U.S. Department of Health and Human Services

Office of Inspector General

Medicaid Fraud Control Units Fiscal Year 2016 Annual Report

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INTRODUCTION

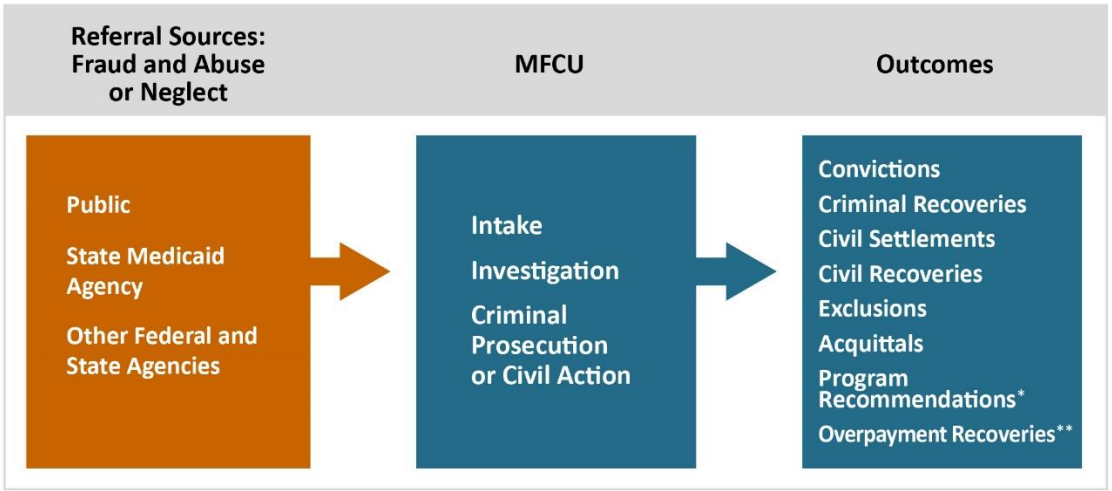
The mission of Medicaid Fraud Control Units (MFCUs or Units) is to investigate and prosecute under State law Medicaid provider fraud and patient abuse or neglect.[1] The Social Security Act (the Act) requires each State to operate a MFCU, unless the Secretary of Health and Human Services (HHS) determines 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]

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

- be a single, identifiable entity of State Government, distinct from the State Medicaid agency;[4]
- employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney;[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]

Unit staff review referrals of possible fraud and patient abuse or neglect to determine their potential for criminal prosecution and/or civil action. As illustrated below (Exhibit 1), Unit cases may begin as a referral from a single source or from multiple sources. If accepted by the Unit for investigation, these cases may result in various outcomes, including convictions, civil settlements, and monetary recoveries.

Exhibit 1: Lifecycle of a Unit Case



*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.

**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.

INTRODUCTION

OIG Oversight of the MFCU Program

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 the 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) 2016, combined Federal and State expenditures for the Units totaled approximately $259 million, $194 million of which represented Federal funds.[10] Strengthening the effectiveness of MFCUs as key partners combatting fraud and abuse is a top OIG priority.

OIG administers 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.[12]

In recertifying the Units, OIG annually assesses each Unit's compliance with the Federal requirements for MFCUs contained in statute, regulations, and OIG policy transmittals. Additionally, OIG examines Units' adherence to 12 performance standards, such as those for staffing, maintaining adequate referrals, and cooperation with Federal authorities.[13]

On an annual basis, OIG collects and disseminates statistical data reported by the MFCUs regarding outcomes such as the number of convictions and amounts of recoveries by Units. OIG maintains statistical data, including an interactive map, about MFCU outcomes on its Web site, located here: FY 2016 Interactive Map.[14]

OIG also provides ongoing technical assistance and guidance to Units. The assistance and guidance is provided in a variety of ways, including responding to questions from Units and more formal activities, such as developing and issuing policy transmittals to all Units.

Additionally, OIG conducts onsite reviews of some Units each year. These reviews allow OIG staff to examine a Unit's outcomes from investigating and prosecuting cases, as well as assess a Unit's compliance with Federal laws, regulations, and policies and adherence to performance standards. Public reports based on these reviews contain recommendations from OIG, as warranted, for improvement or corrective actions by the Units. Some reports also contain observations by OIG about Units' practices. Appendix A contains a list of beneficial practices that OIG cited in onsite review reports published since FY 2011.

Methodology

We based the information in this report on an analysis of statistical data submitted by the 50 MFCUs, as well as materials MFCUs submitted to OIG for recertification.[15] We analyzed the data submitted by the MFCUs for FYs 2012 through 2016 and requested additional data and clarification as needed. We summarized key case outcomes, such as criminal convictions, civil settlements and judgments, and monetary recoveries across all Units. In addition, for FY 2016, we summarized the reported investigations and outcomes by provider type. We also conducted trend analysis on key case outcomes for the 5-year period of FYs 2012 through 2016.

INTRODUCTION

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.

CASE OUTCOMES

In FY 2016, Units reported 1,564 convictions, 998 civil settlements and judgments, and almost $1.9 billion in criminal and civil recoveries

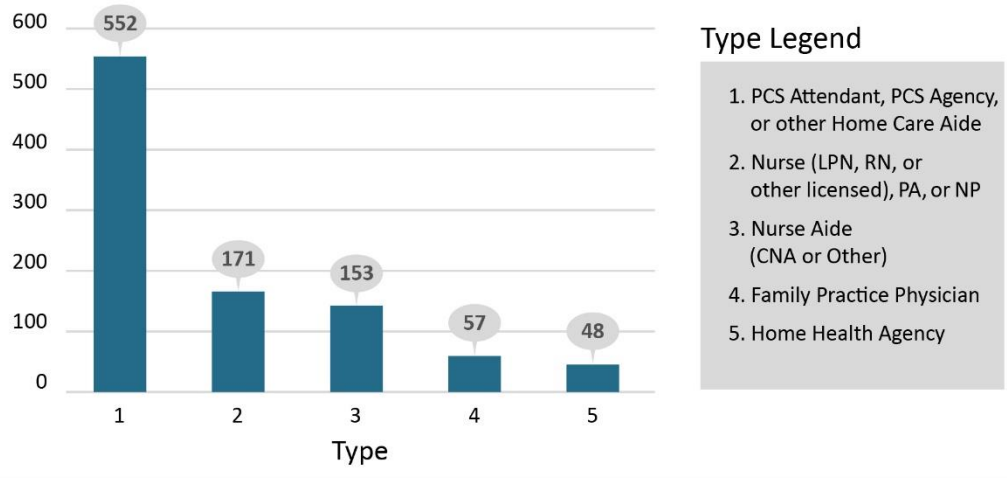
In FY 2016, Units reported 1,564 convictions, just over one-third of which involved personal care services attendants. Seventy-four percent of the 1,564 total convictions involved fraud (e.g., billing for services that were not provided) and twenty-six percent involved patient abuse or neglect (e.g., assault of a long-term care facility patient). For the same period, Units reported 998 civil settlements and judgments, almost half of which involved pharmaceutical manufacturers (e.g., the unlawful promotion of certain prescription drugs). Units also reported approximately $1.9 billion in criminal and civil recoveries.

Over one-third of convictions involved personal care services attendants

Personal care services (PCS) was the largest category of convictions in FY 2016. Thirty-five percent (552 of 1,564) of the reported convictions were of PCS attendants, representatives of PCS agencies, or other home care aides. Of these 552 reported convictions, 500 involved provider fraud and 52 involved patient abuse or neglect. For example, in one fraud case, a home care aide submitted timesheets for services rendered while the patient was in an acute-care hospital and, therefore, unable to receive care from the home care aide. The aide was fined and sentenced to 2 years in State prison.

The second largest category of FY 2016 convictions involved nursing care; 11 percent (171 of 1,564) of total convictions were of licensed practical nurses (LPN), registered nurses (RN), physician assistants (PA), or nurse practitioners (NP). Another 10 percent (153 of 1,564) of total convictions were of nurse aides. These convictions typically involve abuse or neglect, provision of services without a license, and services not rendered, among other charges. Exhibit 2 depicts the number of criminal convictions for the five provider types with the most convictions.

Exhibit 2: Convictions by Provider Type, FY 2016



Source: OIG analysis of FY 2016 Annual Statistical Report.

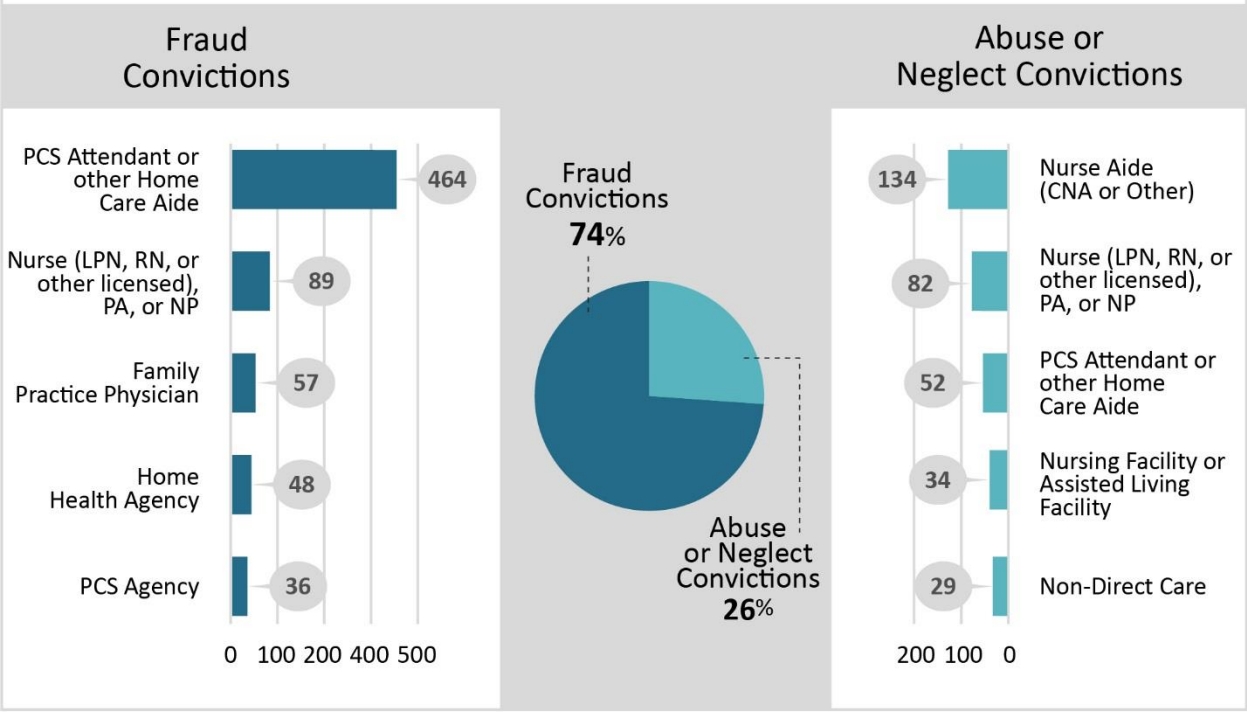
Note: Units reported 50 provider types that had 47 or fewer convictions. Together, these 50 provider types accounted for 37 percent (583 of 1,564) of convictions. Exhibit 2 does not reflect these providers. The five provider types reflected in this exhibit account for 63 percent of Unit convictions.

CASE OUTCOMES

Fraud cases accounted for 74 percent of convictions in FY 2016

Seventy-four percent (1,160 of 1,564) of all convictions involved fraud and twenty-six percent (404 of 1,564) involved abuse or neglect. Of the fraud convictions, almost half involved unlicensed providers. As was the case with convictions overall, PCS attendants accounted for the greatest number of fraud convictions (464 of 1,160). Exhibit 3 depicts the provider types with the most convictions by type of case. Nurse aides was the provider type that accounted for the greatest number of patient abuse or neglect convictions (134 of 404). Appendix B displays the case outcomes and open investigations for fraud and abuse or neglect cases by provider type.

Exhibit 3: Provider Types with Most Convictions by Case Type



Source: OIG analysis of FY 2016 Annual Statistical Reports.

The number of drug diversion convictions increased from FY 2015

Drug diversion cases involving false or improper claims to the Medicaid program are a significant and growing case area for the MFCUs, and OIG began collecting statistical information about such cases in FY 2015. Drug diversion investigations typically involve fraudulent billing of the Medicaid program for a drug not delivered to the intended beneficiary and diverted from legal and medically necessary uses. In FY 2016, Units reported 186 convictions related to drug diversion, or 12 percent of total convictions, and $15.7 million in criminal recoveries. This was an increase from FY 2015, when Units reported 117 convictions related to drug diversion, or 8 percent of total convictions. As with Units' other investigations, drug diversion cases may be conducted jointly with other State or Federal agencies, such as OIG or the U.S. Drug Enforcement Administration. In one especially egregious case, a doctor was convicted at trial on 3 counts of second-degree murder and 23 counts of prescribing addictive

prescription drugs to persons who had no medical need for them. Testimony revealed that the doctor did not change her prescribing habits after being notified of the death of her patients. The doctor was sentenced to 30 years in prison for homicide.

Almost half of the civil settlements and judgments involved pharmaceutical manufacturers

Of the 998 civil settlements and judgments that Units reported, 463 (46 percent) involved pharmaceutical manufacturers, making it the provider type with the greatest number of settlements and judgments. Pharmaceutical manufacturer settlements typically relate to the marketing of prescription drugs. An additional 70 settlements and judgments involved laboratories, 67 involved medical device manufacturers, and 57 involved retail and wholesale pharmacies. All Units reported such civil settlements or judgments in FY 2016, ranging from 9 to 97 per Unit.

Units reported almost $1.9 billion in recoveries in FY 2016

Of the almost $1.9 billion in reported recoveries, $1.5 billion were from civil recoveries and another $368 million were from criminal recoveries. Units spent $259 million in State and Federal funds in FY 2016. Therefore, Units recovered an average of over $7 for every dollar spent.[16] Appendix C displays the amount of criminal and civil recoveries and other outcomes for each State.

CIVIL CASES

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

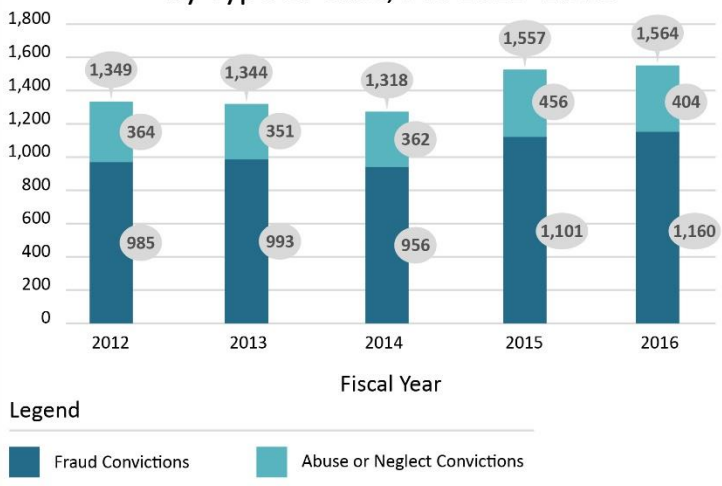
A global case is a civil case that involves both the Federal government and a group of States and is coordinated by the National Association of Medicaid Fraud Control Units (NAMFCU).

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

FY 2016 continued a trend of increasing numbers of convictions; civil settlements/judgments were the highest among the last 5 years

The number of convictions generally has increased over the past 5 years, from 1,349 in FY 2012 to 1,564 in FY 2016, a 5-year high. Civil settlements and judgments reached a 5-year high of 998 in FY 2016.

Exhibit 4: Number of Criminal Convictions by Type of Case, FYs 2012–2016



Source: OIG analysis of Quarterly Statistical Reports for FYs 2012–2016 and Annual Statistical Reports for FYs 2015 and 2016.

Unit convictions continued to increase in FY 2016

In FY 2016, Units reported a total of 1,564 convictions, 7 more than reported in FY 2015. Fraud convictions reported by Units increased from 1,101 in FY 2015 to 1,160 in FY 2016, whereas abuse or neglect convictions decreased from 456 in FY 2015 to 404 in FY 2016.

CASE OUTCOMES

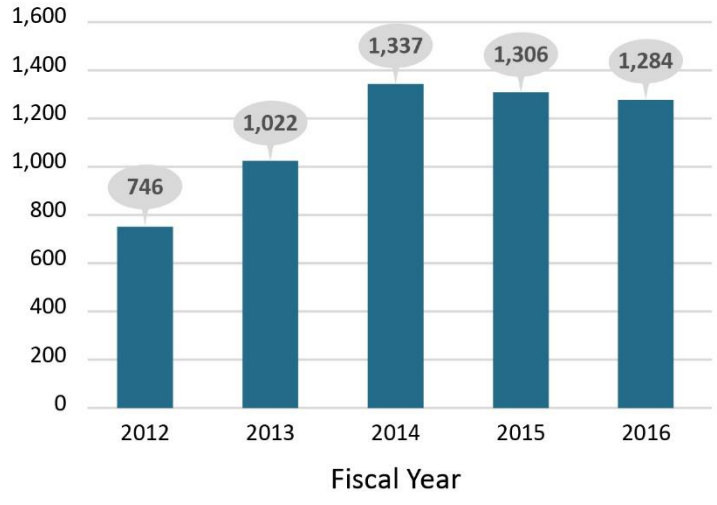
As shown in Exhibit 4, both fraud and patient abuse or neglect convictions were higher in FYs 2015 and 2016 than in FYs 2012 through 2014.

One patient neglect conviction in FY 2016 involved the owner of an unlicensed residential care facility who failed to staff the facility at night, thereby endangering the facility's residents. The facility owner was sentenced to 5 years in State prison and was ordered to pay $21,000 in fines.

The number of FY 2016 OIG exclusions resulting from Unit conviction referrals decreased slightly, compared to the prior 2 years

OIG has the authority to exclude convicted individuals and entities from Federal 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. After reaching a high of 1,337 in FY 2014, the number of exclusions from convictions referred by Units was slightly lower in both FYs 2015 and 2016 (1,306 and 1,284, respectively). However, as shown in Exhibit 5, all 3 recent years (FYs 2014 through 2016) saw considerably higher numbers of exclusions resulting from Unit referrals than in either FYs 2012 or 2013. In FY 2016, Unit referrals accounted for 35 percent of total OIG exclusions (1,284 of 3,635).

Exhibit 5: OIG Exclusions Based on Unit Referrals, FYs 2012–2016



Source: OIG analysis of Quarterly Statistical Reports for FYs 2012–2016 and Annual Statistical Reports for FYs 2015 and 2016.

CASE OUTCOMES

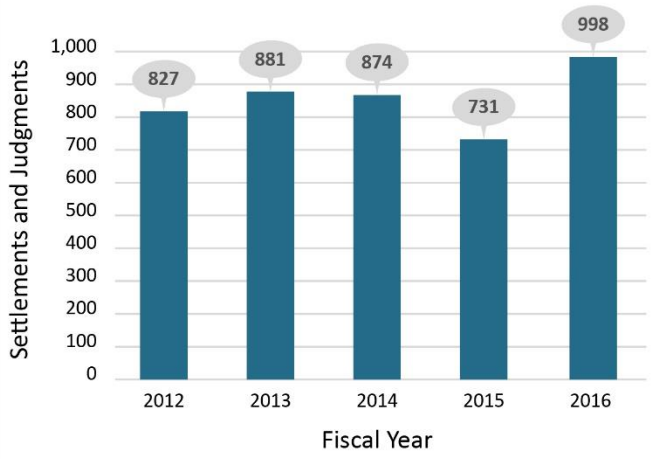
In FY 2016, Units reported the highest number of civil settlements/judgments among the last 5 years

The number of reported civil settlements and judgments has fluctuated over the last 5 years. The number of civil settlements and judgments averaged 861 in FYs 2012 through 2014, then decreased to 731 in FY 2015, before increasing substantially in FY 2016 to 998. Exhibit 6 shows the trend in civil settlements and judgments over the past 5 years.

Civil recoveries have varied significantly over the last 5 years, from a high of $2.6 billion in FY 2012, to a low of $395 million in FY 2015. As shown in Exhibit 7, civil recoveries in FY 2016 were in the mid-range over the 5-year period, at $1.5 billion. Over half of these recoveries were attributable to settlements of global cases against two pharmaceutical manufacturers that totaled $982 million.

Since the 1990s, a significant number of pharmaceutical companies have been the subject of large monetary settlements in civil fraud actions. As a condition of those settlements, pharmaceutical companies were required to adopt corporate integrity agreements, 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. Many of the large

Exhibit 6: Civil Settlements and Judgments, FYs 2012–2016



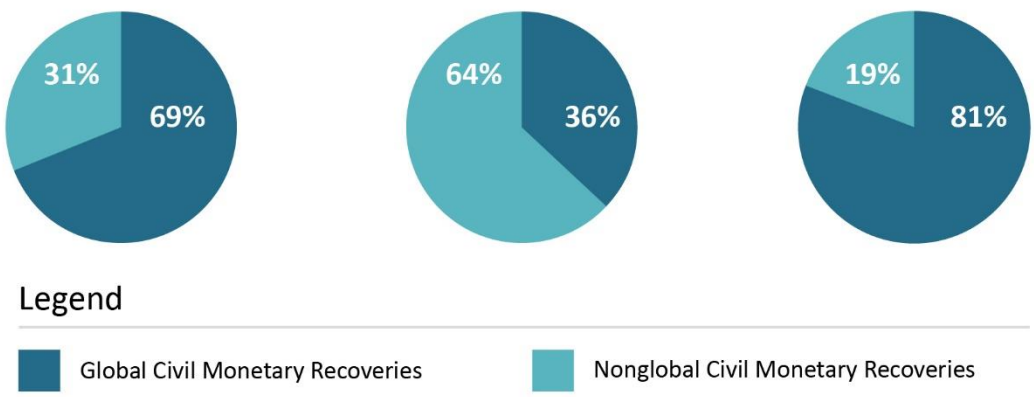
Source: OIG analysis of Quarterly Statistical Reports for FYs 2012–2016 and Annual Statistical Reports for FYs 2015 and 2016.

Exhibit 7: Civil Recoveries, FYs 2012–2016 (in Millions)

Source: OIG analysis of Quarterly Statistical Reports for FYs 2012–2016 and Annual Statistical Reports for FYs 2015 and 2016.

pharmaceutical settlements and the associated recoveries involve global civil cases. Although in FY 2015 global recoveries accounted for only 36 percent of civil recoveries, they accounted for 69 percent in FY 2014 and 81 percent in FY 2016, as shown in Exhibit 8.

Exhibit 8: Civil Recoveries by Settlement Type for FYs 2014–2016



Source: OIG analysis of Quarterly Statistical Reports for FY 2014 and Annual Statistical Report for FYs 2015 and 2016.

APPENDIXES

Appendix A: Noted Beneficial Practices from Unit Reports Published in FYs 2011–2016

This appendix summarizes beneficial practices identified through OIG's onsite reviews of Units and that were included in OIG reports published since FY 2011. This summary updates Appendix D of *Medicaid Fraud Control Units Fiscal Year 2015 Annual Report* with practices identified in the reviews of the following States: Arizona, California, Florida, Maryland, Massachusetts, North Carolina, Oregon, South Dakota, Virginia, and Washington. All of the reports may be accessed at: http://oig.hhs.gov/reports-and-publications/oei/m.asp#mfcu.

State and Report Number	Noted Beneficial Practices	Summary*
Arizona OEI-07-15-00280	Outreach activities	The Unit attended quarterly meetings between the State Medicaid agency and managed care organizations (MCOs) to provide guidance about what constituted a quality fraud referral. The Unit also provided training to Adult Protective Services staff and distributed outreach materials regarding prevention of fraud and elder abuse/neglect to law enforcement and community advocacy organizations.
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 State Office of Long Term Care.
California OEI-09-15-00070	MCO fraud referrals	The Unit provided quarterly training conferences for MCO representatives that resulted in increased MCO fraud referrals to the Unit.
	Outreach activities	The Unit hired a field representative to provide outreach and increase the number of fraud referrals sent to the Unit. The field representative acted as a liaison between the Unit and other State agencies and trained staff from these agencies about Medicaid fraud and the Unit's role in combatting provider fraud and patient abuse and neglect.
	Colocation of Unit and OIG staff	Two Unit investigators had workstations at an OIG field office in the San Francisco Bay Area, which facilitated the mutual referral of cases and improved communication and cooperation with OIG on joint cases.

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Noted Beneficial Practices from Unit Reports Published in FYs 2011–2016 (continued)

State and Report Number	Noted Beneficial Practices	Summary*
Florida OEI-07-15-00340	Colocation of Unit and OIG staff	Seven Unit staff had workstations at an OIG field office in Miami, which improved communication and cooperation with OIG on joint cases, including Medicaid provider fraud cases generated through the U.S. Department of Justice's Medicare Strike Force.
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.
Maryland OEI-07-16-00140	New staff training	The Unit developed an internal "boot camp" training program for new staff. Experienced staff gave 1-2 hour lectures on topics such as: civil and criminal investigation procedures, interviewing techniques, and understanding medical codes.
Massachusetts OEI-07-15-00390	Successful partnerships	The Unit developed successful partnerships with other State and Federal agencies and used clinical experts to facilitate the investigation and prosecution of drug diversion and other pharmacy cases.
	Streamlined administrative processes	The Unit used its Intranet system to streamline its administrative processes, such as periodic supervisory case file reviews and supervisory approval to open and close cases.
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.

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Noted Beneficial Practices from Unit Reports Published in FYs 2011-2016 (continued)

State and Report Number	Noted Beneficial Practices	Summary*
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.
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 MCOs.
	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 State 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.

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Noted Beneficial Practices from Unit Reports Published in FYs 2011–2016 (continued)

State and Report Number	Noted Beneficial Practices	Summary*
North Carolina OEI-07-16-00070	Financial investigator training	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	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 its investigative teams.
Oregon OEI-09-16-00200	Outreach activities	The Unit created a patient abuse and neglect outreach group that provided Unit liaisons to each county in Oregon, attended multi-disciplinary team meetings at the county level, and provided outreach about the Unit's mission and legal authorities.
South Dakota OEI-07-16-00170	Peer education as fraud deterrent	The Unit utilized providers previously investigated for Medicaid fraud to educate peers, as a means of deterrence. These providers gave presentations alongside Unit staff at training conferences.
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.
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 12 outreach contacts per year.

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Noted Beneficial Practices from Unit Reports Published in FYs 2011–2016 (continued)

State and Report Number	Noted Beneficial Practices	Summary*
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 and the number of hours spent on each case. The 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 Unit Director helped create the Vermont Elder Justice Working Group, consisting of representatives from State and Federal advocacy, regulatory, and law enforcement agencies.
Virginia OEI-07-15-00290	Successful partnerships	The Unit's partnerships with the Food and Drug Administration, 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 to improve its ability to process, track, and analyze evidence collected during the investigation of civil cases. This software also improved communication with Federal and State partners, thereby facilitating the investigation and prosecution of joint cases.

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Noted Beneficial Practices from Unit Reports Published in FYs 2011–2016 (continued)

State and Report Number	Noted Beneficial Practices	Summary*
Washington OEI-09-16-00010	Managed care referrals	The Unit worked with the State Medicaid agency to revise both the MOU between the Unit and the agency and the agency's contracts with MCOs to ensure that the Unit received copies of all MCO fraud referrals.
	Program integrity recommendations	The Unit used a case closure form to make numerous program integrity recommendations to State agencies and tracked the responses to these recommendations in a database.
West Virginia OEI-07-13-00080	Improved staff credentials and Unit outreach	Two individuals in the Unit passed examinations to become CFEs 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 2011–2016.
*For more details about these noted practices, please see the respective reports at http://oig.hhs.gov/reports-and-publications/oei/m.asp#mfcu.

Appendix B: FY 2016 MFCU Case Outcomes and Open Investigations by Provider Type and Case Type

Exhibit B1: FY 2016 Outcomes: Number of Convictions, Settlements and Judgments, and Recoveries by Provider Type and Case Type

Provider Type	Criminal		Civil	
	Number of Convictions	Amount of Recoveries	Number of Settlements and Judgments	Amount of Recoveries
PATIENT ABUSE OR NEGLECT				
Assisted Living Facility	17	$65,735	0	$0
Developmental Disability Facility (Residential)	12	$7,361	1	$14,599
Non-Direct Care	29	$811,166	0	$0
Nurse (LPN, RN, or other licensed), Nurse Practitioner, or Physician Assistant	82	$177,651	1	$40,582
Nurse Aide (CNA or Other)	134	$229,072	0	$0
Nursing Facilities	17	$16,913	8	$250,000
Personal Care Services Attendant or Other Home Care Aide	52	$247,972	0	$0
Other Individual or Organization	61	$723,758	0	$0
FRAUD: Inpatient and/or Residential Facility-Based Medicaid Providers and Programs				
Assisted Living Facility	2	$9,380	1	$93,876
Developmental Disability Facility (Residential)	0	$0	4	$552,245
Hospice	2	$5,691,146	3	$3,412,603
Hospitals	2	$6,363,529	13	$8,376,065
Mental Health Facility (Inpatient)	1	$0	0	$0
Nursing Facilities	7	$11,940	6	$19,451,697
Other Long Term Care Facility	0	$0	2	$354,962
FRAUD: Outpatient and/or Day Services Facility-Based Medicaid Providers and Programs				
Adult Day Center	2	$0	6	$904,103
Developmental Disability Facility (Non-Residential)	2	$2,072,213	1	$45,000
Mental Health Facility (Non-Residential)	14	$1,190,135	5	$1,618,793
Substance Abuse Treatment Center	13	$54,306	0	$0
Other Facility (Non-Residential)	2	$50,902	8	$5,641,797
FRAUD: Licensed Practitioners				
Audiologist	1	$60,155	0	$0
Chiropractor	1	$203,189	3	$85,492
Clinical Social Worker	24	$2,369,758	2	$54,027
Dentist	17	$2,663,960	23	$8,793,977
Nurse (LPN, RN, or other licensed)	80	$12,371,758	9	$58,223
Nurse Practitioner	7	$53,908	1	$27,896

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Exhibit B1: FY 2016 Outcomes: Number of Convictions, Settlements and Judgments, and Recoveries by Provider Type and Case Type (continued)

Provider Type	Criminal		Civil	
	Number of Convictions	Amount of Recoveries	Number of Settlements and Judgments	Amount of Recoveries
FRAUD: Licensed Practitioners (continued)				
Optometrist	2	$127,283	2	$264,304
Pharmacist	10	$14,725,546	3	$5,943,777
Physician Assistant	2	$0	0	$0
Physical Therapist, Speech Therapist, Occupational Therapist, Radiation Therapist or other licensed Non-Mental Health Therapist	6	$88,132	5	$201,588
Podiatrist	1	$1,178,188	1	$83,678
Psychologist	20	$1,202,250	1	$95,528
Other Licensed Practitioner	24	$6,382,423	7	$5,736,751
FRAUD: Medical Services				
Ambulance	9	$2,251,047	4	$332,535
Billing Services	4	$917,341	1	$32,408
Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)	29	$5,014,066	56	$30,978,589
Home Health Agency	48	$118,661,017	29	$9,058,643
Lab (Clinical)	3	$1,557,683	64	$40,793,287
Lab (Radiology and Physiology)	15	$1,132,120	1	$793,888
Lab (Other)	0	$0	5	$838,230
Medical Device Manufacturer	0	$0	67	$56,517,210
Pain Management Clinic	6	$1,100	0	$0
Personal Care Services Agency	36	$4,108,575	53	$2,302,117
Pharmaceutical Manufacturer	0	$0	463	$1,176,161,182
Pharmacy (Hospital)	0	$0	1	$9,906
Pharmacy (Institutional Wholesale)	1	$11,517	27	$7,077,239
Pharmacy (Retail)	29	$416,410	30	$50,236,115
Transportation (Non-Emergency)	25	$9,398,553	8	$3,370,062
Other Medical Services	13	$212,509	5	$4,688,053
FRAUD: Physicians (MD/Doctor of Osteopathic Medicine, or DO)				
Allergist/Immunologist	1	$176,827	0	$0
Emergency Medicine Physician	0	$0	1	$3,200,000
Family Practice Physician	57	$35,811,403	6	$1,115,881
Internal Medicine Physician	10	$112,220	7	$1,142,697
Neurologist	1	$55,720	0	$0
Obstetrician/Gynecologist	0	$0	3	$138,123

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Exhibit B1: FY 2016 Outcomes: Number of Convictions, Settlements and Judgments, and Recoveries by Provider Type and Case 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)				
Pediatrician	0	$57,400	1	$512,105
Psychiatrist	8	$86,934,035	6	$2,161,274
Radiologist	2	$16,444	0	$0
Surgeon	0	$0	2	$282,543
Other MD/DO	14	$11,234,484	23	$4,021,079
FRAUD: Other Individual Providers				
Nurse Aide (CNA or Other)	19	$64,348	2	$39,733
Optician	4	$0	2	$34,000
Personal Care Services Attendant	464	$7,560,502	5	$23,916
Pharmacy Technician	5	$29,712	0	$0
Unlicensed Counselor (Mental Health)	22	$703,831	0	$0
Unlicensed Therapist (Non-Mental Health)	2	$130,640	0	$0
Other Individual Providers	59	$9,778,506	3	$512,338
FRAUD: Program Related				
Managed Care Organization	3	$3,251,433	3	$49,290,010
Medicaid Program Administration	6	$6,165,676	1	$80,000
Other Program Related	23	$3,583,884	3	$189,384
Total	**1,564**	**$368,498,733***	**998**	**$1,508,034,109***

Source: OIG analysis of MFCUs' Annual Statistical Report data for FY 2016.

*This total does not exactly match the total of the rows above because of rounding.

Exhibit B2: Number of Open Investigations at the End of FY 2016 by Provider Type and Case Type

Provider Type	Open Criminal Investigations	Open Civil Investigations	Total Open Investigations
PATIENT ABUSE OR NEGLECT			
Assisted Living Facility	191	1	192
Developmental Disability Facility (Residential)	94	3	97
Hospice	5	0	5
Non-Direct Care	167	0	167
Nurse (LPN, RN, or other licensed), Nurse Practitioner, or Physician Assistant	478	1	479
Nurse Aide (CNA or Other)	519	0	519
Nursing Facilities	958	50	1,008
Personal Care Services Attendant or Other Home Care Aide	252	0	252
Other Individual or Organization	500	2	502
FRAUD: Inpatient and/or Residential Facility-Based Medicaid Providers and Programs			
Assisted Living Facility	40	14	54
Developmental Disability Facility (Residential)	30	10	40
Hospice	61	52	113
Hospitals	129	213	342
Inpatient Psychiatric Services for Individuals Under Age 21	5	4	9
Nursing Facilities	151	230	381
Other Inpatient Mental Health Facility	16	27	43
Other Long Term Care Facility	13	7	20
FRAUD: Outpatient and/or Day Services Facility-Based Medicaid Providers and Programs			
Adult Day Center	74	13	87
Ambulatory Surgical Center	1	7	8
Developmental Disability Facility (Non-Residential)	20	8	28
Dialysis Center	4	36	40
Mental Health Facility (Non-Residential)	137	37	174
Substance Abuse Treatment Center	104	25	129
Other Facility (Non-Residential)	117	51	168
FRAUD: Licensed Practitioners			
Audiologist	8	2	10
Chiropractor	33	7	40
Clinical Social Worker	97	7	104
Dental Hygienist	4	2	6
Dentist	407	84	491
Nurse (LPN, RN, or other licensed)	444	8	452
Nurse Practitioner	36	4	40
Optometrist	34	3	37
Pharmacist	71	44	115
Physician Assistant	21	0	21

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Exhibit B2: Number of Open Investigations at the end of FY 2016 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	72	19	91
Podiatrist	32	4	36
Psychologist	102	4	106
Other Licensed Practitioner	175	19	194
FRAUD: Medical Services			
Ambulance	143	18	161
Billing Services	29	13	42
Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)	244	445	689
Home Health Agency	677	78	755
Lab (Clinical)	68	438	506
Lab (Radiology and Physiology)	11	28	39
Lab (Other)	13	108	121
Medical Device Manufacturer	3	528	531
Pain Management Clinic	52	6	58
Personal Care Services Agency	229	21	250
Pharmaceutical Manufacturer	153	3,235	3,388
Pharmacy (Hospital)	0	1	1
Pharmacy (Institutional Wholesale)	14	237	251
Pharmacy (Retail)	157	594	751
Transportation (Non-Emergency)	225	22	247
Other Medical Services	123	159	282
FRAUD: Physicians (MD/DO)			
Allergist/Immunologist	8	3	11
Cardiologist	26	13	39
Emergency Medicine Physician	12	5	17
Family Practice Physician	316	15	331
Geriatrician	6	0	6
Internal Medicine Physician	166	15	181
Neurologist	32	3	35
Obstetrician/Gynecologist	38	4	42
Ophthalmologist	14	7	21
Pediatrician	37	8	45
Physical Medicine and Rehabilitation Physician	28	12	40
Psychiatrist	95	7	102
Radiologist	10	8	18
Surgeon	35	2	37
Urologist	5	0	5

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Exhibit B2: Number of Open Investigations at the end of FY 2016 by Provider Type (continued)

Provider Type	Open Criminal Investigations	Open Civil Investigations	Total Open Investigations
FRAUD: Physicians (MD/DO) (continued)			
Other MD/DO	286	72	358
FRAUD: Other Individual Providers			
Nurse Aide (CNA or Other)	70	3	73
Optician	8	4	12
Personal Care Services Attendant	1,919	10	1,929
Pharmacy Technician	9	0	9
Unlicensed Counselor (Mental Health)	97	0	97
Unlicensed Therapist (Non-Mental Health)	10	0	10
Other Individual Providers	274	38	312
FRAUD: Program Related			
Managed Care Organization	13	99	112
Medicaid Program Administration	16	15	31
Other Program Related	45	140	185
Total	**11,318**	**7,412**	**18,730**

Source: OIG analysis of MFCUs' Annual Statistical Report data for FY 2016.

Appendix C: Selected FY 2016 Statistical Data

Exhibit C1: Investigations, Indictments or Charges, Criminal Convictions, and Civil Settlements and Judgments by State*

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	43	21	7	16	3	17	11	0
Alaska	140	1	18	0	29	0	11	0
Arizona	133	38	46	30	61	14	11	0
Arkansas	118	29	16	6	20	7	20	6
California	1,169	566	147	84	98	75	32	0
Colorado	223	3	7	0	12	0	97	0
Connecticut	81	1	3	0	6	0	19	0
Delaware	603	32	5	15	11	8	10	0
District of Columbia	126	3	1	0	6	1	10	0
Florida	606	58	61	17	41	10	21	0
Georgia	479	16	17	2	14	1	18	0
Hawaii	405	36	6	0	4	1	13	0
Idaho	110	6	3	0	3	0	9	0
Illinois	281	48	53	18	46	11	13	0
Indiana	1,264	481	18	9	37	10	26	1
Iowa	267	42	42	38	37	26	22	0
Kansas	141	17	6	0	7	0	11	0
Kentucky	77	40	26	4	10	9	16	0
Louisiana	406	86	64	22	69	6	16	0
Maine	74	14	2	7	0	3	12	0
Maryland	294	87	2	5	5	4	20	0
Massachusetts	437	48	15	0	4	0	33	2
Michigan	472	39	14	5	14	10	26	0
Minnesota	392	5	62	3	42	0	12	0
Mississippi	101	426	14	40	6	58	14	0
Missouri	153	18	21	2	20	1	16	0
Montana	46	9	4	3	4	2	13	0
Nebraska	92	7	7	2	10	2	21	0
Nevada	413	4	14	0	14	0	15	0
New Hampshire	32	34	0	2	0	1	9	0

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Exhibit 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	379	25	8	6	21	4	13	0
New Mexico	181	3	6	0	6	0	15	0
New York	589	118	71	42	88	32	80	0
North Carolina	378	9	15	5	22	3	23	0
Ohio	1,017	443	102	20	110	16	16	0
Oklahoma	206	48	28	9	15	10	16	0
Oregon	87	7	28	2	24	6	13	0
Pennsylvania	451	35	83	2	81	0	11	0
Rhode Island	76	14	5	10	2	8	12	0
South Carolina	146	49	6	7	9	6	16	0
South Dakota	40	6	3	0	1	0	19	1
Tennessee	242	31	22	13	21	19	22	0
Texas	1,236	131	97	12	51	9	21	0
Utah	106	28	1	6	0	4	29	0
Vermont	53	8	8	2	15	1	17	0
Virginia	409	3	40	3	38	4	21	0
Washington	193	8	6	1	9	1	17	0
West Virginia	143	15	19	1	6	4	21	0
Wisconsin	344	23	0	0	7	0	18	0
Wyoming	55	2	0	1	1	0	11	0
TOTAL	**15,509**	**3,221**	**1,249**	**472**	**1,160**	**404**	**988**	**10**
GRAND TOTAL	**18,730**		**1,721**		**1,564**		**998**	

Source: OIG analysis of MFCUs' Annual Statistical Report data for FY 2016.

*The information in this table is accurate as of February 15, 2017.

Exhibit C2: Recoveries and Expenditures by State*

State	Recoveries				Expenditures	
	Criminal	Non-Global Civil Monetary	Global Civil Monetary	Total	Total MFCU	Total Medicaid
Alabama	$113,178	$0	$16,921,363	$17,034,541	$1,379,111	$5,657,488,854
Alaska	$1,804,185	$0	$1,288,904	$3,093,089	$1,394,058	$1,929,110,081
Arizona	$6,514,601	$0	$4,010,571	$10,525,172	$2,770,174	$11,343,767,402
Arkansas	$204,922	$976,797	$8,085,098	$9,266,817	$2,437,992	$6,337,245,143
California	$27,240,288	$5,585,684	$103,375,056	$136,201,028	$32,469,156	$86,608,583,280
Colorado	$899,190	$4,413,980	$9,304,300	$14,617,470	$2,178,699	$8,289,970,721
Connecticut	$63,457	$2,693,048	$18,029,857	$20,786,363	$2,135,726	$7,790,671,895
Delaware	$197,534	$199,894	$1,615,472	$2,012,900	$1,989,706	$2,003,364,878
District of Columbia	$83,344,915	$6,151,303	$1,710,850	$91,207,067	$2,812,205	$2,935,002,292
Florida	$101,059,813	$6,072,461	$58,413,444	$165,545,718	$17,316,568	$22,457,578,621
Georgia	$2,634,624	$16,249,785	$12,686,801	$31,571,210	$4,719,262	$10,283,904,205
Hawaii	$91,071	$0	$1,765,033	$1,856,104	$1,622,502	$2,271,886,352
Idaho	$15,126	$0	$2,640,039	$2,655,166	$833,297	$1,794,759,439
Illinois	$4,605,086	$650,000	$30,223,829	$35,478,915	$7,137,131	$20,172,293,337
Indiana	$2,739,336	$1,464,844	$32,724,220	$36,928,401	$6,484,688	$10,901,014,576
Iowa	$230,695	$3,402,374	$7,023,005	$10,656,073	$1,133,997	$4,914,249,752
Kansas	$47,736	$300,000	$8,927,256	$9,274,992	$1,337,183	$3,421,881,490
Kentucky	$131,735	$24,224,084	$23,279,694	$47,635,513	$3,415,842	$9,893,628,407
Louisiana	$10,770,898	$11,280,735	$18,323,027	$40,374,660	$5,710,826	$8,837,228,184
Maine	$650	$0	$24,386,418	$24,387,068	$910,641	$2,636,443,851
Maryland	$129,969	$336,355	$9,930,035	$10,396,359	$3,843,664	$10,819,233,860
Massachusetts	$54,616	$4,814,263	$77,975,202	$82,844,082	$5,394,276	$17,865,505,404
Michigan	$191,390	$1,440,225	$30,681,104	$32,312,718	$5,053,299	$17,438,676,650
Minnesota	$1,181,413	$2,750	$24,945,482	$26,129,645	$2,367,287	$11,544,958,884
Mississippi	$7,814,578	$531,040	$11,476,226	$19,821,844	$3,406,068	$5,563,413,438
Missouri	$479,804	$526,359	$12,488,713	$13,494,876	$2,215,566	$10,201,941,673
Montana	$45,403	$0	$1,548,360	$1,593,763	$679,021	$1,446,698,958
Nebraska	$15,080,673	$1,021,119	$3,341,351	$19,443,143	$934,567	$2,092,993,865
Nevada	$593,799	$65,500	$1,730,172	$2,389,471	$2,093,050	$3,520,421,319
New Hampshire	$8,214	$0	$2,050,785	$2,058,999	$770,510	$2,076,589,333
New Jersey	$1,269,801	$0	$46,051,017	$47,320,818	$3,899,420	$15,080,356,828

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Exhibit 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	$50,413	$2,688,923	$3,465,867	$6,205,203	$2,190,671	$5,537,037,048
New York	$157,846	$83,441,327	$145,266,934	$228,866,107	$47,018,833	$62,909,519,309
North Carolina	$11,875,419	$5,497,242	$63,043,469	$80,416,129	$5,944,944	$12,821,165,394
Ohio	$23,031,251	$613,899	$40,365,343	$64,010,493	$11,278,343	$22,485,693,773
Oklahoma	$1,642,636	$5,852,102	$13,974,669	$21,469,407	$2,433,434	$4,698,727,448
Oregon	$937,896	$412,500	$8,962,548	$10,312,944	$2,380,639	$8,814,205,907
Pennsylvania	$1,722,619	$0	$40,418,181	$42,140,800	$7,415,937	$28,220,307,793
Rhode Island	$9,003	$273,609	$6,090,923	$6,373,535	$1,326,223	$2,626,681,914
South Carolina	$793,391	$534,152	$15,168,293	$16,495,835	$1,704,531	$6,230,510,941
South Dakota	$1,094	$309,560	$2,009,259	$2,319,912	$438,343	$875,472,076
Tennessee	$1,451,883	$11,160,515	$93,223,123	$105,835,521	$4,828,604	$9,928,469,426
Texas	$53,618,692	$956,471	$73,682,086	$128,257,249	$18,832,570	$41,068,187,142
Utah	$53,620	$7,856,124	$2,123,664	$10,033,408	$2,056,785	$2,251,931,573
Vermont	$271,096	$829,519	$6,806,872	$7,907,487	$928,835	$1,768,236,337
Virginia	$2,499,780	$5,520,880	$25,868,433	$33,889,093	$11,445,452	$8,927,198,595
Washington	$122,620	$2,748,078	$52,435,513	$55,306,211	$4,534,668	$11,458,035,943
West Virginia	$488,454	$1,227,123	$3,556,154	$5,271,732	$1,257,637	$3,813,616,346
Wisconsin	$104,688	$60,000,000	$20,967,132	$81,071,820	$1,342,631	$8,026,421,926
Wyoming	$107,632	$0	$1,328,341	$1,435,973	$493,574	$637,273,743
TOTAL	**$368,498,733**	**$282,324,622**	**$1,225,709,487**	**$1,876,532,842**	**$258,698,147**	**$571,229,555,606**

Source: OIG analysis of MFCUs' Annual Statistical Report data for FY 2016.

*The information in this table is accurate as of February 15, 2017.

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ENDNOTES

[1] The Act § 1903(q)(3). Regulations at 42 CFR § 1007.11(b)(1) add that a Unit's responsibilities may include reviewing complaints of misappropriation of patients' private funds in residential health care facilities. Unit investigations of patient abuse and neglect are limited to incidents occurring in: (1) health care facilities that receive Medicaid payments, or (2) board and care facilities, which are residential settings that receive payment on behalf of two or more unrelated adults who reside in the facility and for whom nursing care services or a substantial amount of personal care services are provided. The Act § 1903(q)(4).
[2] The Act § 1902(a)(61).
[3] North Dakota and the territories of American Samoa, Guam, the Northern Marianas Islands, Puerto Rico, and the U.S. Virgin Islands have not established Units.
[4] The Act § 1903(q)(2); 42 CFR § 1007.9(a).
[5] The Act § 1903(q)(6); 42 CFR § 1007.13.
[6] 42 CFR § 1007.9(d).
[7] The Act § 1903(q)(1).
[8] The Act § 1903(a)(6).
[9] Ibid.
[10] OIG analysis of FY 2016 MFCU annual statistical reporting data.
[11] The Act § 1903(a)(6). The Act authorizes the Secretary of HHS to award grants to the Units; the Secretary delegated this authority to the OIG.
[12] 42 CFR § 1007.15.
[13] MFCU performance standards are published at 77 Fed. Reg. 32645 (June 1, 2012).
[14] The FY 2016 Interactive Map may be accessed at: http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/maps/interactive-map2016.asp. OIG also maintains a FY 2016 Statistical Chart, which may be accessed at: http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2016-statistical-chart.pdf.
[15] Prior to FY 2014, Units submitted data on a quarterly basis, through Quarterly Statistical Reports. Beginning in FY 2015, Units submitted data on an annual basis, through Annual Statistical Reports. Materials Units submit for recertification include a response to a recertification questionnaire and an annual report that details the Unit's activities.
[16] Return on investment was calculated by dividing Unit recoveries by the total MFCU grant expenditures. The calculation included settlements and judgments on global cases coordinated by NAMFCU.
[17] According to the Act § 1128, 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 March 2, 2017.