large fraud case with a recovery amount totaling $268 million.[14]

In FY 2019, the Florida Unit prosecuted a case that resulted in a large amount of criminal recoveries. In this case, a pharmacist was sentenced to 78 months in prison and ordered to pay nearly $5 million in restitution for engaging in a fraud scheme. The pharmacist submitted false and fraudulent claims for compounded drugs and other medications that were not medically necessary and/or were never provided.[15]

Exhibit 6: In FY 2019, criminal recoveries decreased below the average for FYs 2015–2019.



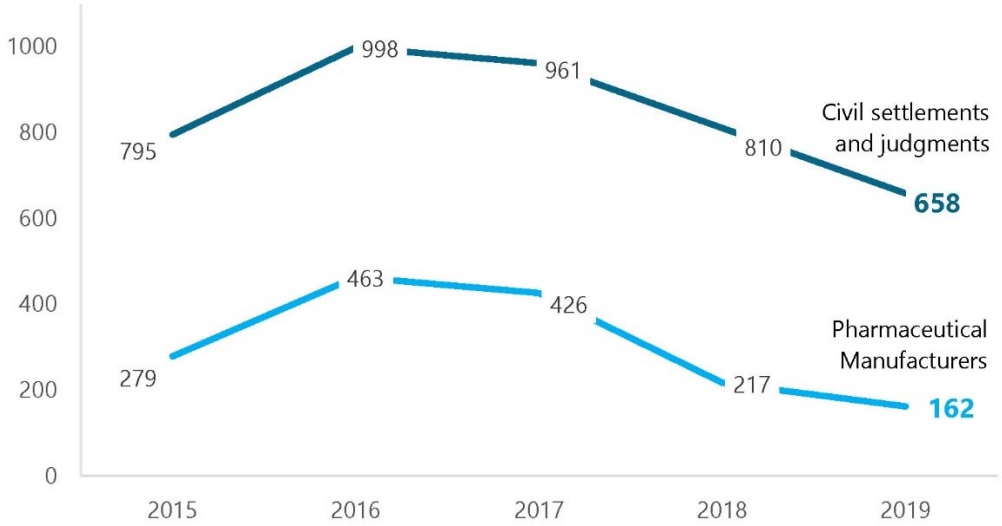
Source: OIG analysis of Annual Statistical Reports for FYs 2015–2019.

The number of civil settlements and judgments declined for the third consecutive year

In FY 2019, MFCUs were responsible for 658 civil settlements and judgments; this was the third consecutive year of decline. Fewer civil settlements and judgments involving pharmaceutical manufacturers accounted for most of the overall decline in the total number of civil settlements and judgments in recent years. As shown in Exhibit 7 on the next page, both the total number of civil settlements and judgments and those involving pharmaceutical manufacturers declined since FY 2016.

Exhibit 7: The total amount of civil settlements and judgments in FY 2019 was the lowest in the 5-year period.

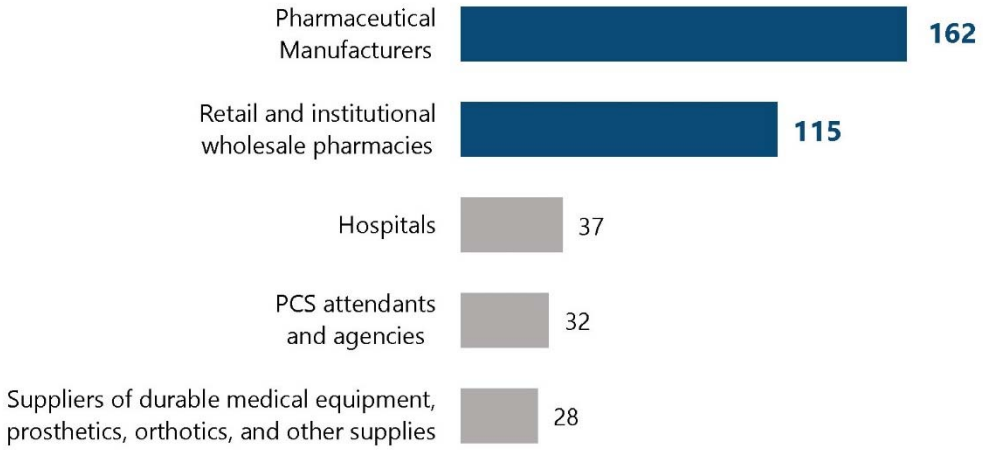
The number of civil settlements and judgments involving pharmaceutical cases also declined during the same period.



Source: OIG analysis of Annual Statistical Reports for FYs 2015–2019.

Nonetheless, more civil settlements and judgments involved pharmaceutical manufacturers than any other provider type. In FY 2019, pharmaceutical manufacturers accounted for 162 of the 658 civil settlements and judgments (25 percent). Retail and institutional wholesale pharmacies had the second-highest level of civil settlements and judgments (see Exhibit 8).

Exhibit 8: Pharmaceutical manufacturers had the highest number of civil settlements and judgments in FY 2019, followed by retail and institutional wholesale pharmacies.



Source: OIG analysis of FY 2019 Annual Statistical Reports.

Civil recoveries almost tripled from FY 2018

Civil recoveries significantly increased, from $545 million in FY 2018 to $1.6 billion in FY 2019, and were above the 5-year average. Exhibit 9 shows the amounts of civil recoveries for FYs 2015 through 2019 in relation to the 5-year average.

Exhibit 9: In FY 2019, civil recoveries increased above the 5-year average.

Large monetary settlements or judgments may contribute to annual variability.

NOTE: The dollar values were rounded to the nearest tenth.

Source: OIG analysis of Annual Statistical Reports for FYs 2015–2019.

Approximately $1.2 billion (or 72 percent) of the $1.6 billion in civil recoveries derived from "global" cases.[16] The remaining $460 million (28 percent) derived from "nonglobal" cases.

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.

Two global cases accounted for a significant portion of the civil recoveries. In one case involving a pharmaceutical manufacturer, the Virginia MFCU partnered with other State and Federal agencies to obtain a record recovery for a case involving an opioid drug, Suboxone.[17] While the civil portion of the settlement amounted to approximately $700 million, the pharmaceutical manufacturer agreed to pay a total of $1.4 billion to resolve its potential criminal and civil liability related to the marketing of the opioid addiction treatment drug.[18] In the second case, 43 States partnered with Federal agencies to pursue allegations involving the distribution of unapproved and adulterated drugs by a pharmaceutical distributor. As a result of the investigation, the pharmaceutical distributor will pay $625 million, $99.9 million of which is designated for State Medicaid programs.[19]

CONCLUSION

MFCUs play a vital role in fighting fraud in the Medicaid program and in protecting facility residents from patient abuse or neglect. In FY 2019, MFCUs' efforts contributed to total recoveries of $1.9 billion, with an ROI of $6.41 for every $1 spent.

MFCUs developed innovative practices to achieve the significant case outcomes identified in this report and maximize their effectiveness. As one technique for encouraging MFCU success, OIG identifies beneficial practices during its oversight activities that may be considered for adoption by other States. A list summarizing these practices and organized by State is included in Appendix B. Some beneficial practices include:

- *Ensuring Quality Referrals*: The Kansas Unit's nurse investigator examined closed complaints of nursing home abuse or neglect that were maintained by the State Medicaid agency and arranged for the simultaneous receipt with local law enforcement of patient abuse or neglect referrals.
- *Use of Technology*: The New York Unit, one of the 20 MFCUs with waiver authority to operate a data mining program, established data analytics working groups to provide guidance, training, and an assessment of the Unit's data mining efforts. The groups include (1) the Data Analytics Tools group; (2) the Data Sources group; (3) the Fraud and Abuse group; and (4) the Governance group.
- *Recommending Program Integrity Improvements*: The New Mexico Unit consistently made program integrity recommendations as a part of quarterly meetings. One of these recommendations involved a technical change to the State's managed care organization (MCO) contracts clarifying the Medicaid agency's responsibility to refer "verified" allegations of fraud, waste, or abuse in a managed care setting.

In addition to identifying beneficial practices to spur continued improvement, OIG annually recognizes the efforts of one MFCU with the Inspector General's Award for Excellence in Fighting Fraud, Waste, and Abuse. In 2020, the Arizona MFCU received this award for its significant FY 2019 case outcome results, focus on drug diversion cases, and successful collaboration with its partners in joint investigations.

APPENDIX A

Office of Inspector General Priority Outcome: Maximizing Medicaid Fraud Control Unit Effectiveness

It is a top OIG priority to strengthen the effectiveness of MFCUs as key partners in combating fraud and abuse. As part of its oversight, OIG 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) enhancing 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 2015–2019 and the target that OIG aims to achieve in FY 2020 and FY 2021.[20]

Key Performance Indicators	FY 2015 (actual)	FY 2016 (actual)	FY 2017 (actual)	FY 2018 (actual)	FY 2019 (actual)	FY 2020 Target	FY 2021 Target
Indictment Rate	16.1%	16.3%	17.2%	16.7%	18.8%	18.0%	19.1%
Conviction Rate	91.2%	89.6%	88.7%	89.8%	90.3%	90.6%	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 Office of Inspector General Onsite Reports

This appendix summarizes MFCU practices that OIG 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 September 2017	Successful investigative 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. Also, the Unit collaborated with Federal and State partners to investigate allegations of PCS fraud that led to convictions and significant monetary recoveries.
	Recommendations for program integrity improvements	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 December 2015	Ensuring quality referrals	MFCU staff attended quarterly meetings with the State Medicaid agency and 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 September 2013	Ensuring quality referrals	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.

continued on the next page

Beneficial Practices Described in Office of Inspector General Onsite Reports (continued)

STATE REPORT NUMBER	PRACTICE CATEGORY	DESCRIPTION
California OEI-09-15-00070 February 2016	Ensuring quality referrals	The Unit provided quarterly training for MCO representatives that resulted in increased fraud referrals from MCOs to the Unit.
	Ensuring quality referrals	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 trained staff from these agencies about Medicaid fraud and the Unit's role in combating provider fraud and patient abuse or neglect.
	Colocation of Unit and OIG staff	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	Colocation of Unit and OIG staff	Unit staff have workstations in 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 (DOJ) Medicare Strike Force.
Idaho OEI-12-18-00320 August 2019	Use of media sources to report convictions	The Unit's legal secretary monitored media sources for patient abuse and neglect convictions. Although the convictions were a result of investigations by local authorities and not the Unit, the legal secretary reviewed the conviction information and submitted the police reports and court documents to OIG. As a result of those efforts, OIG has excluded seven individuals from Federal health programs.

continued on the next page

Beneficial Practices Described in Office of Inspector General Onsite Reports (continued)

STATE REPORT NUMBER	PRACTICE CATEGORY	DESCRIPTION
Kansas OEI-12-18-00210 July 2019	Ensuring quality referrals	The Unit's nurse investigator reviewed patient abuse or neglect complaints 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 that the State's survey and certification agency sent the complaints to local law enforcement agencies. After reviewing the complaints, the nurse investigator would contact the law enforcement agencies to help determine whether further investigation by those agencies or the Unit was warranted.
Kentucky OEI-06-17-00030 September 2017	Ensuring quality referrals	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 to help Unit attorneys develop litigation skills. The executive advisor also mentored new attorneys and served as a cochair on Unit prosecutions.
Maryland OEI-07-16-00140 September 2016	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.

continued on the next page

Beneficial Practices Described in Office of Inspector General Onsite Reports (continued)

STATE REPORT NUMBER	PRACTICE CATEGORY	DESCRIPTION
Massachusetts OEI-07-15-00390 June 2016	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 pharmaceutical 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 January 2014	Colocation of Unit and OIG staff	The Unit made workspace available to an OIG agent. Colocation facilitated communication between the MFCU and OIG in their assessment of potential fraud referrals and their work on joint cases.
	Case management tools	Unit management and the Michigan Department of Licensing and Regulatory Affairs developed a streamlined process for referring cases of patient abuse or neglect. This process helped to ensure that referrals from the Department of Licensing and Regulatory Affairs were consistent with the Unit's statutory functions, thereby promoting Unit efficiency and case flow.
Minnesota OEI-06-13-00200 March 2014	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.

continued on the next page

Beneficial Practices Described in Office of Inspector General Onsite Reports (continued)

STATE REPORT NUMBER	PRACTICE CATEGORY	DESCRIPTION
New Mexico OEI-09-14-00240 February 2015	Ensuring quality referrals	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.
	Recommendations for 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 in 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 September 2018	Improved staff skills	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.
	Use of technology	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 Groups; 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.

continued on the next page

Beneficial Practices Described in Office of Inspector General Onsite Reports (continued)

STATE REPORT NUMBER	PRACTICE CATEGORY	DESCRIPTION
North Carolina OEI-07-16-00070 September 2016	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 April 2015	Successful partnerships	The Unit helped to establish 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.
	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 December 2016	Ensuring quality referrals	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 September 2016	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; this helped to highlight Medicaid billing issues and the implications of Medicaid fraud.

continued on the next page

Beneficial Practices Described in Office of Inspector General Onsite Reports (continued)

STATE REPORT NUMBER	PRACTICE CATEGORY	DESCRIPTION
Texas OEI-06-13-00300 April 2014	Ensuring quality referrals	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.
Vermont OEI-02-13-00360 December 2013	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 August 2016	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.

continued on the next page

Beneficial Practices Described in Office of Inspector General Onsite Reports (continued)

STATE REPORT NUMBER	PRACTICE CATEGORY	DESCRIPTION
Washington OEI-09-16-00010 September 2016	Ensuring quality referrals	The Unit worked with the State Medicaid agency to revise both the memorandum of understanding 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.
	Recommendations for 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 October 2013	Improved staff skills	Unit staff learned new skills and obtained certifications as Certified Fraud Examiners and Certified Coding Professionals.
	Ensuring quality referrals	The Unit focused on managed care by holding meetings with MCO administrators to obtain referrals.
Wyoming OEI-09-16-00530 September 2017	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

Medicaid Fraud Control Unit Case Outcomes and Open Investigations by Provider Type and Case Type for Fiscal Year 2019

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	18	$121,686	0	$0
Developmental Disability Facility	7	$20,157	1	$1,000
Hospice	0	$0	0	$0
Nondirect Care Staff	29	$703,889	0	$0
Nurse Aide (CNA or Other)	86	$135,164	2	$40,000
Nursing Facilities	28	$144,959	15	$669,500
Nurse (LPN, RN, NP) or Physician Assistant	98	$149,706	1	$500
Personal Care Aide or Other Home Care Aide	45	$55,776	0	$0
Other	105	$3,418,029	2	$122,788
Fraud—Facility-Based Medicaid Providers and Programs—Inpatient and/or Residential				
Assisted Living Facility	5	$2,088,948	0	$0
Developmental Disability Facility (Residential)	1	$14,425	0	$0
Hospice	4	$637,403	2	$296,075
Hospital	2	$8,336,592	37	$41,668,365
Inpatient Psychiatric Services for Individuals Under Age 21	1	$17,733	1	$213,858
Nursing Facility	8	$57,997	14	$30,765,608
Other Inpatient Mental Health Facility	0	$0	0	$0
Other Long-Term Care Facility	0	$0	1	$548,410

continued on the next page

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	$17,405	6	$1,313,325
Ambulatory Surgical Center	0	$0	0	$0
Developmental Disability Facility (Nonresidential)	3	$116,981	5	$7,398,510
Dialysis Center	0	$0	0	$0
Mental Health Facility (Nonresidential)	19	$11,099,104	9	$143,133
Substance Abuse Treatment Center	4	$359,754	14	$23,080,543
Other Facility (Nonresidential)	11	$14,467	9	$7,562,486
Fraud—Licensed Practitioners				
Audiologist	0	$0	1	$686,000
Chiropractor	1	$47,086	1	$211,000
Clinical Social Worker	10	$2,651,143	6	$444,131
Dental Hygienist	2	$3,536	0	$0
Dentist	25	$16,842,150	21	$19,553,712
Nurse (LPN, RN, or Other Licensed)	82	$22,952,138	1	$2,664
Nurse Practitioner	17	$816,896	1	$445,641
Optometrist	3	$90,414	3	$54,660
Pharmacist	11	$796,903	5	$15,945,439
Physician Assistant	3	$2,355,889	0	$0
Podiatrist	0	$0	2	$163,870
Psychologist	14	$7,518,044	4	$1,100,020
Therapist (Non-Mental Health, PT, ST, OT, RT)	8	$6,215,627	6	$836,050
Other Practitioner	16	$2,301,119	6	$590,895
Fraud—Medical Services				
Ambulance	7	$16,408,618	2	$35,285
Billing Services	1	$44,438	9	$722,599

continued on the next page

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	47	$62,845,537	14	$16,595,564
Lab (Clinical)	0	$0	11	$1,663,390
Lab (Radiology and Physiology)	1	$536,143	0	$0
Lab (Other)	5	$1,222,737	5	$655,643
Medical Device Manufacturer	0	$0	23	$17,906,806
Pain Management Clinic	4	$2,378,326	0	$0
Personal Care Services Agency	35	$9,759,420	6	$8,260,506
Pharmaceutical Manufacturer	0	$0	162	$1,180,092,512
Pharmacy (Hospital)	0	$0	0	$0
Pharmacy (Institutional Wholesale)	2	$53,034	14	$22,061,954
Pharmacy (Retail)	32	$9,354,182	101	$158,630,017
Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	13	$10,712,116	28	$26,265,141
Transportation (Nonemergency)	26	$2,808,165	11	$1,388,634
Other	8	$299,707	8	$3,585,632
Fraud—Other Individual Providers				
Emergency Medical Technician or Paramedic	0	$0	0	$0
Nurse's Aide (CNA or Other)	19	$94,302	1	$1,250
Optician	0	$0	0	$0
Personal Care Services Attendant	457	$9,705,245	26	$221,181
Pharmacy Technician	4	$112,952	0	$0
Unlicensed Counselor (Mental Health)	27	$1,744,456	1	$1,728
Unlicensed Therapist (Non-Mental Health)	3	$108,537	1	$1,000
Other	71	$9,015,488	6	$4,692,613

continued on the next page

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				
Allergist/Immunologist	0	$0	0	$0
Cardiologist	3	$4,070,058	2	$40,037
Emergency Medicine	2	$13,410	2	$163,028
Family Practice	23	$46,454,051	5	$5,547,674
Geriatrician	0	$0	0	$0
Internal Medicine	6	$144,937	2	$648,227
Neurologist	3	$376,000	1	$61,175
Obstetrician/Gynecologist	1	$15,000	4	$1,031,227
Ophthalmologist	0	$0	1	$6,650,000
Pediatrician	1	$77,000	5	$483,645
Physical Medicine and Rehabilitation	2	$3,139	1	$96,151
Psychiatrist	3	$90,326	3	$569,371
Radiologist	0	$0	2	$2,294,406
Surgeon	0	$0	2	$103,338
Urologist	0	$0	0	$0
Other MD/DO	20	$5,629,802	9	$2,343,481
Fraud—Program Related				
Managed Care Organization (MCO)	0	$0	9	$14,699,119
Medicaid Program Administration	2	$198,765	2	$158,551
Other	31	$20,718,865	3	$548,808
TOTAL	**1,527**	**$305,095,878**	**658**	**$1,632,077,878**

Exhibit C2: Number of open investigations at the end of FY 2019 by provider type and case type

PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Patient Abuse or Neglect			
Assisted Living Facility	202	0	202
Developmental Disability Facility	132	3	135
Hospice	3	0	3
Nondirect Care Staff	123	0	123
Nurse Aide (CNA or Other)	525	4	529
Nursing Facilities	947	38	985
Nurse (RN, LPN, NP) or Physician Assistant	371	0	371
Personal Care Aide or Other Home Care Aide	438	0	438
Other	845	2	847
Fraud—Facility-Based Medicaid Providers and Programs—Inpatient and/or Residential			
Assisted Living Facility	44	8	52
Developmental Disability Facility (Residential)	34	4	38
Hospice	74	33	107
Hospital	72	235	307
Inpatient Psychiatric Services for Individuals Under Age 21	10	22	32
Nursing Facility	132	204	336
Other Inpatient Mental Health Facility	15	45	60
Other Long-Term Care Facility	31	31	62
Fraud—Facility-Based Medicaid Providers and Programs—Outpatient and/or Day Services			
Adult Day Center	81	4	85
Ambulatory Surgical Center	2	7	9
Developmental Disability Facility (Nonresidential)	23	12	35
Dialysis Center	0	58	58
Mental Health Facility (Nonresidential)	282	48	330
Substance Abuse Treatment Center	125	34	159
Other Facility (Nonresidential)	103	63	166

continued on the next page

Exhibit C2: Number of open investigations at the end of FY 2019 by provider type and case type

PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Fraud—Licensed Practitioners			
Audiologist	3	1	4
Chiropractor	17	9	26
Clinical Social Worker	82	3	85
Dental Hygienist	2	2	4
Dentist	300	55	355
Nurse (LPN, RN, or Other Licensed)	522	4	526
Nurse Practitioner	68	2	70
Optometrist	31	8	39
Pharmacist	58	23	81
Physician Assistant	33	0	33
Podiatrist	20	7	27
Psychologist	71	17	88
Therapist (Non-Mental Health, PT, ST, OT, RT)	76	22	98
Other Practitioner	141	21	162
Fraud—Medical Services			
Ambulance	84	16	100
Billing Services	28	67	95
Home Health Agency	715	95	810
Lab (Clinical)	88	463	551
Lab (Radiology and Physiology)	15	32	47
Lab (Other)	25	201	226
Medical Device Manufacturer	1	573	574
Pain Management Clinic	55	21	76
Personal Care Services Agency	221	17	238
Pharmaceutical Manufacturer	158	2,733	2,891
Pharmacy (Hospital)	1	4	5
Pharmacy (Institutional Wholesale)	20	176	196
Pharmacy (Retail)	278	667	945
Transportation (Nonemergency)	230	11	241
Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	168	567	735
Other	79	260	339

continued on the next page

Exhibit C2: Number of open investigations at the end of FY 2019 by provider type and case type

PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Fraud—Other Individual Providers			
Emergency Medical Technician or Paramedic	3	0	3
Nurse Aide (CNA or Other)	55	0	55
Optician	3	7	10
Personal Care Services Attendant	1,760	19	1,779
Pharmacy Technician	13	0	13
Unlicensed Counselor (Mental Health)	65	5	70
Unlicensed Therapist (Non-Mental Health)	8	3	11
Other	369	45	414
Fraud—Physicians (MD/DO) by Medical Specialty			
Allergist/Immunologist	6	2	8
Cardiologist	14	14	28
Emergency Medicine	14	27	41
Family Practice	265	23	288
Geriatrician	2	0	2
Internal Medicine	159	19	178
Neurologist	33	4	37
Obstetrician/Gynecologist	25	7	32
Ophthalmologist	19	11	30
Pediatrician	46	6	52
Physical Medicine and Rehabilitation	25	10	35
Psychiatrist	97	11	108
Radiologist	11	16	27
Surgeon	23	6	29
Urologist	2	2	4
Other MD/DO	327	86	413
Fraud—Program Related			
Managed Care Organization (MCO)	21	74	95
Medicaid Program Administration	12	12	24
Other	114	117	231
Total	**11,695**	**7,458**	**19,153**

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

Christina Lester served as the team leader for this study, and Kira Evsanaa served as the lead analyst. Office of Evaluation and Inspections (OEI) staff who provided support include Susan Burbach, Jordan Clementi, Kevin Farber, and Keith Peters.

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

This report was prepared under the direction of Blaine Collins, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, and Abby Amoroso and Michael Henry, Deputy Regional Inspectors General, in consultation with Richard Stern, Director of the Medicaid Fraud Policy and Oversight Division.

Contact

To obtain additional information concerning this report, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov. OIG reports and other information can be found on the OIG website at oig.hhs.gov.

Office of Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201

ABOUT THE OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice (DOJ) and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

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. Unit investigations of patient abuse and neglect are limited to incidents occurring in: (1) health care facilities that receive Medicaid payments; and (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 (PCS) are provided. SSA § 1903(q)(4).

[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 the Units (SSA § 1903(q)). The Secretary delegated this authority to OIG. See also 42 CFR 1007.15. 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 (SSA § 1903(q)(2); 42 CFR 1007.5(a) and 1007.9(a)); employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney (SSA § 1903(q)(6); 42 CFR 1007.13); 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 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 were certified to operate in FY 2019.

[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 analysis of FY 2019 MFCU Annual Statistical Reports.

[7] 42 CFR 1007.20. To conduct data mining, MFCUs must receive approval from OIG. As of February 2020, 20 MFCUs were approved for data mining. HHS OIG, "Data Mining Applications," n.d., https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/data-mining.asp. Accessed on February 4, 2020.

[8] SSA § 1128, 42 U.S.C. 1320a-7. See also HHS OIG, "Background Information," n.d., https://oig.hhs.gov/exclusions/background.asp. Accessed on January 22, 2020.

[9] 42 CFR 1007.15.

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

[11] To calculate the ROI for MFCUs, we first calculated the total recoveries by adding the $305 million in criminal case recoveries to $1.6 billion in civil case recoveries. We then divided the $1.9 billion in total recoveries by the total MFCU grant expenditures of $302 million, resulting in the overall ROI of $6.41.

[12] The list of OIG-excluded individuals or entities can be found on the OIG website. HHS OIG, "LEIE Downloadable Databases," n.d., https://oig.hhs.gov/exclusions/exclusions_list.asp. Accessed on January 22, 2020.

[13] Recoveries, which are defined as the amount of money that defendants are required to pay as a result of settlement, judgment, or prefiling settlement in criminal and civil cases, may not reflect the actual collection amount. Recoveries may involve cases that include participation by other Federal and State agencies.

[14] One large, 268-million-dollar case prosecuted in FY 2017 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.

[15] DOJ, "South Florida Pharmacist Sentenced to Over Six Years in Prison for Role in $5 Million Compounding Pharmacy Scheme," November 29, 2018, https://www.justice.gov/opa/pr/south-florida-pharmacist-sentenced-over-six-years-prison-role-5-million-compounding-pharmacy. Accessed on January 15, 2020.
[16] To calculate the percentages for civil global and nonglobal recoveries, we used the total civil recoveries of $1,632,077,878. The dollar values in civil recoveries were rounded to the nearest tenth. Total civil recoveries accounted for $1.632 billion and global cases accounted for $1.172 billion in FY 2019.
[17] In a July 2019 press release, DOJ noted that this was the largest recovery in a case concerning an opioid drug in U.S. history. DOJ, "Justice Department Obtains $1.4 Billion from Reckitt Benckiser Group in Largest Recovery in a Case Concerning an Opioid Drug in United States History," July 11, 2019, https://www.justice.gov/opa/pr/justice-department-obtains-14-billion-reckitt-benckiser-group-largest-recovery-case. Accessed on February 28, 2020.
[18] Ibid.
[19] National Association of Medicaid Fraud Control Units, "AmerisourceBergen Corporation Pays $625 Million To Settle Allegations of Distributing Unapproved and Adulterated Drug," October 1, 2018, https://www.namfcu.net/assets/files/press-releases/AmerisourceBergen%20Press%20Release.pdf. Accessed on January 7, 2020.
[20] Since the publication of the *Medicaid Fraud Control Units Fiscal Year 2018 Annual Report*, we have amended the indictment and conviction rates for FYs 2015–2018 to reflect the most current data as revised by the Units.