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Office of Inspector General

Medicaid Fraud Control Units Fiscal Year 2015 Annual Report

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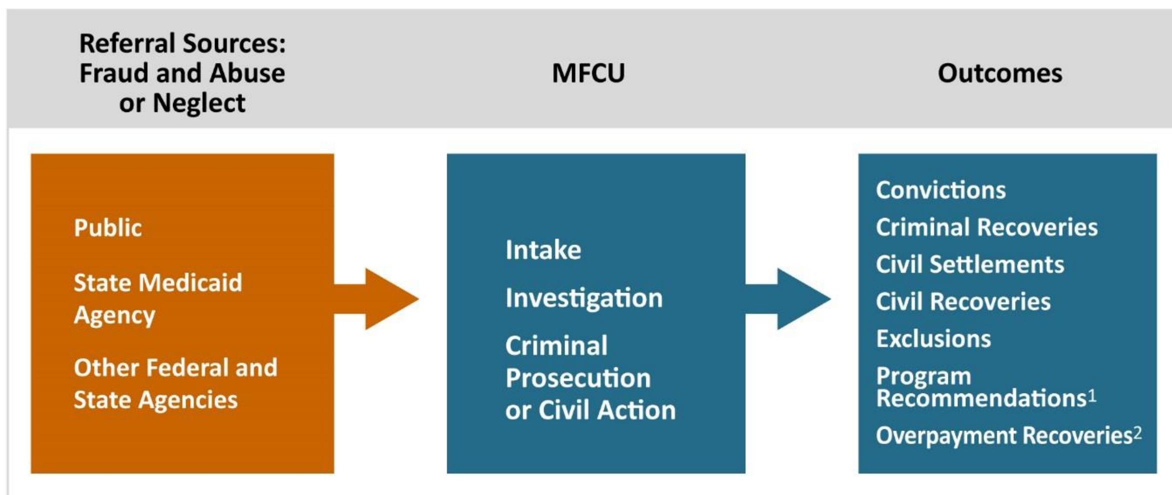
INTRODUCTION

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

Each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.[4] Unit staff review referrals of potential fraud and patient abuse or neglect to determine their potential for criminal prosecution and/or civil action. As illustrated below, Unit cases begin as referrals from multiple sources to be processed by the Unit, and result in various outcomes, including convictions, settlements, and monetary recoveries.

Lifecycle of a Unit Case



[1]Units may make statutory or programmatic recommendations, when warranted, to the State government. These recommendations may improve the operation of the Unit or address Medicaid operations or funding.

[2]When an investigation is closed or a case results in an acquittal with no finding of fraud, there may still be an overpayment that is owed to the Medicaid program.

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, distinct from the State Medicaid agency;[5]
- develop a formal agreement, such as a memorandum of understanding (MOU), describing the Unit's relationship with the State Medicaid agency;[6] and
- have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority.[7]

MFCU Funding

Each MFCU is funded jointly by its State and the Federal government. Federal funding for the MFCUs is provided as part of the Federal Medicaid appropriation, but it is administered by Office of Inspector General (OIG).[8] Each Unit receives Federal financial participation equivalent to 75 percent of its total expenditures, with State funds contributing the remaining 25 percent.[9] In fiscal year (FY) 2015, combined Federal and State expenditures for the Units totaled approximately $251 million, $188 million of which represented Federal funds.[10]

Administration and Oversight of the MFCU Program

The Secretary of HHS delegated to OIG the authority to administer the MFCU grant program.[11] To receive Federal reimbursement, each Unit must submit an initial application to OIG for approval and be recertified each year thereafter.

In annually recertifying the Units, OIG evaluates Unit compliance with Federal requirements and adherence to performance standards. The Federal requirements for Units are contained in the SSA, regulations, and policy guidance.[12] In addition, OIG has published 12 performance standards that it uses to assess whether a Unit is performing its responsibilities effectively.[13] The standards address topics such as staffing, maintaining adequate referrals, and cooperation with Federal authorities.

OIG also performs onsite reviews of the Units. During these onsite reviews, OIG evaluates Units' compliance with laws, regulations, and policies, as well as adherence to the 12 performance standards. OIG also makes observations about best practices, provides recommendations to the Units, and monitors the implementation of the recommendations.

OIG provides additional oversight including the collection and dissemination of performance data, training, and technical assistance. OIG maintains pertinent information for each MFCU on the OIG Web site, including an interactive map with statistical information about each MFCU.[14]

Methodology

We based the information in this report on an analysis of data from three sources: (1) annual statistical report data submitted for FY 2015; (2) quarterly statistical reports for FYs 2011 through 2014; and (3) onsite review reports published in FYs 2011 through 2015. Appendix A provides details of our methodology.

Standards

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

Units reported 1,553 convictions, 731 civil settlements, and $744 million in criminal and civil recoveries

In FY 2015, Units reported 1,553 convictions. Seventy-one percent of these convictions involved fraud and 29 percent involved abuse or neglect. For the same period, Units reported 731 civil settlements and judgments and $744 million in criminal and civil recoveries.

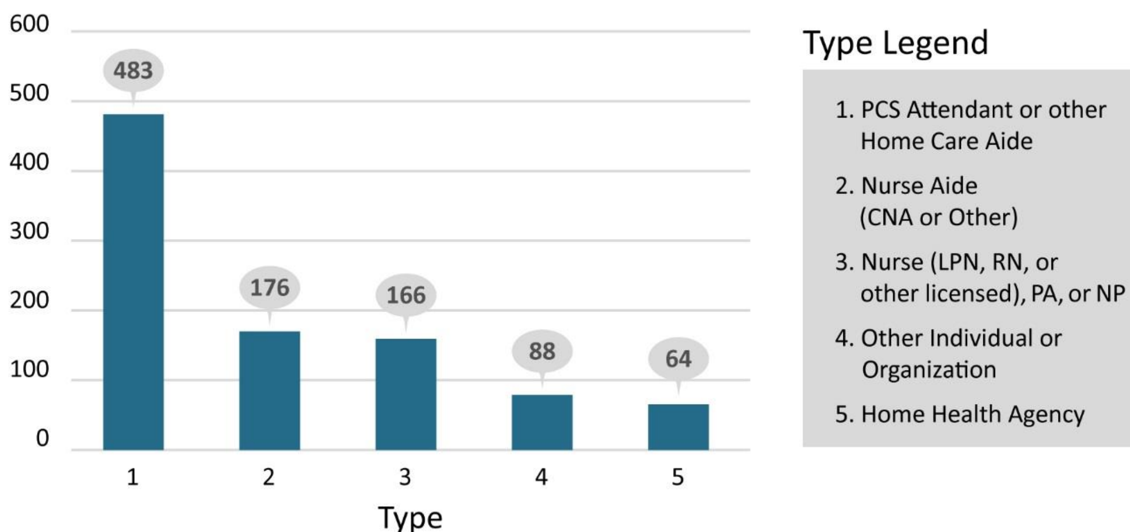
ANNUAL STATISTICAL REPORTING

Units annually report to the OIG their activities and outcomes related to intake, investigation, criminal prosecution, and civil litigation of provider fraud and patient abuse or neglect.

These outcomes are published on the OIG website http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp.

Nearly one-third of convictions involved personal care services attendants

Thirty-one percent (483 of 1,553) of the reported convictions were of personal care services (PCS) attendants or other home care aides. In one case, a PCS attendant submitted timesheets for services rendered while the patient was hospitalized and unable to receive care from the PCS attendant. The attendant continued to submit the timesheets even after the individual died. Eleven percent (176 of 1,553) of convictions were of nurse aides. Another 11 percent (166 of 1,553) of convictions were of licensed nurses, physician assistants (PA), or nurse practitioners (NP). These convictions involved abuse or neglect, provision of services without a license, and services not rendered, among other charges. Chart 1 depicts the number of criminal convictions for the five provider types with the most convictions.

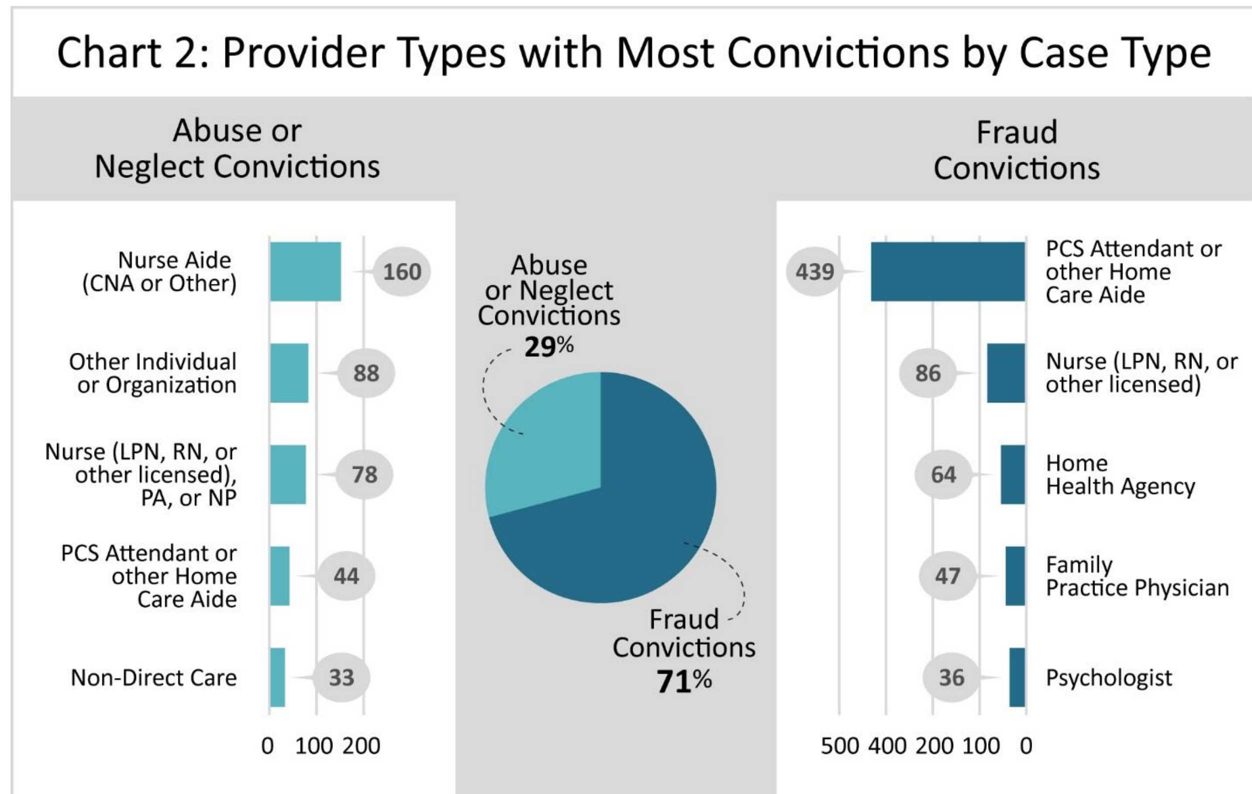


Source: OIG analysis Annual Statistical Report for FY 2015.

Note: Units reported fifty provider types that had 47 or fewer convictions. Together these 50 provider types accounted for 37 percent (576 of 1,533) of convictions. Chart 1 does not reflect these providers. The five provider types reflected in this chart account for 63 percent of Unit convictions.

Fraud cases accounted for 71 percent of convictions in FY 2015

Seventy-one percent (1,097 of 1,553) of all convictions involved fraud and 29 percent (456 of 1,553) involved abuse or neglect. Of the fraud convictions, almost half involved unlicensed providers, including PCS attendants and other home care aides. The provider type with the greatest number of fraud convictions was PCS attendants, with 439 convictions (or 65 percent of all fraud convictions). Chart 2 depicts the five provider types with the most convictions by type of case. The provider type that had the most abuse or neglect convictions was nurse aides, with 160 convictions (or 40 percent of all abuse or neglect convictions). Appendix B displays the outcomes for fraud and abuse or neglect cases by provider type.



Source: OIG analysis Annual Statistical Report for FY 2015.

Drug diversion cases accounted for 8 percent of convictions

Units reported 117 drug diversion convictions and $4.4 million in criminal recoveries in FY 2015. Drug diversion investigations involve fraudulent billing of the Medicaid program for a drug not delivered to the intended beneficiary and diverted from legal and medically necessary uses. As with the Units' other investigative work, drug diversion cases may be conducted jointly with other appropriate State or Federal agencies, such as the OIG Office of Investigations or the Drug Enforcement Agency (DEA) (e.g., opioid cases). In one such case, a pharmacist pleaded guilty of conspiracy to fraudulently dispense and distribute controlled substances for dispensing over 145,440 pills of oxycodone through fraudulent prescriptions. The pharmacist was sentenced to six months home detention, three years' probation, and ordered to pay $4.7 million in restitution.

Over a third of the civil settlements involved pharmaceutical manufacturers

Of the 731 civil settlements and judgments Units reported, 279 (38 percent) involved pharmaceutical manufacturers, making it the provider type that accounted for the greatest percentage of settlements and judgments. Pharmaceutical manufacturer settlements typically were related to the marketing of drugs. An additional 54 settlements and judgments involved retail and wholesale pharmacies. In one such settlement, a pharmacy automatically refilled prescriptions that were not requested by the patients or caregivers.[15] This pharmacy was ordered to pay the State more than $1.5 million in restitution for the overpayments. All Units reported civil settlements or judgments in FY 2015, ranging from 3 to 69 per Unit.

Units reported over $700 million recoveries in FY 2015; one Unit accounted for over a quarter of these recoveries

Of the $744 million in recoveries Units reported, $394 million were from civil recoveries and another $350 million were from criminal recoveries. Total recoveries exceeded the $251 million in State and Federal funds Units expended in FY 2015. In fact, on average Units recovered almost $3 for every dollar spent.[16]

Although the Texas Unit expended only 7 percent of the total expenditures for all MFCUs in FY 2015, the Unit reported over a quarter ($210 million of $744 million) of the total recoveries reported by Units. Specifically, Texas accounted for 28 percent of total Unit recoveries and 59 percent of all Unit criminal recoveries. Texas reported $207 million in criminal recoveries and another $3 million in civil recoveries, or $210 million in total recoveries. In FY 2015, the Texas Unit had several large, multiple defendant cases which all came to fruition within the year. This resulted in an unusual number of very large restitution amounts being reported.

New York, Tennessee, California, Florida, and Wisconsin, combined accounted for 50 percent of civil recoveries. These five States reported $196 million of the $394 million in civil recoveries. Appendix C displays the amount of criminal and civil recoveries and other outcomes for each State.

Convictions over the past 5 years have increased, while the number of civil settlements and amount of recoveries have decreased

The number of convictions has increased over the past 5 years, from 1,235 in FY 2011 to 1,553 in FY 2015. During the same period, civil settlements and judgments decreased from 908 in FY 2011 to 731 in FY 2015. Although Units reported over $1.5 billion in civil recoveries each year from FY 2011 through FY 2014, Units reported less than $400 million in civil recoveries for FY 2015. This decrease was consistent with national trends in health care civil recoveries.

In FY 2015, Units reported the highest number of convictions in the last 5 years

In FY 2015, Units reported a total of 1,553 convictions, 235 more than reported in FY 2014. Units had increases in both fraud and abuse or neglect convictions, as demonstrated in Chart 3. Fraud convictions increased from 825 in FY 2011 to 1,097 in FY 2015.

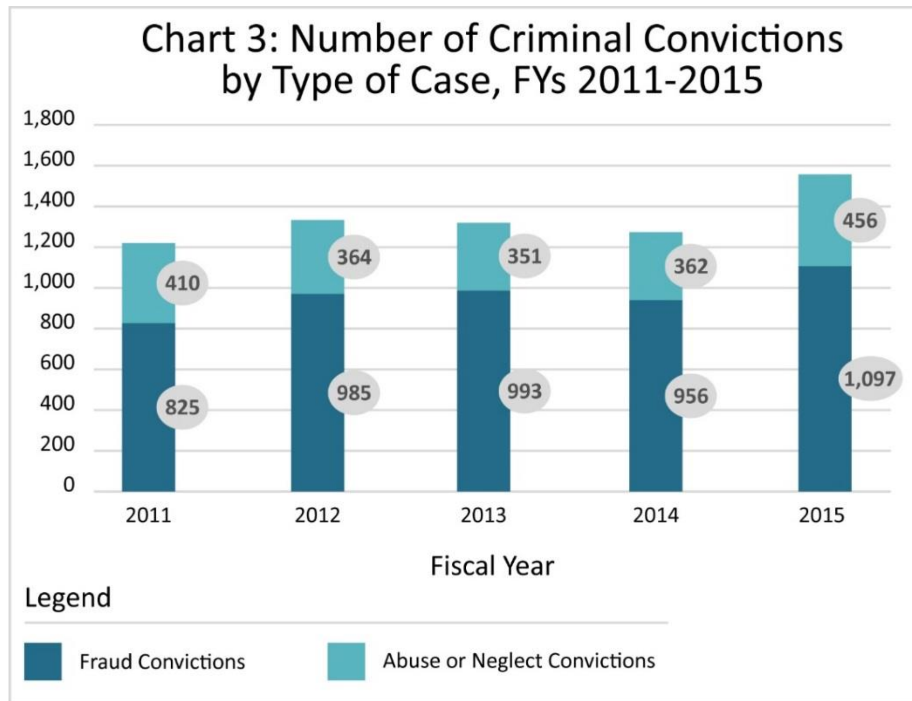
Although abuse or neglect convictions declined between FY 2011 and FY 2014, abuse or neglect convictions increased from 362 to 456 between FY 2014 and FY 2015. One such abuse conviction involved a nurse in an assisted living facility who was captured on hidden video assaulting a resident who resisted attempts to be dressed. The nurse was sentenced to 2 years of probation and barred from employment in any Federally funded healthcare program.

CIVIL CASES

Units conduct two types of civil cases- global and nonglobal.

A global case is defined as a civil case that involves both the Federal government and a group of states and is coordinated by the National Association of Medicaid Fraud Control Units (NAMFCU).

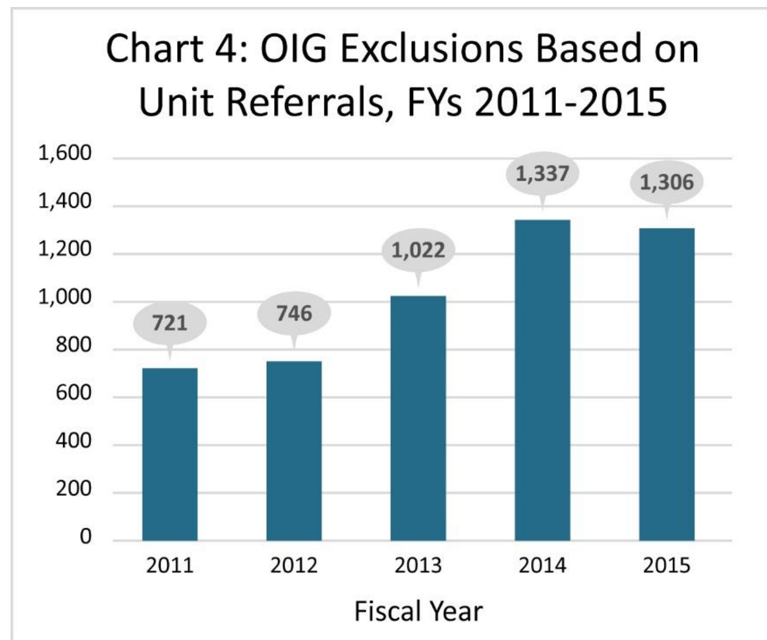
A nonglobal case is a civil case that does not involve NAMFCU.



Source: OIG analysis of Quarterly Statistical Reports for FYs 2011-2014 and Annual Statistical Report for FY 2015.

OIG exclusions resulting from Unit conviction referrals have grown since 2011

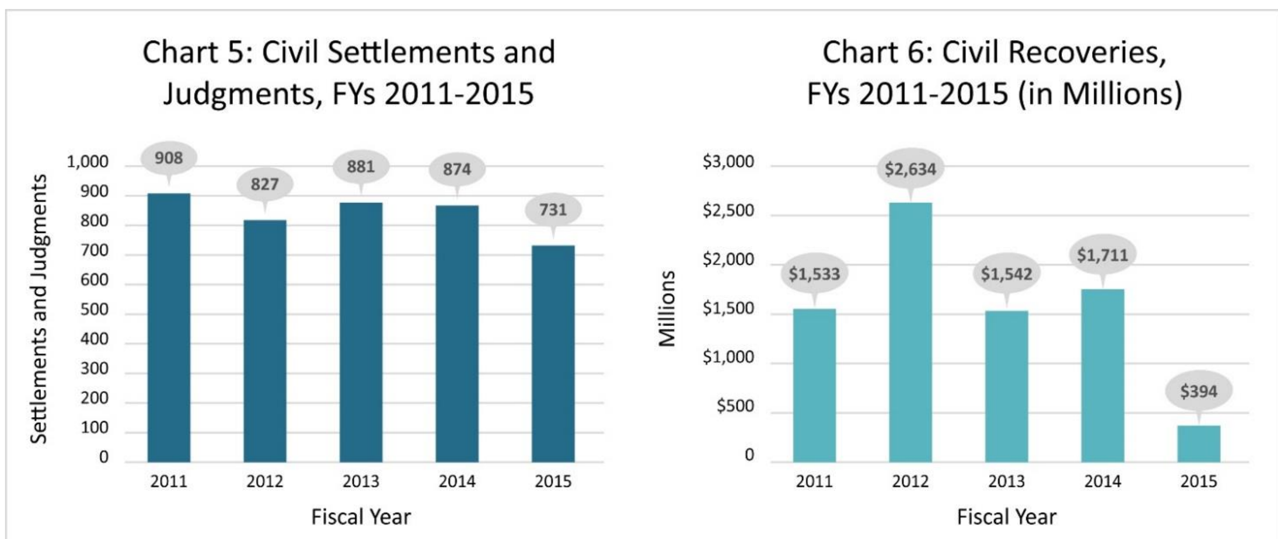
In FYs 2015 and 2014 the number of exclusions resulting from Unit referrals was significantly higher than the number of annual exclusions from Unit referrals in FYs 2011 through 2013, as shown in Chart 4. OIG has the authority to exclude convicted individuals and entities from Federally funded health care programs and maintains a list of all currently excluded individuals and entities.[17] Anyone who hires an individual or entity on this list may be subject to civil monetary penalties. In FY 2015, OIG excluded 4,112 individuals or entities; 1,306 (32 percent) resulted from convictions referred by Units.



Source: OIG analysis of Quarterly Statistical Reports for FYs 2011-2014 and Annual Statistical Report for FY 2015.

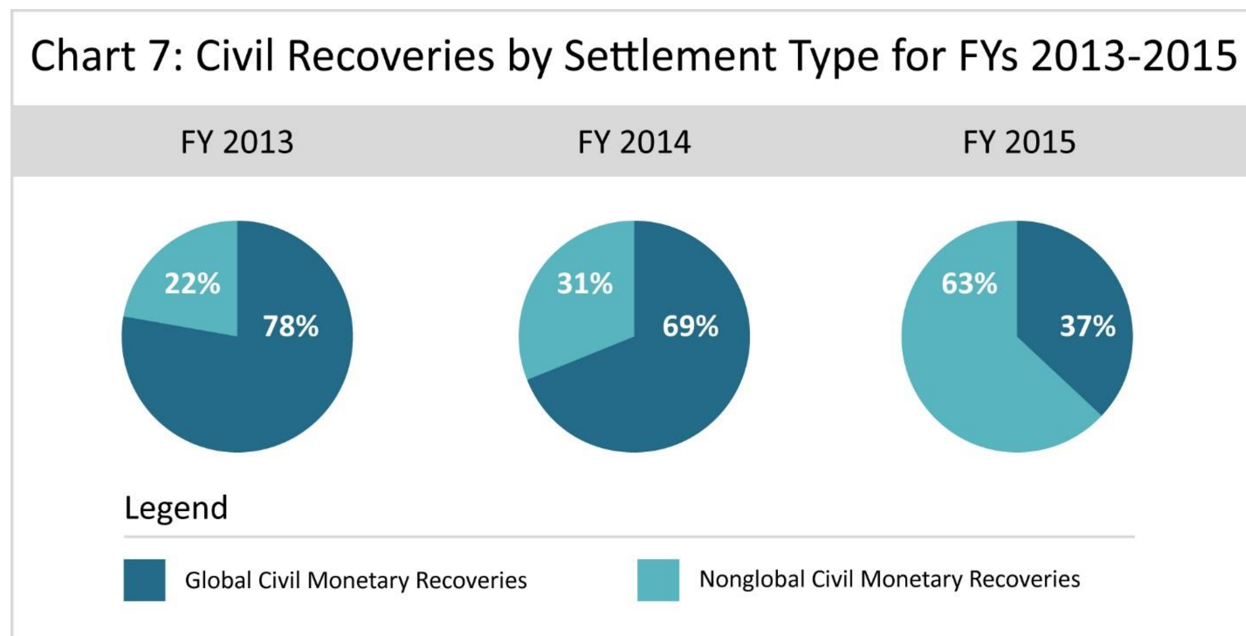
Civil settlements and judgments have decreased modestly over the last 5 years, and civil recovery amounts have decreased significantly

The number of civil settlements and judgments decreased from 908 in FY 2011 to 731 in FY 2015. Chart 5 shows the decrease in civil settlements and judgments over the past 5 years. Civil recoveries averaged $1.9 billion a year for the last 4 years and decreased significantly in FY 2015, to a low of $394 million. Chart 6 shows civil recoveries reported for FYs 2011 through 2015.



Source: OIG analysis of Quarterly Statistical Reports for FYs 2011-2014 and Annual Statistical Report for FY 2015.

The decrease in the Units' civil settlements, judgements, and recoveries is part of a national trend of declining civil health care fraud complaint settlements, especially those involving large pharmaceutical companies. From the 1990s through the early 2000s, a significant number of pharmaceutical companies were the subject of large monetary settlements in civil fraud actions.[18] Many of the large pharmaceutical settlements and the associated recoveries involved global civil cases. Although in FYs 2013 and 2014 global recoveries accounted for 78 and 69 percent of civil recoveries, respectively, in FY 2015, global recoveries accounted for only 37 percent of total civil recoveries, as shown in Chart 7.



Source: OIG analysis of Quarterly Statistical Reports for FYs 2013 and 2014; and Annual Statistical Report for FY 2015.

Many Units made operational improvements in response to OIG recommendations

Units made improvements in Unit operations in response to recommendations made in OIG onsite review reports. Between FYs 2011 and 2015, OIG published 32 onsite review reports. In these reports, the most common recommendations were in response to a lack of case file documentation of supervisory reviews and approvals, late or no required reporting of convictions to OIG and the National Practitioner Data Bank (NPDB), deficiencies in Units' MOU with State Medicaid program integrity units, and Unit policies and procedures.[19, 20] Each of the 32 Units reviewed received at least one recommendation related to these areas, for a total of 65 recommendations. Units made improvements in their operations in response to 62 of these recommendations. In addition to recommendations, some reports noted Unit practices that improved Unit operations.

Twenty-six Units made improvements related to case file documentation

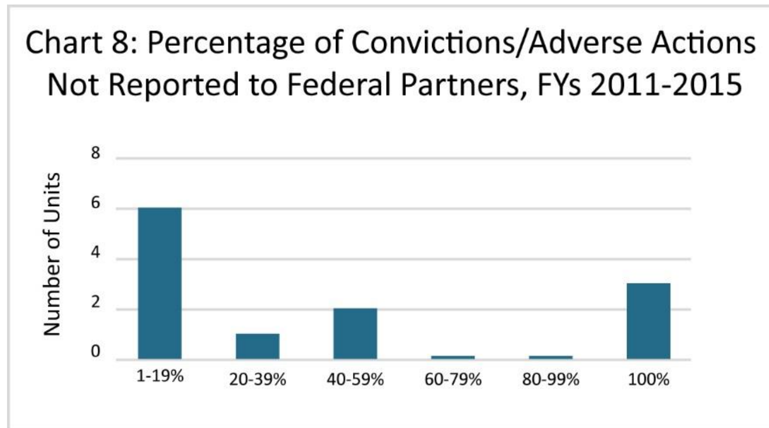
All 26 Units that received a recommendation related to documentation of supervisory reviews and approvals made improvements to address OIG recommendations. For example, many Units

revised their policies and procedures to specify the timeframes and/or documentation required for supervisory reviews in case files. Other Units developed new forms to document supervisory reviews. Supervisory reviews help ensure that cases are opened and closed in a timely manner and facilitate case progress.

Twenty Units made improvements related to required reporting to Federal partners

Twenty of the 23 Units that received a recommendation related to required reporting to OIG and NPDB improved their reporting process to address OIG recommendations. For example, one Unit developed an automated case tracking system that sends email reminders to investigators and supervisors to send the appropriate notification to OIG when a provider is sentenced. Another Unit modified their system to prevent a case from being closed in the system until the adverse action has been submitted to NPDB. As of August 2016, the remaining three Units had not reported any improvements to OIG to address these recommendations, and OIG continues to follow-up with these Units regarding their implementation status.

Twelve of these 23 Units did not report some or all of their convictions or adverse actions to Federal partners, as required. As Chart 8 illustrates, the percentage of convictions and adverse actions Units did not report varied widely. Units should report to OIG all convictions for the purpose of exclusion from Federal health care programs within 30 days of sentencing.[21] Units also should report any adverse actions resulting from investigations or prosecutions of healthcare providers to the NPDB within 30 days.[22] If a Unit fails to refer convicted providers for exclusion, those providers may continue to submit claims and receive payments from Medicaid and other Federal programs.



Source: OIG analysis of findings in MFCU reports published in FYs 2011-2015.

Sixteen Units made improvements related to MOUs and policy and procedures

All 16 Units that received a recommendation related to their MOUs and/or policies and procedures made improvements to address OIG recommendations.

Every Unit that had a recommendation concerning their policies and procedures either updated their policies to reflect their current operations, or revised their policies and procedures to address the recommendations. For example, one Unit incorporated written policies regarding referral of cases to other agencies into its procedures manual as required; another, implemented policies and procedures to ensure the accuracy of claims submitted for Federal reimbursement.

For every Unit that had a recommendation concerning its MOU, OIG found that the Unit's MOU did not reflect current requirements or practices. For example, one Unit's MOU did not include

a provision describing the referral process between the Unit and the State Medicaid agency, as required. In addition, the Unit did not have regular communication nor meetings with the State Medicaid agency. Since the onsite review, the Unit has worked to improve the quality and frequency of communication with the State Medicaid agency and updated its MOU to include all requirements.

Units employed a variety of practices to improve Unit operations

Units took many steps on their own initiative to improve Unit operations and outcomes. These were reported to the OIG during onsite reviews conducted between FYs 2011 and 2015. For example, Units described outreach activities that were beneficial to the Unit's mission. Generally, these efforts improved relationships with stakeholders, increased referrals, and raised Unit visibility in the health care community. Other Units noted that their efforts to enhance relationships with external State and Federal entities had positive effects. Appendix D provides detailed Unit reported information on the activities and practices to improve Unit operations.

APPENDIXES

Appendix A: Methodology

We based the information in this report on an analysis of data from three sources: (1) annual statistical report data submitted by each of the 50 State MFCUs for FY 2015; (2) quarterly statistical reports for FYs 2011 through 2014; and (3) onsite review reports published in FYs 2011 through FY 2015.

Review of annual statistical reports. We analyzed the annual statistical reports submitted for FY 2015 for all MFCUs and requested additional data and clarification as needed. We summarized key indicators, such as criminal convictions, civil settlements and judgments, and monetary recoveries across all Units. In addition, we summarized the reported investigations by provider type. Finally, we looked for other noteworthy trends in the data. The data was downloaded on April 28, 2016.

Review of onsite review reports. We analyzed the onsite review reports published in FY 2011 through FY 2015 to identify themes reflected in multiple reports. We combined our review of the onsite reports with OIG data on implementation of recommendations.

Appendix B: FY 2015 MFCU Outcomes and Open Investigations by Provider Type

Table B1: FY 2015 Outcomes: Number of Convictions, Settlements and Judgments, and Recoveries by Provider Type

Provider Type	Criminal		Civil	
	Number of Convictions	Amount of Recoveries	Number of Settlements and Judgments	Amount of Recoveries
ABUSE OR NEGLECT				
Assisted Living Facility	14	$125,813	0	$0
Developmental Disability Facility (Residential)	8	$8,570	1	$2,335
Non-Direct Care	33	$1,545,837	0	$0
Nurse (LPN, RN, or other licensed), Nurse Practitioner, or Physician Assistant	78	$80,757	0	$0
Nurse Aide (CNA or Other)	160	$231,600	1	$20,000
Nursing Facilities	31	$1,682,058	6	$2,835,186
Personal Care Services Attendant or Other Home Care Aide	44	$59,734	1	$12,083
Other Individual or Organization	88	$1,438,566	1	$101,694
FRAUD: Inpatient and/or Residential Facility-Based Medicaid Providers and Programs				
Assisted Living Facility	1	$1,465	0	$0
Hospice	2	$8,186,035	4	$11,873,583
Hospitals	9	$137,862,282	42	$44,098,432
Nursing Facilities	9	$512,535	14	$19,927,514
Other Long Term Care Facility	5	$37,210	0	$0
FRAUD: Outpatient and/or Day Services Facility-Based Medicaid Providers and Programs				
Adult Day Center	2	$370,428	3	$899,280
Developmental Disability Facility (Non-Residential)	2	$49,281	3	$145,637
Dialysis Center	0	$0	4	$16,670,658
Mental Health Facility (Non-Residential)	11	$5,292,586	7	$8,985,660
Substance Abuse Treatment Center	11	$410,317	2	$54,593
Other Facility (Non-Residential)	7	$294,945	6	$2,672,769
FRAUD - Licensed Practitioners				
Chiropractor	5	$1,403,593	1	$2,983
Clinical Social Worker	14	$1,330,296	2	$115,000
Dentist	16	$2,556,478	19	$11,318,559
Nurse (LPN, RN, or other licensed)	86	$2,962,032	11	$4,430,251
Nurse Practitioner	0	$0	1	$6,464
Optometrist	2	$176,185	1	$150,000
Pharmacist	14	$10,120,661	1	$5,189,784

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Table B1: FY 2015 Outcomes: Number of Convictions, Settlements and Judgments, and Recoveries by Provider Type (continued)

Provider Type	Criminal		Civil	
	Number of Convictions	Amount of Recoveries	Number of Settlements and Judgments	Amount of Recoveries
FRAUD - Licensed Practitioners (continued)				
Physician Assistant	2	$53,530	0	$0
Physical Therapist, Speech Therapist, Occupational Therapist, Radiation Therapist or other licensed Non-Mental Health Therapist	5	$1,424,259	0	$0
Podiatrist	6	$91,684	4	$106,006
Psychologist	36	$2,076,320	1	$5,000
Other Licensed Practitioner	3	$19,860	6	$574,884
FRAUD - Medical Services				
Ambulance	4	$1,325,342	7	$7,721,420
Billing services	4	$338,185	7	$676,811
Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)	33	$12,701,619	30	$4,255,485
Home Health Agency	64	$9,700,493	58	$44,225,917
Lab (Clinical)	0	$0	6	$137,972
Lab (Radiology and Physiology)	2	$1,458,316	1	$15,040
Lab (Other)	0	$0	1	$632,387
Medical Device Manufacturer	1	$103,174	24	$534,433
Pain Management Clinic	3	$31,561	0	$0
Personal Care Services Agency	22	$1,718,223	27	$3,960,381
Pharmaceutical Manufacturer	1	$0	279	$121,243,710
Pharmacy (Institutional Wholesale)	0	$0	16	$8,275,962
Pharmacy (Retail)	17	$2,149,758	38	$42,911,529
Transportation (Non-Emergency)	12	$1,189,061	11	$2,597,086
Other Medical Services	27	$4,303,405	7	$749,272
FRAUD: Physicians (MD/DO)				
Cardiologist	1	$1,298	1	$3,318,015
Family Practice Physician	47	$36,696,385	8	$1,107,184
Internal Medicine Physician	5	$349,064	3	$494,774
Neurologist	1	$0	1	$13,540
Obstetrician/Gynecologist	9	$756,601	8	$1,490,525
Ophthalmologist	0	$0	1	$790,000
Pediatrician	4	$3,277,110	3	$421,787
Physical Medicine and Rehabilitation Physician	2	$14,454	2	$98,450
Psychiatrist	11	$30,587,001	3	$3,916,949
Radiologist	0	$0	1	$22,653

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Table B1: FY 2015 Outcomes: Number of Convictions, Settlements and Judgments, and Recoveries by Provider Type (continued)

Provider Type	Criminal		Civil	
	Number of Convictions	Amount of Recoveries	Number of Settlements and Judgments	Amount of Recoveries
FRAUD: Physicians (MD/DO) (continued)				
Urologist	1	$11,245	0	$0
Other MD/DO	21	$12,598,885	16	$3,655,814
FRAUD: Other Individual Providers				
Nurse Aide (CNA or Other)	16	$110,144	0	$0
Optician	1	$0	0	$0
Personal Care Services Attendant or Other Home Care Aide	439	$7,302,038	19	$88,484
Pharmacy Technician	6	$136,014	0	$0
Unlicensed Counselor (Mental Health)	34	$3,578,418	1	$500
Unlicensed Therapist (Non-Mental Health)	1	$1,080	0	$0
Other Individual Providers	32	$17,863,786	4	$246,010
FRAUD: Program Related				
Managed Care Organization	11	$16,058,614	0	$12,202
Medicaid Program Administration	7	$1,029,136	0	$0
Other Program Related	10	$3,811,036	6	$10,299,500
Total	**1,553**	**$349,606,363**	**731**	**$394,105,683**

Source: OIG analysis of MFCUs Annual Statistical Report data for FY 2015.

Table B2: Number of Open Investigations at the end of FY 2015 by Provider Type

Provider Type	Open Criminal Investigations	Open Civil Investigations	Total Open Investigations
ABUSE OR NEGLECT			
Assisted Living Facility	205	2	207
Developmental Disability Facility (Residential)	72	4	76
Hospice	5	0	5
Non-Direct Care	193	0	193
Nurse (LPN, RN, or other licensed), Nurse Practitioner, or Physician Assistant	421	1	422
Nurse Aide (CNA or Other)	684	1	685
Nursing Facilities	882	58	940
Personal Care Services Attendant or Other Home Care Aide	254	0	254
Other Individual or Organization	443	1	444
FRAUD: Inpatient and/or Residential Facility-Based Medicaid Providers and Programs			
Assisted Living Facility	25	8	33
Developmental Disability Facility (Residential)	27	11	38
Hospice	35	47	82
Hospitals	101	200	301
Inpatient Psychiatric Services for Individuals Under Age 21	5	3	8
Nursing Facilities	173	165	338
Other Inpatient Mental Health Facility	5	18	23
Other Long Term Care Facility	14	11	25
FRAUD: Outpatient and/or Day Services Facility-Based Medicaid Providers and Programs			
Adult Day Center	78	6	84
Ambulatory Surgical Center	2	3	5
Developmental Disability Facility (Non-Residential)	19	7	26
Dialysis Center	2	30	32
Mental Health Facility (Non-Residential)	156	42	198
Substance Abuse Treatment Center	120	17	137
Other Facility (Non-Residential)	117	45	162
FRAUD - Licensed Practitioners			
Audiologist	5	2	7
Chiropractor	38	3	41
Clinical Social Worker	80	4	84
Dental Hygienist	7	1	8
Dentist	387	69	456
Nurse (LPN, RN, or other licensed)	462	14	476
Nurse Practitioner	26	7	33
Optometrist	25	4	29
Pharmacist	78	45	123
Physician Assistant	15	0	15

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Table B2: Number of Open Investigations at the end of FY 2015 by Provider Type (continued)

Provider Type	Open Criminal Investigations	Open Civil Investigations	Total Open Investigations
FRAUD - Licensed Practitioners (continued)			
Physical Therapist, Speech Therapist, Occupational Therapist, Radiation Therapist or other licensed Non-Mental Health Therapist	70	7	77
Podiatrist	30	5	35
Psychologist	209	10	219
Other Licensed Practitioner	99	11	110
FRAUD - Medical Services			
Ambulance	154	34	188
Billing services	14	20	34
Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)	270	443	713
Home Health Agency	605	109	714
Lab (Clinical)	59	427	486
Lab (Radiology and Physiology)	9	20	29
Lab (Other)	12	144	156
Medical Device Manufacturer	5	478	483
Pain Management Clinic	45	7	52
Personal Care Services Agency	198	164	362
Pharmaceutical Manufacturer	134	3,069	3,203
Pharmacy (Hospital)	2	11	13
Pharmacy (Institutional Wholesale)	15	210	225
Pharmacy (Retail)	161	410	571
Transportation (Non-Emergency)	217	33	250
Other Medical Services	50	121	171
FRAUD: Physicians (MD/DO)			
Allergist/Immunologist	5	4	9
Cardiologist	25	9	34
Emergency Medicine Physician	16	6	22
Family Practice Physician	372	12	384
Geriatrician	6	0	6
Internal Medicine Physician	146	22	168
Neurologist	34	8	42
Obstetrician/Gynecologist	79	8	87
Ophthalmologist	16	6	22
Pediatrician	36	8	44
Physical Medicine and Rehabilitation Physician	25	6	31
Psychiatrist	90	7	97
Radiologist	10	6	16

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Table B2: Number of Open Investigations at the end of FY 2015 by Provider Type (continued)

Provider Type	Open Criminal Investigations	Open Civil Investigations	Total Open Investigations
FRAUD: Physicians (MD/DO) (continued)			
Surgeon	45	2	47
Urologist	4	0	4
Other MD/DO	280	70	350
FRAUD: Other Individual Providers			
Nurse Aide (CNA or Other)	42	1	43
Optician	5	2	7
Personal Care Services Attendant or Other Home Care Aide	1,620	6	1,626
Pharmacy Technician	9	0	9
Unlicensed Counselor (Mental Health)	106	3	109
Unlicensed Therapist (Non-Mental Health)	8	0	8
Other Individual Providers	167	6	173
FRAUD: Program Related			
Managed Care Organization	12	70	82
Medicaid Program Administration	13	10	23
Other Program Related	53	156	209
Total	**10,743**	**6,990**	**17,733**

Source: OIG analysis of MFCUs Annual Statistical Report data for FY 2015.

Appendix C: Selected FY 2015 Statistical Data

Table C1: Investigations, Indictments or Charges, Criminal Convictions, and Civil Settlements and Judgments by State[1]

State	Open Investigations		Indicted/Charged (Criminal)		Convictions (Criminal)		Settlements and Judgments (Civil)	
	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect
Alabama	39	9	8	9	5	4	5	0
Alaska	129	1	32	0	15	0	4	0
Arizona	131	19	56	21	24	24	7	0
Arkansas	69	41	21	13	11	11	9	5
California	1,082	643	138	108	59	56	22	0
Colorado	271	0	8	0	9	0	44	0
Connecticut	78	4	8	0	6	1	12	0
Delaware	586	54	28	10	17	24	9	0
District of Columbia	147	6	11	0	29	1	9	0
Florida	531	37	75	24	54	23	26	0
Georgia	445	11	21	1	12	0	27	0
Hawaii	72	44	2	1	4	2	4	0
Idaho	98	10	4	0	3	1	11	0
Illinois	248	50	41	12	42	13	22	0
Indiana	1,216	390	47	1	38	6	22	0
Iowa	270	21	37	21	33	20	11	0
Kansas	104	8	6	0	15	2	9	0
Kentucky	72	45	9	13	3	10	14	0
Louisiana	356	70	84	7	66	7	24	1
Maine	49	11	0	4	4	4	7	0
Maryland	319	34	8	4	8	2	10	0
Massachusetts	444	58	3	1	9	1	20	1
Michigan	480	46	13	9	23	7	16	0
Minnesota	417	2	22	2	17	2	13	0
Mississippi	85	509	6	69	5	55	9	0
Missouri	162	15	7	4	13	2	29	0
Montana	25	7	5	1	5	2	6	0
Nebraska	97	28	8	2	6	6	7	0
Nevada	61	4	14	0	13	0	9	0
New Hampshire	26	11	0	4	0	0	13	0

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Table C1: Investigations, Indictments or Charges, Criminal Convictions, and Civil Settlements and Judgments by State (continued)

State	Open Investigations		Indicted/Charged (Criminal)		Convictions (Criminal)		Settlements and Judgments (Civil)	
	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect
New Jersey	397	25	24	3	12	6	14	0
New Mexico	199	4	12	0	7	0	12	0
New York	652	146	72	43	57	53	69	0
North Carolina	397	9	13	3	14	4	15	1
Ohio	986	432	139	36	133	27	16	1
Oklahoma	197	66	21	20	17	15	10	0
Oregon	58	6	30	9	30	9	8	0
Pennsylvania	446	28	114	4	93	2	8	0
Rhode Island	26	14	5	9	7	3	15	0
South Carolina	172	44	11	6	15	3	9	0
South Dakota	38	1	2	0	2	0	5	1
Tennessee	222	42	10	13	9	12	18	0
Texas	1,210	146	117	6	68	17	10	0
Utah	118	20	1	3	2	3	13	0
Vermont	70	11	9	0	7	1	4	0
Virginia	378	6	52	2	52	7	21	0
Washington	179	7	13	3	11	4	13	0
West Virginia	128	19	6	2	6	3	16	0
Wisconsin	468	9	11	0	5	0	12	0
Wyoming	57	3	2	0	2	1	3	0
TOTAL	**14,507**	**3,226**	**1,386**	**503**	**1,097**	**456**	**721**	**10**
GRAND TOTAL	**17,733**		**1,889**		**1,553**		**731**	

Source: OIG analysis of MFCUs Annual Statistical Report data for FY 2015.

[1] The information in this table is accurate as of June 9, 2016. States were able to provide revised data for FY 2015. Therefore, the data in this table differs from the data reported in the Statistical Chart on the website available at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm, which was current as of February 16, 2016.

Table C2: Recoveries and Expenditures by State[1]

State	Recoveries[2]				Expenditures	
	Criminal	Non-Global Civil Monetary	Global Civil Monetary	Total	Total MFCU	Total Medicaid
Alabama	$422,078	$0	$4,650,800	$5,072,878	$1,357,240	$5,495,672,054
Alaska	$2,400,512	$0	$60,099	$2,460,611	$1,279,525	$1,223,950,911
Arizona	$457,175	$0	$1,390,536	$1,847,711	$2,811,988	$10,895,032,291
Arkansas	$488,655	$164,103	$1,584,347	$2,237,105	$2,460,200	$5,852,914,637
California	$26,164,226	$2,005,836	$29,732,837	$57,902,899	$32,138,721	$90,614,357,683
Colorado	$645,090	$307,040	$3,739,443	$4,691,573	$1,651,018	$7,687,605,872
Connecticut	$48,721	$395,309	$1,582,975	$2,027,005	$2,108,289	$7,597,012,987
Delaware	$51,940	$0	$993,390	$1,045,330	$1,893,364	$2,023,509,108
District of Columbia	$263,351	$487,500	$1,519,392	$2,270,243	$2,792,615	$2,520,735,076
Florida	$26,004,717	$21,582,272	$10,078,140	$57,665,129	$16,910,095	$21,909,678,011
Georgia	$2,217,127	$5,990,382	$8,104,274	$16,311,783	$4,804,982	$10,245,084,441
Hawaii	$38,143	$55,000	$16,487	$109,630	$1,317,827	$2,076,761,775
Idaho	$118,214	$357,125	$321,457	$796,796	$873,359	$1,819,959,694
Illinois	$650,478	$9,623,544	$6,584,321	$16,858,343	$7,622,227	$17,963,860,929
Indiana	$2,770,349	$22,763,128	$2,603,929	$28,137,406	$5,916,915	$9,721,569,345
Iowa	$223,805	$9,924,685	$650,788	$10,799,278	$1,074,819	$4,672,288,367
Kansas	$571,281	$3,713,967	$99,518	$4,384,766	$1,192,687	$3,193,745,137
Kentucky	$274,862	$118,497	$2,511,193	$2,904,552	$3,393,619	$9,666,336,070
Louisiana	$5,072,526	$4,246,258	$8,586,459	$17,905,243	$5,263,527	$8,152,272,103
Maine	$424,841	$0	$777,418	$1,202,259	$764,429	$2,620,426,632
Maryland	$4,996,364	$1,246,923	$526,035	$6,769,322	$3,697,014	$9,881,703,513
Massachusetts	$9,540,716	$6,473,215	$1,558,979	$17,572,910	$5,364,610	$16,164,091,522
Michigan	$882,447	$475,832	$4,987,244	$6,345,523	$5,630,862	$16,561,360,132
Minnesota	$551,262	$98,400	$1,268,023	$1,917,685	$1,765,979	$11,294,848,324
Mississippi	$11,727,836	$873,442	$2,393,747	$14,995,025	$3,473,671	$5,313,720,236
Missouri	$726,644	$8,717,608	$2,647,957	$12,092,209	$2,345,934	$9,868,941,095
Montana	$151,974	$0	$68,992	$220,966	$825,259	$1,208,709,907
Nebraska	$124,231	$64,593	$482,891	$671,715	$894,437	$1,973,545,225
Nevada	$3,387,397	$1,703,441	$256,843	$5,347,681	$1,932,571	$3,265,706,343
New Hampshire	$5,610	$179,977	$301,247	$486,834	$780,464	$1,840,725,765
New Jersey	$708,957	$0	$2,481,039	$3,189,996	$3,867,591	$14,829,609,984

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Table C2: Recoveries and Expenditures by State (continued)

State	Recoveries				Expenditures	
	Criminal	Non-Global Civil Monetary	Global Civil Monetary	Total	Total MFCU	Total Medicaid
New Mexico	$57,242	$80,701	$213,532	$351,475	$2,124,374	$5,083,042,074
New York	$2,887,003	$52,555,329	$8,027,331	$63,469,663	$47,301,283	$59,681,117,761
North Carolina	$7,633,027	$13,418,973	$1,536,510	$22,588,510	$5,350,038	$13,878,014,268
Ohio	$12,562,704	$378,728	$5,797,800	$18,739,232	$10,109,229	$22,283,505,297
Oklahoma	$1,034,880	$5,200,000	$815,782	$7,050,662	$2,481,047	$4,948,050,867
Oregon	$188,867	$0	$408,520	$597,387	$2,220,933	$8,568,555,342
Pennsylvania	$7,579,541	$0	$4,122,975	$11,702,516	$6,106,400	$24,099,877,747
Rhode Island	$10,949	$457,198	$101,554	$569,701	$1,204,592	$2,729,259,438
South Carolina	$405,932	$4,939	$2,278,899	$2,689,770	$1,659,501	$6,027,888,585
South Dakota	$27,680	$87,047	$75,100	$189,827	$423,692	$860,846,154
Tennessee	$167,309	$35,756,988	$4,048,551	$39,972,848	$4,478,992	$9,506,550,239
Texas	$206,588,242	$31,988	$3,437,584	$210,057,814	$17,634,003	$36,147,676,703
Utah	$194,300	$5,625,000	$409,891	$6,229,191	$1,873,604	$2,300,014,634
Vermont	$69,453	$93,510	$50,609	$213,572	$858,283	$1,666,066,978
Virginia	$6,338,686	$335,698	$4,703,483	$11,377,867	$11,091,982	$8,510,779,754
Washington	$162,701	$3,664,430	$2,151,942	$5,979,073	$4,159,243	$11,074,882,616
West Virginia	$17,931	$1,724,827	$614,307	$2,357,065	$1,417,821	$3,835,749,849
Wisconsin	$1,547,374	$29,275,001	$2,728,557	$33,550,932	$1,512,865	$8,212,122,596
Wyoming	$21,013	$0	$23,435	$44,448	$475,174	$621,092,843
TOTAL[2]	**$349,606,363**	**$250,258,434**	**$144,107,162**	**$743,971,959**	**$250,688,894**	**$548,190,828,914**

Source: OIG analysis of MFCUs Annual Statistical Report data for FY 2015.

[1] The information in this table is accurate as of June 9, 2016. States were able to provide revised data for FY 2015. Therefore, the data in this table differs from the data reported in the Statistical Chart on the website available at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm, which was current as of February 16, 2016.

[2] The civil recoveries Units reported by provider type did not consistently match the civil recoveries reported by case type. Therefore, the total civil recoveries reported in Table B1 does not equal the total recoveries for global and nonglobal civil recoveries reported in Table C2.

Appendix D: Noted Beneficial Practices from Unit Reports Published in FYs 2011-2015

Noted Beneficial Practices from Unit Reports Published in FYs 2011-2015

State and Report Number	Noted Beneficial Practices	Summary[1]
Arkansas OEI-06-12-00720	Outreach activities	The Unit engaged in outreach activities that built relationships with stakeholders and aided the Unit's mission. For example, the Unit director reported that experienced Unit staff often were asked to lead training pertaining to Unit work for external stakeholders, such as a training session by Unit investigators conducted for the Office of Long Term Care.
Idaho OEI-09-12-00220	Investigative checklist and case plan	The Unit implemented an investigative checklist that improved the Unit's case flow. In addition, Unit attorneys discuss the "investigative case plan" for each case with the case investigator prior to the Unit's monthly staff meetings.
Michigan OEI-09-13-00070	OIG workspace within the Unit	The Unit makes workspace available to an OIG Special Agent within the Unit offices.
	Streamlined patient abuse or neglect referral process	Unit management and the Michigan Department of Licensing and Regulatory Affairs developed a streamlined process for referring cases of patient abuse or neglect.
Minnesota OEI-06-13-00200	Legislation that strengthens background checks	The Unit worked with two Minnesota Deputy Attorneys General to research and draft legislation that strengthens Minnesota's background check processes for guardians and conservators. Additionally, the new legislation requires that the court conduct background checks on guardians and conservators every 2 years, rather than every 4 years.
Nevada OEI-09-12-00450	Provider Outreach and "Train the Trainer" Programs	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.

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Noted Beneficial Practices from Unit Reports Published in FYs 2011-2015 (continued)

State and Report Number	Noted Beneficial Practices	Summary
New Hampshire OEI-02-12-00180	Drug Diversion Letter	The Unit sent a letter to nursing facilities and assisted living facilities explaining that drug diversion is a form of patient abuse or neglect. As a result of this letter, facilities made drug diversion-related referrals to the Unit.
New Jersey OEI-02-13-00020	Case management tool	The Unit developed a supervisory review document called a Joint Investigation Plan that includes tasks and deadlines, as well as descriptions of significant investigative and legal issues.
New Mexico OEI-09-14-00240	Managed care 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 Managed Care Organizations (MCO).
	Program integrity recommendations	The Unit consistently provided program integrity recommendations to the State Medicaid agency during quarterly joint protocol meetings.
New York OEI-02-11-00440	Approach to patient abuse or neglect cases	The Unit established a separate Patient Protection Unit. This resulted in the allocation of additional resources and expertise to patient abuse or neglect cases.
	Sharing list of ongoing investigations	The Unit developed a list of individuals and entities associated with ongoing investigations. The Unit shared this list with the Office of the Medicaid Inspector General to facilitate communication about ongoing investigations.
	Use of technology	The Unit established an "Electronic Investigative Support Group" comprised of staff dedicated to providing technical assistance throughout a case.
Ohio OEI-07-14-00290	Program integrity groups	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 the investigative teams.
Tennessee OEI-06-12-00370	Involvement on various task forces	Unit staff and stakeholders reported that relationships formed through participation on task forces, such as the Provider Fraud and Federal Health Care Fraud task forces, were key to the Unit's productivity.

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Noted Beneficial Practices from Unit Reports Published in FYs 2011-2015 (continued)

State and Report Number	Noted Beneficial Practices	Summary
Texas OEI-06-13-00300	Outreach program	The Unit instituted an outreach program to ensure that the public is aware of the Unit's presence and mission for the purpose of increasing the number of referrals to the Unit. The Unit required all investigators and investigative auditors to make one outreach contact per month, or 12 contacts per year.
Utah OEI-09-13-00490	Certified Fraud Examiner Training	The Unit required all Unit auditors and investigators to either be trained as a Certified Fraud Examiner (CFE) or be in training to become a CFE.
	Investigator workload tracking	The Unit tracked investigators' workloads. The chief investigator maintained a spreadsheet documenting the number of cases assigned to each investigator as well as the number of hours spent on each case. This spreadsheet also monitored the complexity of each case, which the Unit took into account when assigning new cases to investigators.
	Managed care referrals	Unit management had discussions among the Unit, the State Medicaid agency (Utah Department of Health), and MCOs to develop provisions in MCO contracts to ensure that MCOs send fraud referrals to the Unit.
Vermont OEI-02-13-00360	Provider Focus Teams	The Unit director created "Provider Focus Teams" in collaboration with the Program Integrity Unit in the Department of Vermont Health Access. The teams facilitate existing cases, develop provider training, and make program recommendations.
	Elder Justice Working Group	The MFCU Unit Director helped create the Vermont Elder Justice Working Group, consisting of representatives from State and Federal advocacy, regulatory, and law enforcement agencies.
West Virginia OEI-07-13-00080	Improved staff credentials and Unit outreach	Two individuals in the Unit passed examinations to become Certified Fraud Examiners and another individual obtained certification as a Certified Coding Professional. In addition, Unit investigators performed outreach at nursing homes.
	Managed care referrals	The Unit began meeting with MCO administrators to obtain referrals.

Source: OIG analysis of other observations in MFCU reports published in FYs 2011-2015.

[1] For more details about these noted practices and observations please see the respective reports at http://oig.hhs.gov/reports-and-publications/oei/m.asp#mfcu.

ENDNOTES

[1] SSA § 1903(q). Regulations at 42 CFR § 1007.11(b)(1) add that the Unit's responsibilities may include reviewing complaints of misappropriation of patients' private funds in residential health care facilities.
[2] SSA § 1902(a)(61).
[3] North Dakota and the territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands have not established Units.
[4] SSA § 1903(q)(6); 42 CFR §1007.13.
[5] SSA § 1903(q)(2); 42 CFR §1007.9.(a)
[6] 42 CFR § 1007.9(d).
[7] SSA § 1903(q)(1).
[8] SSA §1903(a)(6)(B).
[9] Ibid.
[10] OIG, MFCU Statistical Data for Fiscal Year 2015. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm on February 18, 2016.
[11] SSA § 1903(a)(6)(B). The SSA authorizes the Secretary of HHS to award grants to the Units; the Secretary delegated this authority to the OIG.
[12] On occasion, OIG issues policy transmittals to provide guidance and instructions to MFCUs.
[13] 77 Fed. Reg. 32645 (June 1, 2012).
[14] The MFCU interactive map with statistical information can be found at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/maps/interactive-map2015.asp.
[15] National Association of Medicaid Fraud Control Units (NAMFCU), "Medicaid Fraud Report." January/February 2015. Accessed at http://namfcu.net/assets/files/newsletters/15JanFeb.pdf on May 2, 2016.
[16] Return on investment was calculated by dividing unit recoveries by the total grant expenditures. The calculation included settlements on cases coordinated by NAMFCU.
[17] According to SSA § 1128, 42 USC § 1320a-7, OIG is required to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses: Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare, Medicaid, the Children's Health Insurance Program, or other State health care programs; patient abuse or neglect; felony convictions for other health care-related fraud, theft, or other financial misconduct; and felony convictions relating to unlawful manufacture, distribution, prescription, or dispensing of controlled substances. *OIG Exclusions Background Information*. Accessed at http://oig.hhs.gov/exclusions/background.asp on April 21, 2016.
[18] As a condition of those settlements, pharmaceutical companies were required to adopt corporate integrity agreements that were designed to prevent future abusive practices. Other corporations have adopted voluntary compliance programs, promoted by OIG, which may have further reduced the incidence of fraud allegations.
[19] Congress enacted legislation leading to the creation of the NPDB, a national collection program for data on health care fraud and abuse, in an effort to restrict the ability of incompetent physicians and dentists to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance. Accessed at https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp on June 9, 2016.
[20] The Units are required to have an MOU with the State Medicaid agency as a formal agreement between the two entities. According to Performance Standard 10, MOUs should be updated regularly and should reflect current practice, among other indicators.
[21] 77 Fed. Reg. 32648 (June 1, 2012).
[22] 45 CFR § 60.5. In addition to Federal regulations, the Performance Standards also require Units to report to NPDB. Performance Standard 8(g) states that the Unit should report "qualifying cases to the Healthcare Integrity & Protection Databank [HIPDB], the National Practitioner Data Bank, or successor data bases." Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions. See SSA § 1128E(g)(1) and 45 CFR § 60.3.

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