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Fiscal Year 2013

Annual Report

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INTRODUCTION

This Medicaid Fraud Control Unit (MFCU or Unit) Fiscal Year (FY) 2013 Annual Report highlights statistical achievements from the investigations and prosecutions conducted by 50 MFCUs nationwide. The Office of Inspector General (OIG) compiled information from Quarterly Statistical Reports (QSRs) submitted by each Unit, as well as supplemental data gathered by OIG through a variety of methods. See Appendix A for details about data sources used in this Annual Report. OIG maintains updated MFCU information on the OIG Web site, such as an interactive map with statistical information about each MFCU. This report represents a new effort by OIG to compile in one document information about MFCU activities and results, and we anticipate issuing annual reports for future years.

MFCU Operations

MFCUs investigate and prosecute Medicaid provider fraud and patient abuse and neglect in health care facilities or board and care facilities.[1] In FY 2013, 49 States and the District of Columbia (States) operated Units. As part of their Medicaid plans, all States are required to operate a Unit or demonstrate to the Secretary of Health and Human Services that operation of a MFCU would not be cost effective and that other program integrity protections are in place.[2] Units are jointly funded; the Federal government reimburses 75 percent of the costs of operating a Unit, with the States contributing the remaining 25 percent.[3] In FY 2013, combined Federal and State expenditures for the Units totaled $230 million.[4] The 50 Units employed 1,912 individuals at the end of FY 2013.[5]

Each Unit must be a single, identifiable entity of State government, distinct from the single State Medicaid agency, and must develop a formal agreement (i.e., Memorandum of Understanding, or MOU) that describes its relationship with that agency).[6] MFCUs are required to have Statewide authority to prosecute their own cases or have formal procedures to refer suspected criminal violations to an office with such authority.[7] In FY 2013, 44 of the Units were in offices of State Attorneys General; in the remaining 6 States, the Units were in other State agencies.[8]

MFCUs operate on an interdisciplinary model and must employ a combination of investigators, auditors, and attorneys.[9] Unit staff review referrals provided by the State Medicaid agency and other sources and determine the potential for criminal prosecution and/or civil action. Although Units received many referrals of cases of potential fraud, often from the program integrity divisions of State Medicaid agencies, referrals may also come from a variety of other sources, including direct referrals from the general public. Similarly, Units receive referrals of patient abuse and neglect from a variety of sources, including local adult protective services agencies. MFCUs' authority to receive Federal funding for cases of patient abuse and neglect extends to Medicaid-funded health care facilities, such as nursing homes, and to "board and care" facilities, such as assisted living facilities, which may or may not be funded by Medicaid.[10] Additionally, the National Association of Medicaid Fraud Control Units (NAMFCU) coordinates MFCUs, typically through the involvement of MFCU attorneys from around the Nation, to work with the U.S. Department of Justice and OIG on "global"—i.e., multi-State—civil false-claims cases.

INTRODUCTION

OIG Oversight of MFCUs

HHS OIG oversees MFCUs and administers grants that provide Federal funding for Unit operations. As required by statute, OIG developed 12 performance standards for use in assessing the operations of MFCUs. A copy of the MFCU performance standards, most recently revised in June 2012, may be found on the OIG Web site at https://oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf.[11]

On an annual and quarterly basis, MFCUs provide OIG with statistical and other information about Unit operations and the results of investigations and prosecutions. OIG uses this Unit information, as well as information from other sources, to determine whether to annually recertify each Unit. Periodically—approximately every 5 years—OIG conducts an in-depth onsite review of each Unit to evaluate its operations as related to the 12 performance standards and to assess compliance with laws, regulations, and OIG policy guidance.

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.

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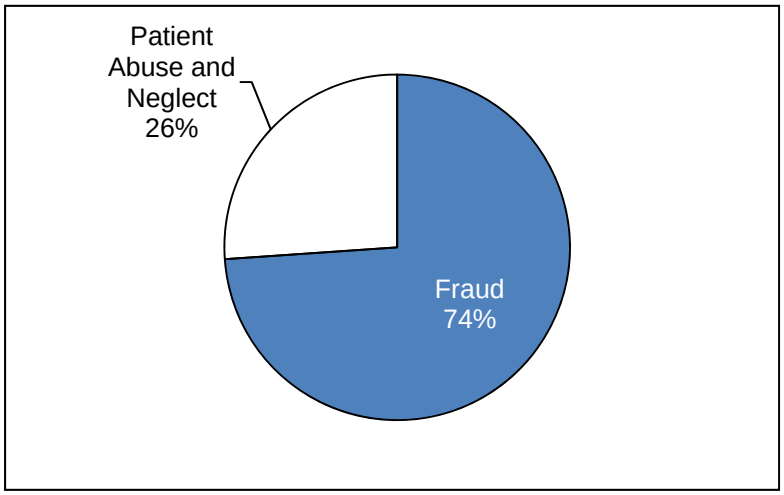
MFCU CASE OUTCOMES

MFCUs reported 1,341 criminal convictions, mostly for fraud, in FY 2013

As shown in Chart 1, about three-quarters of criminal convictions involved fraud; about one-quarter involved patient abuse and neglect.[12]

Chart 1: Percentage of FY 2013 Criminal Convictions by Type of Case (Fraud vs. Patient Abuse and Neglect)



Source: OIG analysis of Quarterly Statistical Report, 2013.

FY 2013 criminal convictions for fraud: 74 percent

Fraud convictions included convictions for (1) conspiracy to commit health care fraud, (2) health care fraud, (3) submitting false statements related to health care matters, (4) making a false statement in regard to health care reimbursements, (5) grand larceny, and (6) violations of anti-kickback statutes. For example, in August 2013, the New York MFCU obtained a conviction of the owner of several pharmacies for stealing $7.7 million from the New York State Medicaid program. The pharmacist submitted phony bills for drugs that were never dispensed to patients. He was sentenced to a prison term of up to 3 years and was ordered to repay the stolen money to the New York Medicaid program.

FY 2013 criminal convictions for patient abuse and neglect: 26 percent

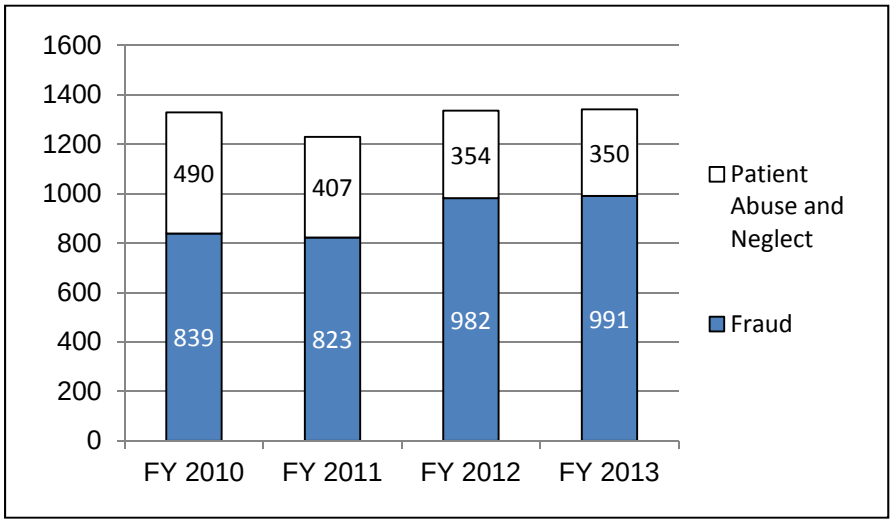
Cases of patient abuse and neglect included aggravated assaults; injury to an elderly or disabled person; and theft of patient funds.[13] For example, in September 2013, the Maryland MFCU obtained a conviction of a nursing home aide for abuse of a vulnerable adult in the second degree. The convicted aide was placed on 2 years of probation, during which time he is prohibited from being employed in any position that includes the supervision of vulnerable adults. As another example, in August 2013, the Connecticut MFCU obtained a conviction of a nursing home accounts-receivable clerk for stealing from a patient's trust account. The clerk was sentenced to serve 7 years in prison with 5 years' probation. The clerk was also ordered to pay $140,171 in restitution to the Connecticut Medicaid program and is prohibited from working in the financial or health care sectors.

MFCU CASE OUTCOMES

FYs 2010–2013 criminal convictions

The total number of criminal convictions has remained relatively consistent in recent years. As shown in Chart 2, convictions related to fraud consistently represented the majority of all criminal convictions.

Chart 2: Number of Criminal Convictions by Type of Case (Fraud vs. Patient Abuse and Neglect), FYs 2010–2013



Source: OIG analysis of Quarterly Statistical Reports, 2013.

FY 2013 criminal convictions involved a variety of provider types, most notably home health agencies

MFCUs criminal convictions most frequently involved home health care aides (26 percent of all criminal convictions), other medical support (7 percent), and physicians (7 percent). See Appendix B for a list of all convictions by provider type.

Home health care aides: 26 percent of criminal convictions

Home health care aides were most commonly convicted of fraud, often for claiming to have rendered services that were not provided to vulnerable beneficiaries. For example, a Nevada MFCU case resulted in the conviction of an individual employed by a home health care company who claimed she provided services, such as bathing, dressing, cleaning, and meal preparation, from February 2011 to September 2011, and who was paid for these services. However, the individual's outside employment conflicted with the care she claimed to have provided. She was convicted of submitting false claims and sentenced to 30 days' incarceration; suspended from participation in the Nevada Medicaid program; required to perform 20 hours of community services; and made to pay $1,250 in restitution, penalties, and costs.

Other medical support: 7 percent of criminal convictions

The category "other medical support" includes individuals, facilities, or organizations, whether licensed or unlicensed, that provide medical support services. This category specifically excludes pharmacies; pharmaceutical manufacturers; suppliers of durable medical equipment; laboratories; providers of transportation; home health care agencies and aides; nurses; physician

assistants; nurse practitioners; and radiologists. Individuals in this provider category were convicted of a wide variety of offenses. For example, a District of Columbia (D.C.) MFCU case resulted in the conviction of the chief executive officer and owner of 2 rehabilitative and therapeutic services companies on 1 count of health care fraud and 34 counts of false statements for submitting more than $7 million in fraudulent claims to the D.C. Medicaid program. According to evidence presented at trial, this individual submitted false claims for therapeutic procedures, such as manual therapy, between January 2006 and April 2008. The defendant billed Medicaid for as many as 48.5 hours of manual therapy for a single patient during a 24-hour period. As of February 2014, the defendant was awaiting sentencing and faced a maximum of 10 years in prison, a $250,000 fine for the health care fraud conviction, and a $250,000 fine for each of the false-statement convictions.

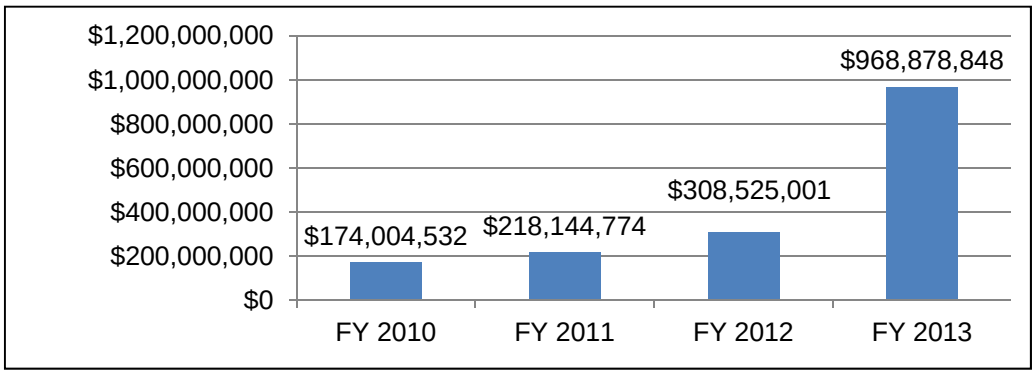
Physicians: 7 percent of criminal convictions

Criminal convictions of physicians involved offenses such as fraud (including prescription fraud) and billing for services not rendered. For example, a California MFCU case resulted in the conviction of two physicians for grand theft and receiving unlawful remuneration. The physicians worked at a pregnancy clinic alongside marketers who wore scrubs and offered pregnant women free baby gifts to visit the clinic. The women were told to use false names and birth dates so they could visit repeatedly for more gifts. The clinic enrolled the women in Medi-Cal's (California's Medicaid program) program for prenatal care (which uses a presumptive eligibility standard, then performed cursory examinations, billed Medi-Cal for extensive prenatal services that were never rendered, and paid the marketers $100 per patient.

FY 2013 criminal case recoveries reached nearly $1 billion

As shown in Chart 3, recoveries in FY 2013 exceeded the combined amount of recoveries in FYs 2010–2012. A single case accounted for the bulk of these FY 2013 recoveries. In that case, the Virginia MFCU led a joint State-Federal investigation of Abbott Laboratories, which admitted liability for unlawful promotion of a prescription drug (Depakote) for uses not approved by the Food and Drug Administration. The case resulted in the largest State MFCU criminal recovery in U.S. history.

Chart 3: Criminal Recoveries, FYs 2010-2013



Source: OIG analysis of Quarterly Statistical Reports, 2013.

MFCU CASE OUTCOMES

MFCUs reported 879 civil settlements and judgments in FY 2013

FY 2013 global civil settlements and judgments: 65 percent

In FY 2013, MFCUs participated in the resolution of NAMFCU-coordinated global cases involving 588 civil settlements and 13 judgments.[14] One example of a global civil settlement is the case of ISTA Pharmaceuticals, Inc., in which numerous MFCUs reached a $15 million agreement to settle allegations that between January 2006 and March 2011, ISTA marketed one drug for uses not approved by the Food and Drug Administration and allegations that ISTA paid doctors to write prescriptions for another unapproved ISTA drug. ISTA paid approximately $18.5 million in a related criminal case in addition to the civil settlement.

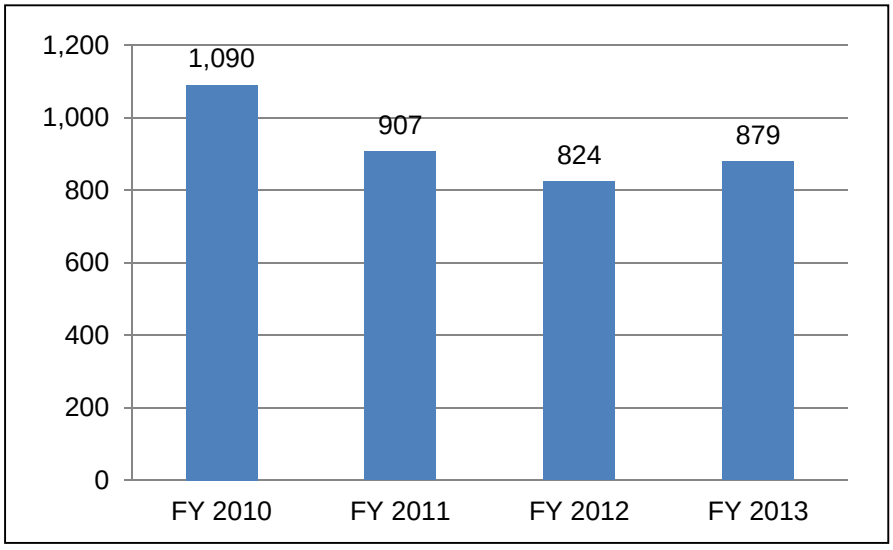
FY 2013 "State-only" civil settlements and judgments: 35 percent

"State-only" cases are civil cases that involve only the State as the plaintiff. For example, the New York MFCU was responsible for investigating a case in which the State reached a $268,494 settlement with a dental center that received Medicaid payments for services that were in violation of State regulations. The dental clinic billed Medicaid for patient teeth cleanings that took place more frequently than the allowed once every 6 months, failed to properly document billed services, and billed for noncovered services, all in violation of State Medicaid regulations.

FYs 2010–2013 civil settlements and judgments

As shown in Chart 4, the total number of civil settlements and judgments remained relatively consistent in recent years.

Chart 4: Total Number of Civil Settlements and Judgments, FYs 2010-2013



Source: OIG Analysis of Quarterly Statistical Reports, 2013.

MFCU CASE OUTCOMES

FY 2013 civil settlements and judgments involved a variety of provider types, most notably pharmaceutical companies

MFCUs most often obtained settlements and judgments from pharmaceutical manufacturers (62 percent of all civil settlements and judgments), pharmacies (6 percent), and home health care agencies (5 percent). See Appendix B for a list of all convictions by provider type.

Pharmaceutical manufacturing: 62 percent of civil settlements and judgments

In FY 2013, pharmaceutical manufacturing cases accounted for more than half of all MFCU cases with civil settlements and judgments. As an example, the Virginia MFCU led an investigation, along with 44 other Units organized through NAMFCU, the District of Columbia, and the Federal Government, that reached a $1.5 billion civil settlement agreement with Abbott Laboratories. This action settled allegations that Abbott Laboratories (1) illegally marketed the drug Depakote for uses that were not approved by the Food and Drug Administration as safe and effective; (2) made false and misleading statements about the safety, efficacy, dosing and cost-effectiveness of Depakote for some unapproved uses; improperly marketed the product in nursing homes; and paid illegal remuneration to health care professionals and long-term-care pharmacy providers to induce them to promote and/or prescribe Depakote.

Pharmacies: 6 percent of civil settlements and judgments

Pharmacies were the second most common provider type in civil settlements and judgments. In one case, the Vermont MFCU settled with a pharmacy over allegations that the pharmacy obtained excessive payment from the Vermont Medicaid program by submitting claims for dispensing drugs more frequently than instructed by physicians and more frequently than permitted under Medicaid rules, and by charging beneficiaries illegal administrative fees and copayments. The pharmacy agreed to make a settlement payment of $250,000, with additional payments, plus interest, over 7 years. The pharmacy also agreed to reimburse beneficiaries for copayments and administrative fees, which the State expects to total $111,000. The pharmacy also agreed to heightened monitoring of its Medicaid claims by the State for the next 5 years.

Home health care agencies: 5 percent of civil settlements and judgments

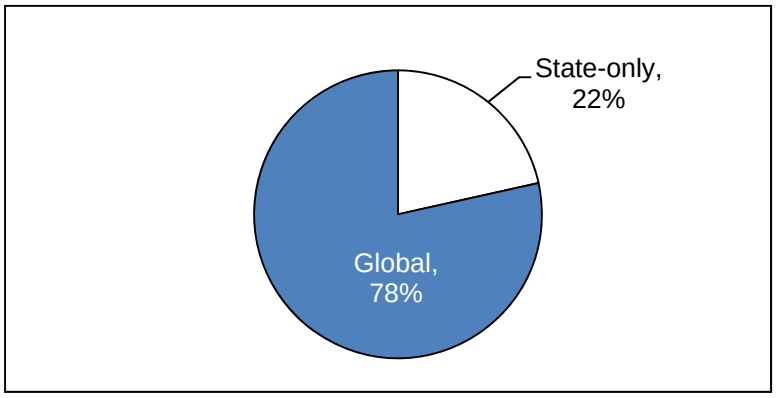
Home health care agencies were the third most common provider type for civil settlements. For example, the Michigan MFCU, along with the U.S. Attorney's Office, the Federal Bureau of Investigation, OIG, and Blue Cross Blue Shield of Michigan, reached a $1 million civil settlement with several health care entities over allegations of conspiracy to pay illegal kickbacks to practitioners and others for referring patients to clinics and agencies. As part of the civil settlements, the owner of one home health agency agreed to a 20-year exclusion from Federal health care programs, including Medicaid and Medicare.

MFCU CASE OUTCOMES

FY 2013 recoveries from civil cases totaled over $1.5 billion—most from multi-State, global settlements—generally consistent with recent years

As shown in Chart 5, recoveries from global cases accounted for 78 percent of the $1.5 billion in civil recoveries in FY 2013. As mentioned above, global cases often involve large pharmaceutical manufacturing companies, multiple MFCUs, and the U.S. Department of Justice, and result in large financial settlements.

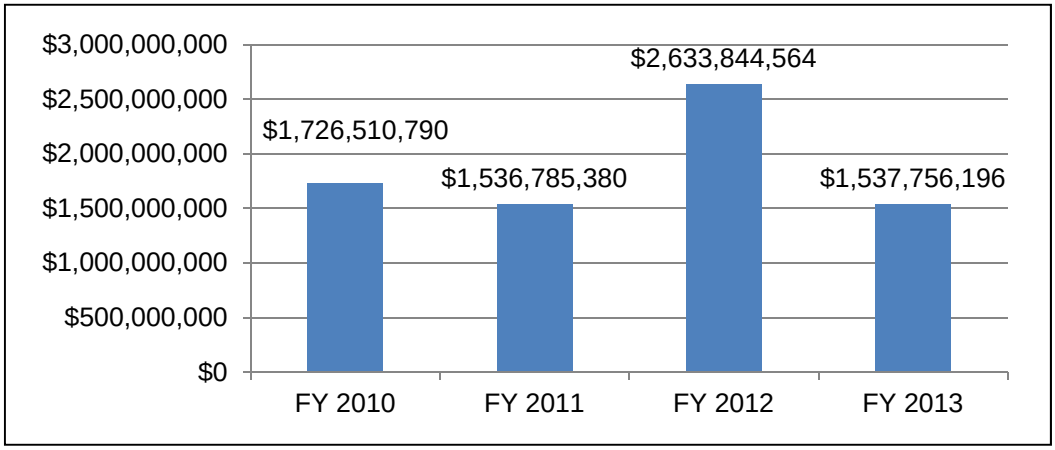
Chart 5: Percentage of Civil Recoveries That Resulted from Global and State-Only Settlements, FY 2013*



Source: OIG Analysis of FY 2013 MFCU Annual Report Supplemental Data Collection, 2013.
*This information differs slightly from that reported in the Quarterly Statistical Reports, which does not break out civil recoveries into global and State-only categories. Additionally, not all Units were able to provide civil recovery information broken out into these two categories.

As shown in Chart 6, total recoveries from MFCU civil settlements and judgments have been consistent in recent years, with the noticeable exception of FY 2012. The somewhat larger amount in FY 2012 is attributable to large global pharmaceutical cases settled that year. See Appendix D for additional analysis of both criminal and civil MFCU outcomes in FYs 2010 through 2013.

Chart 6: Civil Recoveries, FYs 2010-2013



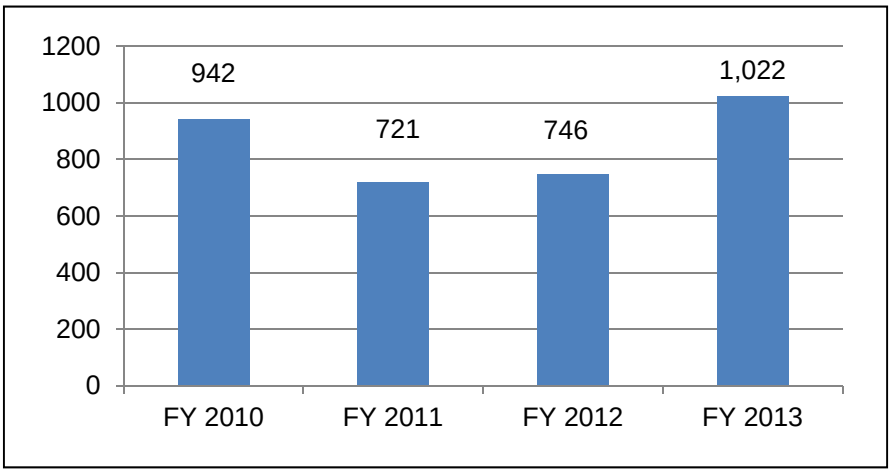
Source: OIG analysis of Quarterly Statistical Reports, 2013.

PROVIDER EXCLUSIONS

MFCU convictions often led to the providers' exclusions from all Federal health care programs

In FY 2013, OIG excluded 1,022 subjects as a result of MFCU investigations, prosecutions, and convictions. As shown in Chart 7, this continues a pattern from previous years, demonstrating that MFCUs are an important source of referrals to OIG for purposes of exclusion. OIG excludes individuals and entities from federally funded health care programs (primarily Medicare and Medicaid) when the providers are convicted of program-related crimes.[15] Exclusion means that no payment will be made for any items or services furnished, ordered, or prescribed by an excluded individual or entity.[16] OIG data show that the number of MFCU cases that lead to exclusions by OIG has accounted for a quarter or more of all OIG exclusions in recent years.

Chart 7: OIG Exclusions Based on MFCU Referrals, FYs 2010-2013



Source: OIG analysis of HHS OIG exclusion data, 2013.

OTHER OBSERVATIONS

Lack of fraud referrals from Medicaid managed care organizations presents challenges for MFCUs

Medicaid services provided under managed care have steadily increased in recent years, with the number of enrollees receiving services through managed care exceeding 42 million in 2011, or about 74 percent of the total Medicaid population.[17] A December 2011 OIG report found that fraud and abuse in managed care was a primary concern to State Medicaid agencies and managed care organizations (MCOs).[18] Like other health care payers, MCOs may receive false or fraudulent claims from providers. Federal regulations require Medicaid MCOs to establish arrangements or procedures to guard against fraud and abuse.[19] For example, MCOs may use "edits" (system processes to ensure proper payment of claims) and retrospective reviews of claims to prevent and detect fraud and abuse. Further, State contracts can require MCOs to report instances of suspected fraud to the State Medicaid agency, the MFCU, or both.

However, in responses gathered for this report, officials from many MFCUs voiced concerns about a lack of fraud referrals from MCOs in their States. Specifically, officials from 21 MFCUs reported that their Units received fewer fraud referrals from Medicaid MCOs than the respondents expected on the basis of the number of managed care-covered beneficiaries in their States. Further, only 25 MFCUs reported receiving any referrals from Medicaid MCOs in FY 2013.[20] Although direct referrals from MCOs are not the only way Units can learn about potential fraud in Medicaid managed care—for example, State agencies can forward allegations of fraud to the Units—the MCOs are a critical source of referrals. This is especially important for the increasing number of States that cover a substantial proportion of Medicaid beneficiaries through managed care arrangements.

Through survey responses, some Unit officials also expressed possible reasons for this low volume. Some respondents noted that because managed care is relatively new for some State programs, MCOs were still developing and refining processes for fraud detection. Others commented that some MCOs had only a small number of employees assigned to fraud prevention, had not established robust efforts for detecting potential fraud, or used a narrow interpretation of the provider activities that would constitute potential fraud and warrant referral. A common concern expressed was that MCOs lack the incentive to detect and refer potential fraud and may even have an incentive *not* to do so. For instance, MCOs indicated that they may find it time-consuming to make referrals and support investigations, that MCOs can lose money if their contracts do not allow them to share in fraud-related recoveries, and that MCO contracts typically do not include negative consequences for a lack of fraud referrals. Thus, some MCOs may find it preferable to remove a provider from their networks, rather than compiling supporting documentation and making a fraud referral to the State Medicaid agency or MFCU. To further examine these issues, OIG is planning (as part of its FY 2014 Work Plan) an evaluation of how effectively Medicaid MCOs identify and address incidents of potential fraud and how States oversee MCOs' efforts to fight fraud and abuse.

Several MFCU officials also identified recent efforts to improve coordination with their States' MCOs to increase the number of referrals, including establishing periodic meetings with MCO program integrity staff to improve coordination, building informal relationships with

MCO program integrity staff, developing data mining for MCO-generated encounter data to detect potential fraud, and working with the State Medicaid agency to adjust incentives to encourage more robust engagement by MCOs in detecting and referring potential fraudulent activity.

Recent payment suspension rules require more coordination between MFCUs and State Medicaid agencies

Federal provisions related to payment suspension were revised in the Patient Protection and Affordable Care Act of 2009 (ACA) and implemented in Federal regulations found at 42 CFR § 455.23, which took effect on March 25, 2011.[21] Under these provisions, State Medicaid programs must suspend payments after the Medicaid agency determines that a credible allegation of fraud exists against a provider enrolled in the Medicaid program.[22] In such cases, regulations require the Medicaid agency to (1) refer the case to the MFCU or other appropriate law enforcement agency and (2) suspend the provider's payments unless the Medicaid agency determines that a "good cause" exception applies, which results in a payment suspension not being imposed despite a credible allegation of fraud.[23]

As of December 2013, 37 MFCUs had updated their MOUs with their State Medicaid agencies to include language that seeks to address payment suspension of Medicaid providers against whom there is a credible allegation of fraud. (Federal regulations require that these MOUs be maintained.) In accordance with MFCU performance standards, Units must update their MOUs with the State Medicaid agency periodically (at least once every 5 years) to reflect current law and practice.[24] The remaining 13 Units had not updated their MOUs since the new payment suspension rule went into effect in 2011. In various communications with OIG, most Units reported already having implemented procedures for coordinating with their respective State Medicaid agencies on such fraud cases, and were in the process of formally updating their MOUs to reflect those procedures.

During OIG's recent onsite reviews of MFCUs, representatives from some MFCUs and State agencies identified potential challenges associated with payment suspension based on credible allegations of fraud. One challenge involves State entities determining what constitutes a credible allegation of fraud. Although, in many cases, the fraudulent activity may be obvious on the basis of initial evidence, interviewees explained that other circumstances may require substantial review to determine whether payment suspension is warranted. Another challenge involves making determinations in a timely manner. To ensure prompt suspension of payments, if warranted, Units and State Medicaid agencies must coordinate in a timely manner when determining whether an allegation is credible. Another challenge involves determining standards for use of "good cause" exceptions. A Unit may request a "good cause" exception to avoid compromising a case by alerting suspects that they are under investigation. A State Medicaid agency may invoke a "good cause" exception if it determines that a payment suspension is not in the best interests of the Medicaid program, such as when no other providers are available to treat Medicaid beneficiaries in a specific geographical area. To further examine these issues, OIG has undertaken additional reviews regarding payment suspension for a credible allegation of fraud.

OIG OVERSIGHT

In FY 2013, OIG conducted 10 onsite reviews of Units, published 8 reports on onsite reviews, issued regulations to allow data mining by MFCUs, and proposed new investigative authority regarding patient abuse and neglect

Onsite reviews

OIG conducted onsite reviews of 10 Units in FY 2013. OIG conducts these oversight reviews for each Unit approximately every 5 years to assess Unit compliance with applicable Federal laws, regulations, and policies, and Unit adherence to the 12 performance standards. During onsite reviews, OIG meets with Unit officials and with other key stakeholders familiar with the Unit's operations, such as the State Medicaid agency's program integrity staff and Federal investigators and prosecutors who sometimes partner with the Unit. OIG reviews the Unit's operations during the onsite visit, including policies, procedures, financial documentation, and information about staffing and staff training. OIG reviews a sample of case files to assess (1) the Unit's compliance and performance in its handling of cases, including whether cases fell within the scope of Unit authority; (2) its supervisory oversight of cases; (3) and the timeliness of its casework.

Reports on onsite reviews

In FY 2013, OIG published 8 reports on MFCU onsite reviews. (See Appendix E for a list of these reports.) Each report includes results from the onsite review; identifies any areas of Unit noncompliance with Federal laws, regulations, or policies; identifies areas in which operations did not adhere to the 12 performance standards; and includes other observations, as appropriate. The reports also contain recommendations for any corrective action that the Unit needs to take. Findings from these reviews revealed a few common concerns:

- **Unit submission of conviction information**: Onsite reviews revealed differences in interpretation about which convictions Units should refer to OIG. In 2013, OIG officials issued additional guidance to MFCUs clarifying that Units should submit to OIG all pertinent information on MFCU convictions—including charging documents, plea agreements, and sentencing orders—within 30 days of sentencing so that OIG may determine whether to impose exclusion.[25]
- **Case file documentation and reviews**: Onsite reviews revealed variation in Unit practices for maintaining records in case files and for ensuring supervisory review of ongoing investigations. The reports identified situations in which case file practices did not adhere to performance standards and recommended corrective actions, as appropriate.
- **Completeness of MFCU staff training plans**: Onsite reviews revealed that several Units' training plans did not fully address the needs of professional staff (i.e., attorneys, auditors, and investigators). Reports made recommendations, as appropriate.
- **Collaboration with the State Medicaid agency's program integrity staff**: Several onsite review reports highlighted critical interactions between MFCU staff, who investigate and prosecute Medicaid fraud, and their counterparts in the State Medicaid agency's program integrity unit, who often detect fraud and implement fraud prevention

initiatives. These reports included findings and observations showing healthy and innovative collaboration in some States, as well as challenges that prevented effective collaboration in others. OIG encourages MFCU and Medicaid agency officials in all States to continue to improve how their entities work together to identify and deter Medicaid fraud.

Regulation on data mining

On May 17, 2013, OIG issued regulations giving new authority to MFCUs for data mining.[26] Units may now submit plans—subject to OIG approval, in consultation with CMS—to receive Federal matching funds for screening and analyzing State Medicaid data. As described in the background to the revised regulation, analysis of Medicaid claims data has historically been the responsibility of each State Medicaid agency, and MFCUs have been prohibited from receiving Federal funding to conduct data mining. However, this practice of relying on State Medicaid agencies has required MFCUs to remain highly dependent on referrals from those agencies. Under the new regulation, MFCUs may submit applications to OIG for approval to conduct data mining; these applications must include information about the Unit's methods for 1) coordination with the State Medicaid agency, 2) staying current regarding programmatic knowledge, and 3) training MFCU staff in data mining techniques. As part of its approval process, OIG coordinates with CMS, which oversees the Medicaid program at the Federal level.

Legislative proposal to expand authority regarding cases of patient abuse and neglect

The President's FY 2014 budget includes an OIG proposal to expand MFCUs' authority with regard to cases of patient abuse and neglect.[27] Under current law, MFCUs are limited in their investigations of such cases to complaints arising either in Medicaid-funded facilities (such as hospitals or nursing homes) or in "board and care" facilities (such as assisted living facilities). The proposal, reflecting the Medicaid program's increasing reliance on home and community-based services, would permit the investigation and prosecution of patient abuse and neglect arising when Medicaid services are provided in a home or community-based setting. MFCUs investigate a large number of cases of fraud in personal care services and other fraud cases that arise in the home or community. The proposal would permit the Units to also investigate situations of abuse and neglect that arise in these nontraditional settings.

APPENDIXES

Appendix A: Methodology

We based the information in this report on an analysis of data from six sources: (1) Quarterly Statistical Reports; (2) supplemental data collection for the FY 2013 MFCU Annual Report; (3) HHS OIG exclusion data; (4) information gathered through onsite reviews; (5) MFCUs' MOUs with their State Medicaid agencies; and (6) the annual reports of individual MFCUs. We analyzed data from all six sources to describe the criminal and civil case outcomes of MFCUs during FY 2013 and in previous years when data was available. We also analyzed data to describe exclusions from Federal health care programs, other observations about the environment in which MFCUs operate, and OIG oversight of MFCUs. All statistical information is current as of January 31, 2014, except where otherwise noted.

Data Collection and Analysis

Review of Quarterly Statistical Reports. In 2013 and in prior years, MFCUs submitted statistical data to OIG each quarter. In the Quarterly Statistical Reports, Units reported data elements such as the number of open investigations; the number of persons indicted or charged; the number of criminal convictions; the number of civil settlements and judgments; the amount of criminal and civil recoveries; and the number of staff employed. We reviewed Quarterly Statistical Reports for FYs 2010 through 2013 to determine the number of convictions for fraud and for patient abuse and neglect; recoveries associated with those convictions; the number of civil settlements and judgments; and recoveries associated with those civil outcomes.

Supplemental data collection for the FY 2013 MFCU Annual Report. We requested additional data from all MFCUs in November 2013. We received responses from 49 of the 50 Units. We used this supplemental information to provide statistical information about the types of providers that were most frequently convicted in criminal cases or involved in civil settlements and judgments in FY 2013. We determined the number of State-only and global civil settlements and judgments and the recoveries associated with those civil outcomes. The supplemental data collection also provided information about referrals that MFCUs received from MCOs.

HHS OIG exclusion data. We reviewed HHS OIG Exclusion Data to determine the number of Federal health care program exclusions that OIG made on the basis of information referred by MFCUs.

Information from onsite reviews. We examined information gathered during onsite reviews to identify other observations about the environment in which MFCUs operate, such as challenges in receiving referrals from MCOs and the extent to which the new rules on payment suspension require more coordination between MFCUs and State Medicaid agencies.

MOUs between MFCUs and State Medicaid agencies. As a requirement for recertification and to fully adhere to the performance standards, each MFCU must have an MOU with its State Medicaid agency, review the MOU every 5 years, and ensure that the MOU reflects current practice, policy, and legal requirements, including 42 CFR §§ 455.21 and 455.23. We reviewed the most current MOUs as of January 15, 2014, to determine the extent to which they included language about the payment suspension provisions at 42 CFR § 455.23. For purposes of the Annual Report, we identified only whether each MOU referenced the functions outlined in

42 CFR § 455.23; we did not attempt to assess the adequacy or sufficiency of the processes described in the MOUs.

MFCU Annual Reports. As a grant requirement, each MFCU must submit to OIG an annual report that highlights its activities. We reviewed the most recent annual report from each MFCU for case examples of frequently convicted provider types (such as home health care agencies) and provider types with which MFCUs were frequently involved in civil settlements and judgments (such as pharmaceutical manufacturers).

Appendix B: FY 2013 MFCU Criminal and Civil Outcomes by Provider Type

Table B1: FY 2013 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
TOTAL	1,377	$980,130,529	898	$1,499,049,422
ABUSE AND NEGLECT				
Certified Nursing Assistants	75	$39,644	1	$0
Home/Personal Care Aides	14	$147,118	0	$0
Nursing Facilities	10	$154,692	6	$770,845
Registered/Licensed Nurses, Physician Assistants, and Nurse Practitioners	62	$80,284	5	$2,500
Other Long-Term Care	21	$156,538	1	$25,000
Other	44	$40,078	4	$14,790
FRAUD: Facilities				
Hospitals	4	$17,890,082	21	$12,706,211
Nursing Facilities	14	$1,121,053	16	$8,305,826
Substance Abuse Treatment Centers	1	$628,678	2	$22,047
Other Long-Term Care	11	$340,562	3	$2,067,897
Other	10	$4,446,605	13	$7,015,534
FRAUD: Medical Support				
Suppliers of Durable Medical Equipment	35	$22,099,494	7	$2,793,305
Home Health Care Agencies	68	$57,500,409	46	$4,324,719
Home Health Care Aides	363	$6,572,537	25	$325,738
Laboratories	4	$0	5	$28,952,346
Nurses, Physician Assistants, and Nurse Practitioners	59	$1,094,172	10	$256,090
Pharmacies	45	$721,463,280	55	$39,048,460
Pharmaceutical Manufacturers	0	$0	558	$1,344,013,697
Radiologists	0	$0	0	$0
Transportation Providers	38	$8,658,649	12	$3,537,155
Other	92	$5,048,778	13	$13,881,130

Continued on the next page.

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Table B1: FY 2013 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
FRAUD: Practitioners				
Chiropractors	3	$2,061,921	0	$0
Counselors/Psychologists	59	$16,875,233	9	$2,329,487
Dentists	31	$6,620,336	17	$3,483,034
Optometrists/Opticians	6	$1,194,862	3	$282,922
Physicians or Doctors of Osteopathy	94	$95,226,296	42	$21,798,724
Podiatrists	1	$1,363,070	0	$0
Other	14	$1,496,519	6	$257,808
FRAUD: Program Related				
Billing Companies	1	$23,063	1	$240,000
Managed Care Organizations	6	$2,718,602	0	$36,607
Medicaid Program Administration	7	$956,138	0	$0
Other	56	$2,010,511	14	$12,547,974
THEFT OF PATIENT FUNDS				
Certified Nursing Assistants	35	$116,978	0	$0
Nondirect Care	23	$703,901	0	$0
Registered/Licensed Nurses, Physician Assistants, and Nurse Practitioners	6	$7,872	1	$10,000
Other	65	$1,272,572	2	$25

Source: OIG Analysis of supplemental data collection for the FY 2013 MFCU Annual Report, 2013.
*This information differs slightly from that reported in the Quarterly Statistical Reports. Not all Units were able to all provide the information requested in the supplemental data collection for the FY 2013 MFCU Annual Report.
*Some categories are current as of February 21, 2014.

APPENDIX C: Selected FY 2013 Statistical Data

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

State	Investigations		Indictments or Charges		Criminal Convictions		Civil Settlements and Judgments
	Fraud	Abuse and Neglect	Fraud	Abuse and Neglect	Fraud	Abuse and Neglect	
Alabama	10	17	2	2	0	0	8
Alaska	202	17	57	1	17	2	10
Arizona	237	83	50	22	29	8	0
Arkansas	52	38	6	14	3	7	16
California	718	439	69	60	41	27	19
Colorado	241	8	18	0	13	0	36
Connecticut	53	11	15	1	6	1	11
Delaware	478	81	0	5	0	7	9
District of Columbia	115	71	0	1	4	2	15
Florida	596	62	39	28	48	19	28
Georgia	336	4	13	0	10	1	15
Hawaii	50	63	0	7	4	5	13
Idaho	115	4	5	0	4	0	12
Illinois	236	75	41	21	38	26	21
Indiana	812	252	13	2	16	9	30
Iowa	205	35	31	19	18	13	13
Kansas	127	19	7	1	13	0	15
Kentucky	104	14	8	2	8	0	17
Louisiana	317	79	76	17	47	15	39
Maine	31	7	7	2	6	4	6
Maryland	284	36	7	6	12	5	29
Massachusetts	497	186	20	2	17	0	32
Michigan	436	49	11	8	11	17	16
Minnesota	86	3	24	0	20	3	21
Mississippi	78	611	3	33	0	54	14
Missouri	280	21	7	1	13	1	31
Montana	26	1	4	0	6	0	9
Nebraska	75	22	4	0	9	5	19
Nevada	19	3	12	2	13	3	15
New Hampshire	31	7	0	2	1	3	15
New Jersey	352	12	19	3	11	3	14
New Mexico	107	5	8	0	9	1	30
New York	677	124	131	44	110	28	69

Continued on the next page.

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Table C1: Investigations, Indictments or Charges, Criminal Convictions, and Civil Settlements and Judgments by State							
State	**Investigations**		**Indictments or Charges**		**Criminal Convictions**		**Civil Settlements and Judgments**
	Fraud	**Abuse and Neglect**	**Fraud**	**Abuse and Neglect**	**Fraud**	**Abuse and Neglect**	
North Carolina	402	16	20	0	28	2	18
Ohio	701	348	138	15	133	15	21
Oklahoma	135	78	12	11	15	6	20
Oregon	46	4	23	4	27	2	13
Pennsylvania	337	15	76	0	51	3	13
Rhode Island	48	23	9	8	9	0	4
South Carolina	151	26	32	13	21	13	18
South Dakota	42	7	1	1	1	1	0
Tennessee	187	26	14	8	10	14	17
Texas	1165	114	104	8	82	15	18
Utah	93	13	2	0	3	1	15
Vermont	116	18	7	2	9	0	12
Virginia	363	10	24	4	18	3	11
Washington	152	12	10	0	9	2	16
West Virginia	49	42	4	8	7	3	17
Wisconsin	339	11	10	3	8	1	2
Wyoming	57	2	4	0	3	0	17
Total	**12,366**	**3,224**	**1,197**	**391**	**991**	**350**	**879**

Source: OIG analysis of Quarterly Statistical Reports, 2013.

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Table C2: Recoveries, Expenditures, and Staff by State						
State	Recoveries			Expenditures		Staff on Board
	Total	Criminal	Civil	MFCU Grant	Total Medicaid	
Alabama	$16,206,582	$0	$16,206,582	$1,110,349	$5,216,155,508	8
Alaska	$1,093,136	$53,058	$1,040,078	$1,156,792	$1,446,189,444	8
Arizona	$622,974	$589,704	$33,270	$2,408,103	$8,669,976,278	21
Arkansas	$14,622,465	$32,643	$14,589,822	$2,211,756	$4,428,390,909	21
California	$57,748,650	$19,975,038	$37,773,612	$30,260,728	$66,056,757,855	172
Colorado	$8,131,662	$226,252	$7,905,409	$2,046,627	$5,314,867,064	16
Connecticut	$28,228,261	$140,246	$28,088,014	$1,629,583	$6,723,113,621	11
Delaware	$398,817	$28,000	$370,817	$1,877,814	$1,655,387,071	17
District of Columbia	$7,805,484	$3,937,198	$3,868,286	$2,473,055	$2,397,083,097	21
Florida	$40,891,858	$9,048,765	$31,843,093	$14,179,446	$19,180,703,866	151
Georgia	$28,881,718	$1,793,138	$27,088,580	$4,029,111	$9,359,038,151	42
Hawaii	$4,537,670	$48,017	$4,489,653	$1,288,535	$1,696,678,001	13
Idaho	$6,553,493	$204,312	$6,349,180	$695,463	$1,761,758,211	7
Illinois	$60,041,822	$917,903	$59,123,919	$9,541,211	$16,536,234,179	58
Indiana	$28,246,064	$7,934,941	$20,311,123	$5,236,624	$8,367,085,690	58
Iowa	$10,717,543	$150,132	$10,567,411	$1,040,525	$3,805,810,851	9
Kansas	$23,438,027	$2,298,195	$21,139,833	$1,514,339	$2,720,787,284	15
Kentucky	$39,547,876	$289,576	$39,258,300	$2,608,934	$5,931,446,503	28
Louisiana	$187,601,191	$63,873,287	$123,727,904	$4,863,800	$7,181,407,383	52
Maine	$7,403,483	$110,124	$7,293,360	$700,451	$2,959,349,126	6.5
Maryland	$22,331,246	$198,147	$22,133,100	$2,839,746	$8,052,966,208	28
Massachusetts	$29,607,993	$884,124	$28,723,869	$5,271,067	$13,687,392,762	43
Michigan	$24,541,893	$353,924	$24,187,969	$4,882,449	$12,970,899,451	33
Minnesota	$14,988,004	$1,922,673	$13,065,331	$1,464,767	$9,343,811,915	14
Mississippi	$27,788,828	$8,771,739	$19,023,789	$3,087,424	$4,879,175,168	35
Missouri	$47,764,282	$2,693,335	$45,070,947	$1,984,423	$9,209,870,025	20
Montana	$985,871	$34,845	$951,026	$654,447	$1,076,709,165	8
Nebraska	$8,593,146	$175,562	$8,417,584	$770,566	$1,906,330,745	8
Nevada	$6,261,358	$2,648,816	$3,612,543	$1,904,689	$1,918,533,349	16
New Hampshire	$3,663,351	$152,162	$3,511,189	$523,160	$1,292,037,438	6
New Jersey	$33,887,934	$1,174,166	$32,713,769	$4,579,683	$11,143,784,058	35
New Mexico	$2,017,386	$31,424	$1,985,962	$1,827,905	$3,471,930,215	17
New York	$134,493,522	$19,177,053	$115,316,469	$45,054,451	$54,192,911,238	300
North Carolina	$47,052,649	$14,294,435	$32,758,214	$5,357,886	$12,463,184,143	48
Ohio	$41,072,514	$5,942,719	$35,129,795	$7,344,992	$17,237,076,852	77
Oklahoma	$28,399,517	$1,360,282	$27,039,234	$1,986,667	$4,752,126,532	22
Oregon	$15,151,850	$895,244	$14,256,606	$1,806,515	$5,600,397,595	14.5

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Table C2: Recoveries, Expenditures, and Staff by State						
State	Recoveries			Expenditures		Staff on Board
	Total	Criminal	Civil	MFCU Grant	Total Medicaid	
Pennsylvania	$30,729,120	$2,666,616	$28,062,504	$4,730,372	$21,698,977,826	33
Rhode Island	$4,381,892	$62,301	$4,319,590	$1,184,944	$2,018,428,048	11
South Carolina	$19,983,522	$1,609,887	$18,373,636	$1,451,006	$4,921,639,527	15
South Dakota	$3,053,873	$365,165	$2,688,709	$384,176	$820,357,642	5
Tennessee	$78,870,739	$1,167,952	$77,702,787	$3,990,162	$9,022,143,146	32
Texas	$196,718,960	$81,995,797	$114,723,163	$15,582,973	$29,086,162,849	181
Utah	$7,989,088	$49,173	$7,939,915	$1,817,277	$2,229,362,038	13
Vermont	$5,507,996	$58,600	$5,449,397	$987,268	$1,499,744,254	7
Virginia	$1,008,988,075	$704,439,186	$304,548,889	$11,249,106	$7,604,993,529	96
Washington	$16,562,704	$192,715	$16,369,988	$3,596,829	$8,407,111,070	30.5
West Virginia	$16,148,738	$3,779,140	$12,369,599	$1,112,518	$3,181,083,472	14
Wisconsin	$54,757,244	$54,750	$54,702,494	$1,274,531	$7,390,660,088	11
Wyoming	$1,623,272	$76,388	$1,546,884	$489,024	$594,690,624	4
Total	**$2,506,642,044**	**$968,878,848**	**$1,537,756,196**	**$230,064,270**	**$453,082,711,064**	**1,911.5**

Source: OIG analysis of Quarterly Statistical Reports, 2013.
*MFCU Grant Expenditure data is current as of February 11, 2014.
*Federal and State Governments for MFCU operations expenditures of $230 million and MFCU reported recoveries of over $2.5 billion translates to a return on investment (ROI) of $10.90 per $1 expended by the MFCU. ROI is calculated as the total dollar amount of recoveries in both civil and criminal cases divided by the total amount of grant expenditures by Federal and State governments.

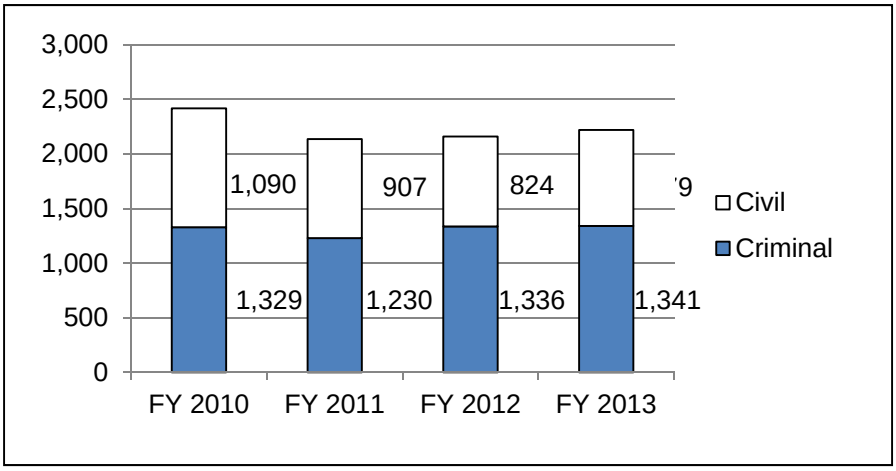
For additional FY 2013 Statistical Data, please see http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/.

Appendix D: Additional Analysis, MFCU Case Outcomes, FYs 2010-2013

Criminal Convictions and Civil Settlements and Judgments, FYs 2010-2013

As shown in Chart D1, the total number of MFCU case outcomes (criminal convictions and civil settlements and judgments) remained steady in FY 2013 compared to recent years. Consistently during each year, the number of criminal convictions was greater than the number of civil settlements and judgments.

Chart D1: Number of Case Outcomes, Criminal and Civil, FYs 2010-2013

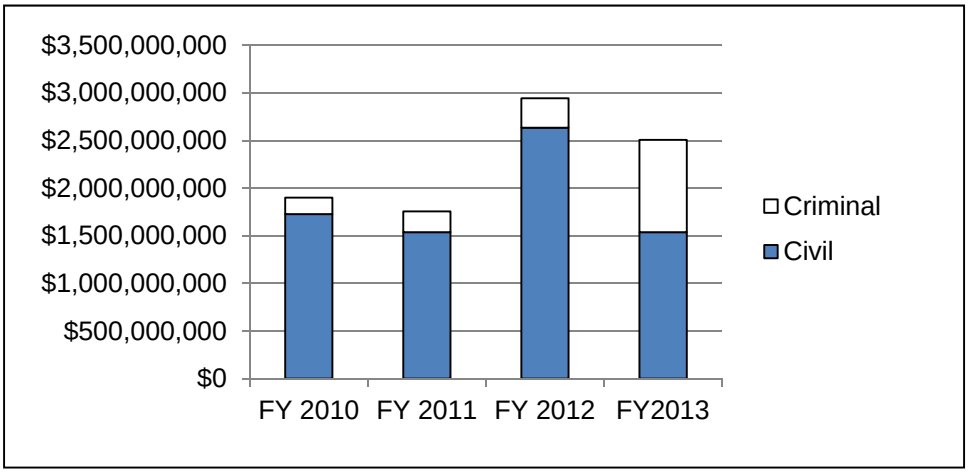


Source: OIG analysis of Quarterly Statistical Reports, 2013.

Criminal and Civil Recoveries, FYs 2010-2013

As shown in Chart D2, the total amount of recoveries resulting from MFCU work varied in recent years—under $2 billion in FYs 2010 and 2011, and exceeding $2 billion in FYs 2012 and 2013.

Chart D2: Criminal and Civil Recoveries, FYs 2010-2013



Source: OIG analysis of Quarterly Statistical Reports, 2013.

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Appendix E: Onsite Reviews Conducted and Reports Published in FY 2013

Onsite Reviews Conducted, FY 2013

MFCU Reviewed	Onsite Review Date
Montana Medicaid Fraud Control Unit	December 2012
New Jersey Medicaid Fraud Control Unit	January 2013
Arkansas Medicaid Fraud Control Unit	January 2013
West Virginia Medicaid Fraud Control Unit	February 2013
Michigan Medicaid Fraud Control Unit	March 2013
Minnesota Medicaid Fraud Control Unit	April 2013
Indiana Medicaid Fraud Control Unit	May 2013
Vermont Medicaid Fraud Control Unit	July 2013
Texas Medicaid Fraud Control Unit	August 2013
Utah Medicaid Fraud Control Unit	September 2013

Source: http://oig.hhs.gov/reports-and-publications/oei/m.asp#mfcu

FY 2013 Reports on Onsite Reviews

Report Title	Release Date	OIG Report Number
Arkansas State Medicaid Fraud Control Unit: 2013 Onsite Review	September 20, 2013	OEI-06-12-00720
New Jersey Medicaid Fraud Control Unit: 2013 Onsite Review	September 18, 2013	OEI-02-13-00020
Illinois State Medicaid Fraud Control Unit: 2012 Onsite Review	June 12, 2013	OEI-07-12-00510
Tennessee State Medicaid Fraud Control Unit: 2012 Onsite Review	April 24, 2013	OEI-6-12-00370
Idaho State Medicaid Fraud Control Unit: 2012 Onsite Review	April 16, 2013	OEI-09-12-00220
Louisiana State Medicaid Fraud Control Unit: 2012 Onsite Review	December 28, 2012	OEI-09-12-00010
New Hampshire Medicaid Fraud Control Unit: 2012 Onsite Review	October 19, 2012	OEI-02-12-00180
South Carolina State Medicaid Fraud Control Unit: 2011 Onsite Review	October 17, 2012	OEI-09-11-00610

Source: http://oig.hhs.gov/reports-and-publications/oei/m.asp#mfcu

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ENDNOTES

[1] Social Security Act (SSA) § 1903(q).
[2] SSA § 1903(a)(61).
[3] SSA § 1903(a)(6)(B).
[4] Office of Inspector General (OIG), *State Medicaid Fraud Control Units Fiscal Year 2013 Statistical Chart*.
[5] Ibid.
[6] SSA §§ 1903(q) & (q)(2); 42 CFR §§ 1007.5 and 1007.9(d).
[7] SSA § 1903(q)(1).
[8] OIG, Medicaid Fraud Control Units. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp on September 25, 2013.
[9] SSA § 1903(q)(6) and 42 CFR § 1007.13.
[10] SSA § 1903(q)(4).
[11] Prior to the current standards issued in June 2012, MFCU performance standards were previously issued in 1994, and accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp. 59 Fed. Reg. 49080 (Sept. 26, 1994).
[12] Cases may involve participation by other Federal and State law enforcement agencies.
[13] 42 CFR § 1007.11(b)(1) allows Units to receive Federal financial participation (FFP) for reviewing complaints of the misappropriation of patient's private funds. This authority falls under the Units' general patient abuse and neglect duties.
[14] The total number of settlements exceeds the total number of cases finalized by MFCUs in 2013, as in other years. The reason is that many global cases result in multiple settlements - between the defendant and each State MFCU that is party to the investigation and civil matter.
[15] 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 (CHIP), 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. http://oig.hhs.gov/exclusions/background.asp.
[16] OIG, The Effect of Exclusion From Participation in Federal Health Care Programs. Special Advisory Bulletin. September 1999. Accessed at http://oig.hhs.gov/exclusions/effects_of_exclusion.asp on September 17, 2013.
[17] Centers for Medicare & Medicaid Services (CMS), Medicaid Managed Care Enrollment Report: Summary Statistics as of July 1, 2011. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf.
[18] Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards, OEI-01-09-00550.
[19] 42 CFR § 438.608.
[20] The remaining Units either did not report any referrals or explained that MCOs in their States typically made referrals to the State Medicaid agency, and therefore they could not report the actual number of referrals from MCOs separate from other referral sources.
[21] P.L. 111-148, § 6402(h)(2), (March 23, 2010), as amended by the Health Care Reconciliation Act of 2010, P.L. 111-152 (March 30, 2010), collectively known as ACA; 42 CFR § 455.23(a); 76 Fed. Reg. 5862 (February 2, 2011).
[22] Prior to ACA, Medicaid agencies were required to demonstrate "reliable evidence" of provider fraud or willful misrepresentation, before withholding Medicaid payments. (52 Fed. Reg. 48814 (December 28, 1987)). However, pursuant to ACA, the threshold requirement of "reliable evidence" was reduced to a "credible allegation of fraud."
[23] Allegations of fraud come from a variety of sources. Examples of allegation sources include, but are not limited to, fraud hotline complaints, data mining, provider audits, civil false claims cases, and law enforcement investigations. 42 CFR § 455.2. For further information, see CMS guidance to State agencies regarding determination of credible allegation and imposing payment suspensions. CMS, *Guidance to States on Section 6402(h)(2) of ACA Program Integrity Provisions*, CPI-B 11-04, 2011. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/payment-suspensions-info-bulletin-3-25-2011.pdf on July 9, 2013.
[24] Performance Standard 10A.
[25] Performance Standard 8F.
[26] 78 Fed. Reg. 29055 (May 17, 2013).
[27] 2014 Fiscal Year 2014 Budget in Brief, Strengthening Health and Opportunity for all Americans, p. 64, www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf.