U.S. Department of Health and Human Services

Office of Inspector General

Medicaid Fraud Control Units

Fiscal Year 2014

Annual Report

Suzanne Murrin
Deputy Inspector General
for Evaluation and Inspections

April 2015
OEI-06-15-00010

INTRODUCTION

This Medicaid Fraud Control Unit (MFCU or Unit) Fiscal Year (FY) 2014 Annual Report highlights statistical achievements from the investigations and prosecutions conducted by 50 MFCUs nationwide. In FY 2014, MFCUs reported 1,318 criminal convictions involving the spectrum of providers who provide services to Medicaid beneficiaries. Three-quarters of these criminal convictions were for fraud, consistent with recent years, and recoveries in criminal cases reached nearly $300 million. Additionally, MFCU convictions led to the exclusion of 1,337 providers from Federal health care programs. MFCUs also reported 874 civil settlements and judgments that involved a few provider types, most notably pharmaceutical companies. Two-thirds of the $1.7 billion recovered in civil settlements and judgments were "global" settlements, which involved multiple Units and the U.S. Department of Justice.

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. In Appendix B, we have compiled information about MFCU criminal and civil outcomes by provider type. Additionally, OIG maintains updated information for each of the individual MFCUs on the OIG Web site, including an interactive map with statistical information about each MFCU.

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 2014, 49 States and the District of Columbia (States) operated Units.[2] 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.[3]

Units are jointly funded; the Federal government currently reimburses each of the States 75 percent of the costs of operating a Unit, and the States contribute the remaining 25 percent.[4] In FY 2014, combined Federal and State expenditures for the Units totaled $235 million.[5]

MFCUs operate on an interdisciplinary model and must employ a combination of investigators, auditors, and attorneys. At the end of FY 2014, MFCUs employed a total of 1,956 individuals.[6]

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., a Memorandum of Understanding (MOU)—that describes its relationship with that agency.[7] MFCUs are required to have Statewide authority to prosecute their own cases or else have formal procedures to refer suspected criminal violations to an office with such authority.[8] In FY 2014, 44 of the Units were in offices of State Attorneys General; in the remaining 6 States, the Units were in other State agencies.[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. Units received many referrals of potential cases of fraud from the program integrity divisions of State Medicaid agencies and from other sources, including referrals from the general public. Similarly, Units

received 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]

MFCUs may also be involved in global cases, which are civil false claims cases that are brought by the U.S. Department of Justice and involve a group of State MFCUs. The National Association of Medicaid Fraud Control Units (NAMFCU) facilitates the settlement of global cases on behalf of the States.

OIG Oversight of MFCUs

OIG has oversight responsibility for the MFCUs and administers the grants that provide Federal funding for Unit operations. OIG developed 12 performance standards for use in assessing the operations of MFCUs. A copy of the MFCU performance standards, most recently revised in 2012, may be found on the OIG Web site at https://oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf.

On an annual and quarterly basis, MFCUs provide OIG with statistical and other information about Unit operations as well as 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 indepth 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.

TABLE OF CONTENTS

MFCU CRIMINAL CASE OUTCOMES

MFCUs reported 1,318 criminal convictions involving a variety of provider types, most notably home health care aides 4

Three-quarters of MFCU criminal convictions were for fraud, consistent with recent years 5

FY 2014 recoveries from criminal cases reached nearly $300 million 6

MFCU CIVIL CASE OUTCOMES

MFCUs reported 874 civil settlements and judgments involving a variety of provider types, most frequently pharmaceutical companies 7

Two-thirds of MFCU civil settlements and judgments were global settlements 8

FY 2014 recoveries from civil cases totaled $1.7 billion—most from global settlements 9

PROVIDER EXCLUSIONS

MFCU convictions led to the exclusion of 1,337 providers from Federal health care programs 10

OTHER OBSERVATIONS

MFCUs and State Medicaid agency PI units reported challenges with referrals involving credible allegations of fraud and the payment suspension process and referrals from managed care entities 11

MFCUs and State Medicaid agency PI units reported three key elements for successful collaboration: communication, experienced and knowledgeable staff, and joint training 12

OIG OVERSIGHT

In FY 2014, OIG conducted 7 onsite reviews of Units, published 12 reports, and submitted 2 legislative proposals 14

APPENDIXES

A: Methodology 16

B: FY 2014 MFCU Criminal and Civil Outcomes by Provider Type 18

C: Selected FY 2014 Statistical Data 20

D: Onsite Reviews Conducted and Reports Published in FY 2014 24

ACKNOWLEDGMENTS 25

ENDNOTES 26

CASE OUTCOMES

MFCUs reported 1,318 criminal convictions involving a variety of provider types, most notably home health care aides

MFCUs reported 1,318 criminal convictions in FY 2014, similar to FY 2013's total of 1,344 criminal convictions. MFCUs' criminal convictions most frequently involved home health care aides, certified nursing aides, and other medical support. See Appendix B for a list of all convictions by provider type.

Home health care aides: 30 percent of criminal convictions

In FY 2014, criminal convictions of home health care aides represented 30 percent of all MFCU criminal convictions, a small increase from the FY 2013 figure of 26 percent. Most commonly, home health care aides were convicted of fraud, often for claiming to have rendered services that were not provided. For example, the Nebraska MFCU investigated several home health care aides who submitted timesheets for services that were never rendered or timesheets that claimed that the aide was working with more than one patient at the same time in different locations. Two of these Nebraska home health care aides were convicted; one was sentenced to 18 months of probation and ordered to pay restitution, and the other was sentenced to 2 years of probation and ordered to perform 200 hours of community service.

Certified nursing aides: 9 percent of criminal convictions

In FY 2014, criminal convictions of certified nursing aides represented 9 percent of all MFCU criminal convictions, a slight increase from the FY 2013 figure of 8 percent. These convictions involved offenses such as patient abuse, billing for services not rendered, and falsifying timesheets. For example, the New York MFCU investigated a certified nursing aide who falsely documented provision of services. This aide was sentenced to 15 days in jail, fined $125, and required to surrender her certified nursing aide certificate.

Other medical support: 7 percent of criminal convictions

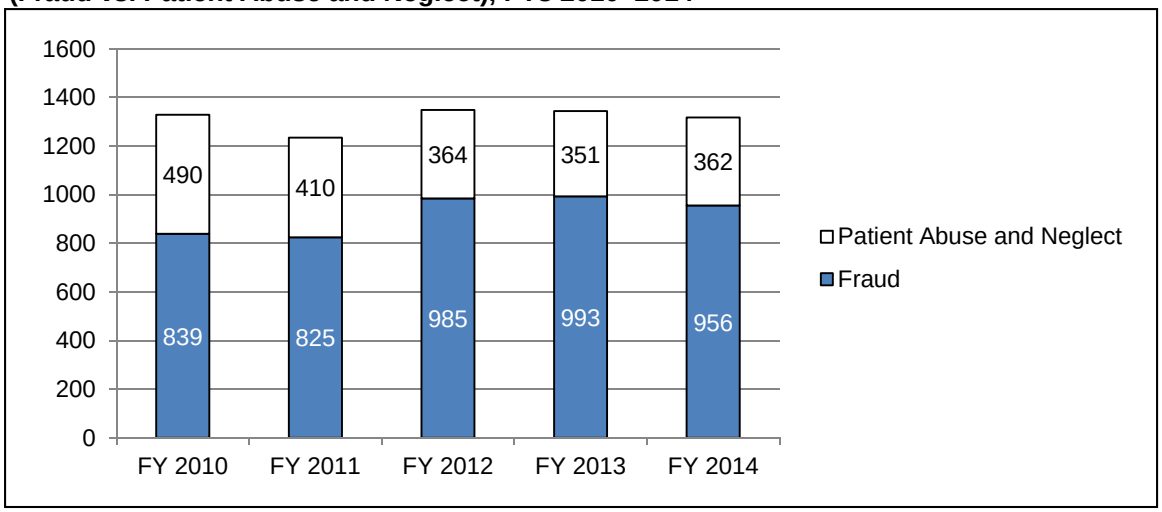
In FY 2014, criminal convictions of other medical support represented 7 percent of all MFCU criminal convictions, the same proportion as in FY 2013. The category "other medical support" includes individuals, facilities, and organizations—whether licensed or unlicensed—that provide medical support services. This category 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, the Florida MFCU obtained a conviction of a billing agent for one count each of organized fraud, Medicaid fraud, and conspiracy to commit Medicaid fraud. The billing agent worked with two other individuals and three adult family homes to bill for services never rendered.

CASE OUTCOMES

Three-quarters of MFCU criminal convictions were for fraud, consistent with recent years

In FY 2014, about three-quarters of criminal convictions involved fraud; about one-quarter involved patient abuse and neglect.[11] As shown in Chart 1, convictions related to fraud consistently represented the majority of all criminal convictions over the past 5 years.

Chart 1: Number of Criminal Convictions by Type of Case (Fraud vs. Patient Abuse and Neglect), FYs 2010–2014



Source: OIG analysis of QSRs, 2015.

FY 2014 criminal convictions for fraud: 73 percent

Fraud convictions reported for FY 2014 by the MFCUs included convictions for (1) conspiracy to commit health care fraud, (2) submitting false statements related to health care matters, (3) making false statements in regard to health care reimbursements, (4) grand larceny, (5) violations of anti-kickback statutes, and (6) improperly prescribing drugs. For example, the Illinois MFCU investigated a doctor who distributed controlled substances illegally in a so-called "pill mill" operation. Between 2006 and 2010, nine patients who received controlled substances distributed by this doctor died from drug overdoses. The doctor was indicted on 1 count of health care fraud and 14 counts of illegal dispensation of a controlled substance. In April 2014, the doctor was sentenced to a year of incarceration.

FY 2014 criminal convictions for patient abuse and neglect: 27 percent

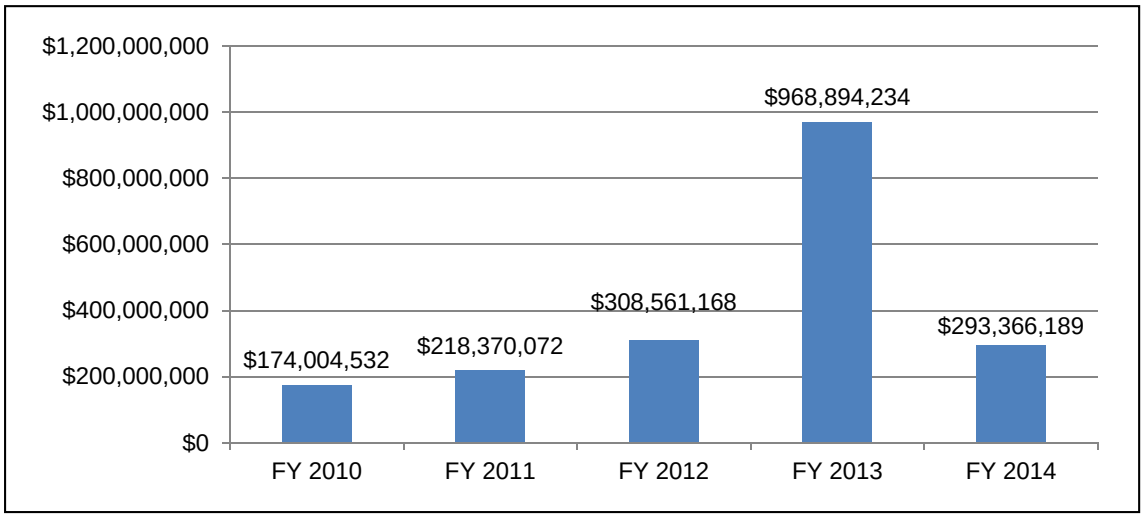
Cases of patient abuse and neglect reported by the MFCUs for FY 2014 included aggravated assaults, injury to elderly or disabled persons, and theft of patient funds.[12] For example, the Florida MFCU investigated an owner of an adult family care home for allegations including neglecting residents, failing to provide medical services for a resident's wounds, willfully abusing a disabled adult, and financially exploiting residents. The owner was convicted and sentenced to more than 8 years of incarceration.

CASE OUTCOMES

FY 2014 recoveries from criminal cases reached nearly $300 million

As shown in Chart 2, recoveries from criminal cases in FY 2014 decreased from those of the previous 2 years. The bulk of the amount for FY 2013 came from the recoveries from a single criminal case—the largest such State MFCU recovery to that time. In FY 2014, the recoveries from criminal cases returned to a more typical amount.

Chart 2: Recoveries From Criminal Cases, FYs 2010–2014



Source: OIG analysis of QSRs, 2015.

CASE OUTCOMES

MFCUs reported 874 civil settlements and judgments that involved a variety of provider types, most frequently pharmaceutical companies

Of the 874 civil settlements and judgments that MFCUs obtained, most involved pharmaceutical manufacturers, pharmacies, and suppliers of durable medical equipment. See Appendix B for a list of criminal and civil outcomes by provider type.

Pharmaceutical manufacturers: 52 percent of civil settlements and judgments

In FY 2014, cases involving pharmaceutical manufacturers accounted for about half (52 percent) of all MFCU cases that resulted in civil settlements and judgments. This was a decrease from FY 2013, when such cases represented 62 percent of all civil settlements and judgments.
In an example of a civil settlement with a pharmaceutical company, the Federal government, 43 States, and the District of Columbia settled with Astellas Pharma US Inc. regarding allegations that the company had caused false claims to be submitted to Federal and State health care programs. These claims were in connection with the company's marketing and promotion of a drug, Mycamine, for pediatric use. Mycamine, a sterile, freeze-dried antifungal agent, was approved by the Food and Drug Administration for adult use only. Astellas Pharma US Inc. will pay $7.3 million to resolve the allegations.

Pharmacies: 10 percent of civil settlements and judgments

Pharmacies were the second most common provider type for civil settlements and judgments. In FY 2014, cases involving pharmacies represented 10 percent of all MFCU cases that resulted in civil settlements and judgments, an increase from the FY 2013 figure of 6 percent. For example, the New York MFCU settled with a New York-based pharmacy regarding allegations that the pharmacy made false statements to the State Medicaid program to expedite authorization for some drugs and that it submitted other false claims to the program. The pharmacy agreed to return $846,224 to the New York Medicaid program.

Suppliers of durable medical equipment: 8 percent of civil settlements and judgments

Suppliers of durable medical equipment were the third most common provider type for civil settlements and judgments. In FY 2014, settlements with such suppliers represented 8 percent of all civil settlements and judgments, a large increase from the FY 2013 figure of 1 percent.
In an example of such a settlement, the West Virginia MFCU entered into a civil agreement with the owner of a durable medical equipment company who agreed to make restitution of $57,500. The allegations were that the company collaborated with an excluded provider and billed both Medicare and Medicaid for back braces that were provided by the excluded company. After submitting the charges to Medicare and Medicaid, the durable medical equipment company allegedly kept one-half of the reimbursement and passed the remaining monies on to the excluded company, using false invoices to support the billing.

CASE OUTCOMES

Two-thirds of MFCU civil settlements and judgments were global settlements

FY 2014 global civil settlements: 66 percent

In FY 2014, MFCUs participated in the resolution of NAMFCU-coordinated global cases involving 650 civil settlements.[13] One global settlement in FY 2014 involved the Federal Government, 50 States, and the District of Columbia settling with Shire Pharmaceutical, LLC regarding allegations that the company engaged in marketing campaigns that improperly promoted the off-label use of 5 of its drugs. Shire is alleged to have unlawfully marketed these drugs for off-label uses, or overstated their efficacy, despite a lack of clinical data. Shire Pharmaceuticals will pay $56.5 million, of which $48.1 million (85 percent) will go to State Medicaid programs.

FY 2014 nonglobal civil settlements and judgments: 34 percent

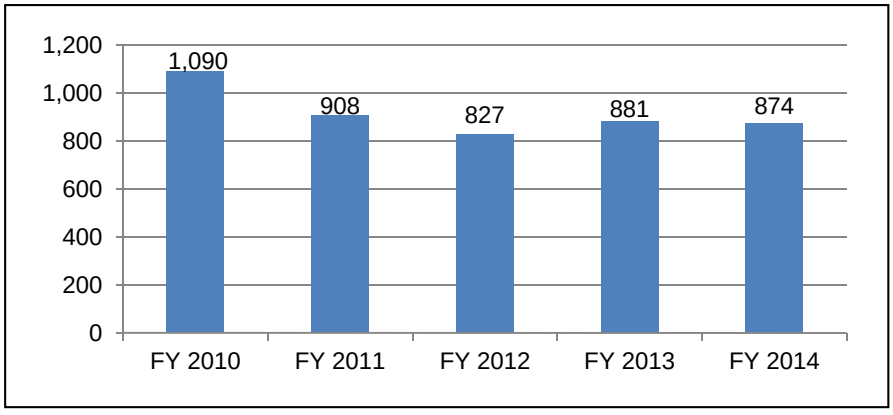
Nonglobal cases are civil cases that do not involve NAMFCU and generally involve a single State as a plaintiff. Currently, 30 States have some type of civil false claims statute.[14] States may qualify for a 10-percent increase in their share of civil fraud recoveries if OIG, in consultation with the U.S. Department of Justice, determines that the State civil false claims statute meets certain qualifications.[15] To date, 18 States have false claims statutes that qualify them for this increase.[16]

In one nonglobal settlement in FY 2014, the Illinois MFCU entered into a settlement agreement in the amount of $346,648 with the owner of a transportation company who was accused of fraudulently billing for 1-day trips. In another settlement, the New Mexico MFCU entered into a settlement of $446,135 with the Los Lunas Community Program, which was accused of failing to support its billing of day habilitation services (i.e., services that help a person acquire, keep, or improve skills related to communication and activities of daily living).

FYs 2010–2014 civil settlements and judgments

As shown in Chart 3, the FY 2014 number of civil settlements and judgments—874—was a slight decrease from FY 2013's total of 881.

Chart 3: Total Number of Civil Settlements and Judgments, FYs 2010–2014



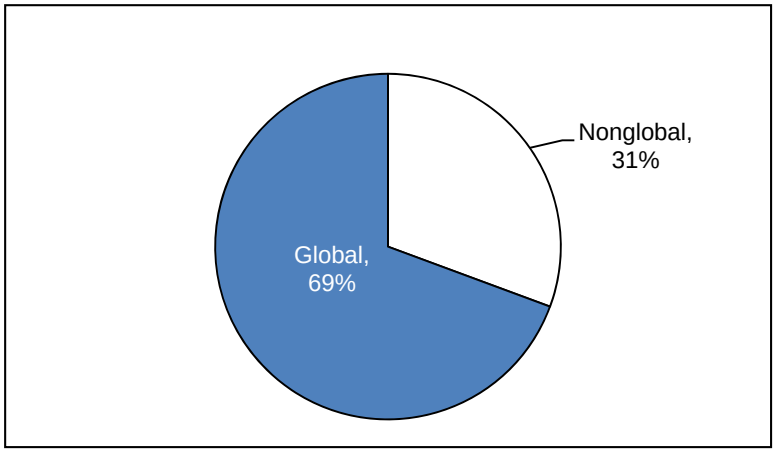
Source: OIG analysis of QSRs, 2015.

CASE OUTCOMES

FY 2014 recoveries from civil cases totaled $1.7 billion—most from global settlements

As shown in Chart 4, recoveries from global cases accounted for 69 percent of the $1.7 billion in civil recoveries in FY 2014.

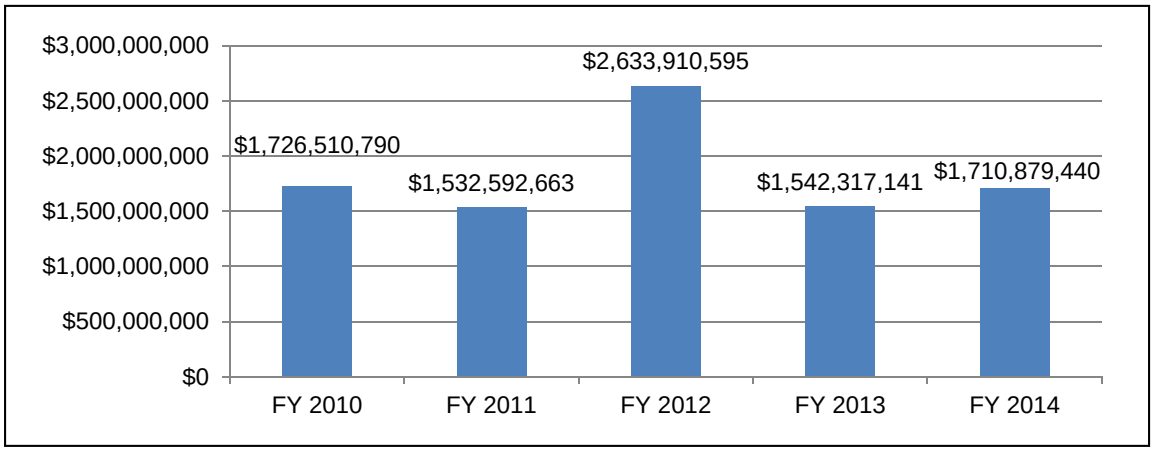
Chart 4: Percentage of Civil Recoveries That Resulted From Global and Nonglobal Settlements, FY 2014*



Source: OIG analysis of supplemental data collection for the FY 2014 MFCU Annual Report, 2015.
*Information differs slightly from that reported in the QSRs, which does not divide civil recoveries into these categories.

As shown in Chart 5, total recoveries from MFCU civil settlements and judgments have varied in recent years. FY 2014 shows a slight increase from FY 2013 and had the third-highest recovery amount of the past 5 fiscal years.

Chart 5: Civil Recoveries, FYs 2010–2014



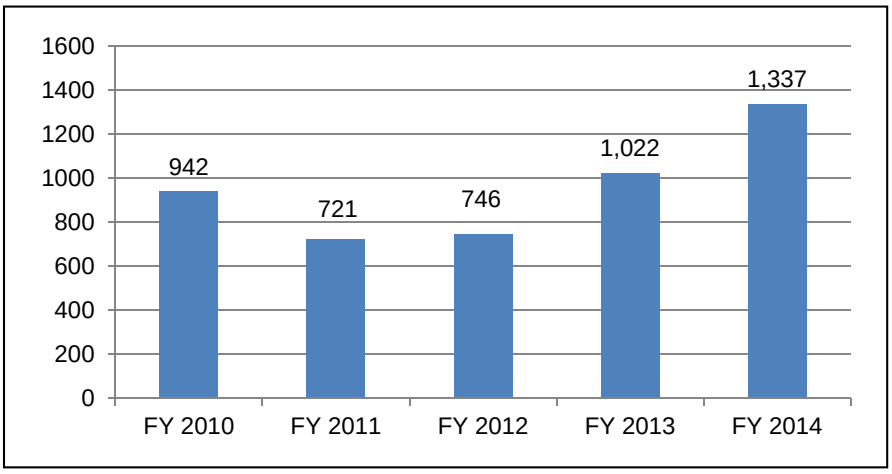
Source: OIG analysis of QSRs, 2015.

PROVIDER EXCLUSIONS

MFCU convictions led to the exclusion of 1,337 providers from Federal health care programs

OIG excludes individuals and entities from federally funded health care programs (primarily Medicare and Medicaid) when the providers are convicted of program-related crimes.[17] Exclusion means that no payment will be made for any health care items or services furnished, ordered, or prescribed by an excluded individual or entity.[18] In FY 2014, OIG excluded 4,017 subjects, of which 1,337 were excluded as a result of MFCU investigations, prosecutions, and convictions. This number was a 31-percent increase over the previous year's figure. As shown in Chart 6, the FY 2014 exclusion numbers continue a pattern from previous years, demonstrating that MFCUs are an important source of referrals to OIG for purpose of exclusion.

Chart 6: OIG Exclusions Based on MFCU Referrals, FYs 2010–2014



Source: OIG analysis of OIG exclusion data, 2015.

OTHER OBSERVATIONS

State Medicaid agency program integrity (PI) units are an important partner for MFCUs. PI units aid in the prevention and reduction of Medicaid provider fraud, waste, and abuse in various ways, such as by examining provider enrollment trends.[19,20] PI units refer cases of suspected fraud to MFCUs, and they also collaborate with MFCUs on ongoing cases and Medicaid program and policy changes.

MFCUs and State Medicaid agency PI units reported challenges with referrals involving credible allegations of fraud and the payment suspension process and referrals from managed care entities

PI units and MFCUs both reported challenges with referrals. For example, MFCUs reported that referrals from PI units sometimes lack key data elements or do not distinguish between fraud and overpayments. Consequently, it can be a challenge for MFCUs to decide whether to open an investigation. PI units reported their perception that MFCUs often take too long to let them know whether the MFCUs are declining or accepting a given referral. This poses a challenge for PI units when a MFCU declines the referral and the PI unit needs to recover overpayments or take other administrative action involving the provider.

Additionally, both entities reported challenges specific to referrals involving credible allegations of fraud and the payment suspension process, as well as challenges with referrals from managed care entities.

Referrals Involving Credible Allegations of Fraud and the Payment Suspension Process. Since 2011, Federal regulations have required Medicaid agencies to suspend payments to a provider on the basis of a credible allegation of fraud for which an investigation is pending, unless the Medicaid agency determines that there is good cause to not suspend payment. When a Medicaid agency determines that an allegation of fraud against a provider is credible, Federal regulations require the Medicaid agency to refer the matter to a MFCU or other law enforcement agency for potential investigation.[21, 22] The MFCU exercises its discretion as to whether to accept the referral. If the MFCU does not accept the referral, the State Medicaid agency may not proceed with a suspension of payments unless the agency has alternative Federal or State authority, or if it makes a referral to another appropriate law enforcement agency. If the MFCU accepts the referral, a suspension of payments may proceed until the MFCU completes its investigation. However, the MFCU may assert a "good cause" exception to the suspension requirement on the basis that notifying the provider about the suspension of payments would jeopardize the investigation.

MFCUs and PI units both reported an increase in the quantity of administrative work involved in payment suspension cases, as well as a change in the way they jointly work these cases. PI units reported that raising the threshold from "suspected" fraud (the standard that existed before 2010) to "credible allegation" of fraud has resulted in a reduced number of referrals to MFCUs.[23] MFCUs must immediately assess any credible allegation of fraud for a law enforcement exemption, regardless of other priorities. Additionally, MFCUs reported that suspending provider payments can complicate investigations when a provider pursues administrative or judicial remedies to challenge a suspension or investigation. For example, one MFCU said that suspending payments to a provider "risks empowering the subject of investigation with access to

judicial relief to limit or otherwise interfere with our investigation." OIG has ongoing work in this area.[24]

Managed Care Entity Referrals. In the 2013 MFCU Annual Report, OIG reported that MFCUs voiced concerns about the lack of fraud referrals from managed care entities. Such referrals may go directly to MFCUs, or they may go to State Medicaid agencies and then be referred to MFCUs if warranted. MFCUs also reported that managed care entities lacked the incentive to detect and refer potential fraud and that managed care entities may have an incentive *not* to do so. Specifically, managed care entities indicated to MFCUs that (1) they can lose money if their contracts do not allow them to share in fraud-related recoveries and (2) their contracts typically do not include negative consequences for a lack of fraud referrals. As a result, a managed care entity may find it preferable to remove a provider from its network rather than to make a referral of fraud to the PI unit or MFCU. As of January 2015, over half of all Medicaid beneficiaries were receiving their care through managed care entities.[25] This year, PI units and MFCUs reported their expectation that the increased prevalence of managed care will exacerbate the lack of referrals from Medicaid agencies.

MFCUs and State Medicaid agency PI units reported three key elements to successful collaboration: communication, experienced and knowledgeable staff, and joint training

Collaboration between the PI units and the MFCUs on ongoing cases and on changes in Medicaid programs and policies is key to a successful working relationship. MFCUs and PI units reported that three key elements help facilitate this collaboration: (1) communication, (2) experienced and knowledgeable staff, and (3) joint training.

Communication. Nearly all PI units and MFCUs reported communication through meetings with each other throughout the year, and many reported ongoing communication (e.g. informal discussions, phone calls, emails). PI units and MFCUs usually meet formally on a monthly basis. MFCUs and PI units reported that meetings are beneficial for discussing potential referrals, ongoing cases, and changes in regulations and policies. Additionally, almost three-fourths of MFCUs reported participating in some type of healthcare taskforce with PI units and Federal partners such as the FBI and OIG. During taskforce meetings, discussions about fraud trends, referrals, and investigations occur, and these discussions could lead to joint cases that might involve Medicaid fraud.

Experienced and Knowledgeable Staff. PI units and MFCUs reported that having experienced staff with complementary skill sets facilitates successful collaboration. For example, several PI units mentioned that MFCU investigators and attorneys are experienced and knowledgeable in investigating and prosecuting Medicaid fraud, while MFCUs praised PI units' knowledge of Medicaid programs and data analysis skills. In some States, PI unit staff and MFCU staff have worked together for many years and have developed a long-term relationship that is invaluable.

Joint Training. Around two-thirds of PI units and MFCUs reported conducting joint training, which they said provides an avenue for experienced staff to inform others about program changes and to learn about the latest fraud trends. For example, some MFCUs have provided

OTHER OBSERVATIONS

PI units with legal training on State false claims acts and on the evidence required for criminal fraud cases. PI units have offered MFCUs training about the information available through data sources such as the Medicaid Management Information System (MMIS), which stores claims data that is often used as evidence of fraudulent billing.

OIG OVERSIGHT

In FY 2014, OIG conducted 7 onsite reviews of MFCUs, published 12 reports, and submitted 2 legislative proposals

Onsite reviews

OIG conducted onsite reviews of seven MFCUs in FY 2014, fewer than in other fiscal years. OIG conducts these oversight reviews for each MFCU approximately every 5 years to assess MFCU compliance with applicable Federal laws, regulations, and policies, and Unit adherence to the 12 performance standards. During onsite reviews, OIG meets with MFCU officials and with other key stakeholders familiar with the MFCU's operations, such as the State Medicaid agency's PI unit staff and Federal investigators and prosecutors who sometimes partner with the Unit. During the onsite visit, OIG reviews the Unit's operations, 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) the Unit's supervisory oversight of cases; and (3) the timeliness of its casework.

Reports on onsite reviews

In FY 2014, OIG published 12 reports on MFCU onsite reviews that were conducted in FYs 2012 through 2014. (See Appendix D 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 any 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 that several Units did not submit conviction information to OIG in an appropriate timeframe. Performance Standard 8 notes that Units should submit all pertinent information—including charging documents, plea agreements, and sentencing orders on MFCU convictions—within 30 days of sentencing.

- **Memorandum of Understanding**: Onsite reviews revealed that several Units' MOUs with their respective State Medicaid agencies did not reflect current law and practice. Additionally, a few Units did not always comply with the MOU provisions.

- **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.

Proposal to support MFCUs for the U.S. territories

The President's FY 2015 budget includes an OIG proposal to encourage U.S. territories (Puerto Rico, Guam, the Northern Mariana Islands, the U.S. Virgin Islands, and American Samoa) to establish MFCUs by eliminating an existing financial disincentive.[26]

The five territories have not established MFCUs, although Puerto Rico has recently expressed interest in doing so. Unlike Medicaid funding for the 50 States and the District of Columbia, Medicaid funding to the territories is capped, and the territories routinely use the full amount of that funding to pay for Medicaid services and to pay for essential administrative functions. Although a MFCU might eventually pay for itself through savings, in the short term a territory would need to fund its MFCU using monies that would otherwise have gone to pay for Medicaid benefits. A proposal in the President's budget would address this budgetary concern by allowing the territories to use appropriated funding to establish and operate a MFCU while retaining the same amount of appropriated dollars for Medicaid services and essential administrative functions.

Proposal on investigative authority regarding patient abuse and neglect

Like the President's FY 2014 budget, the FY 2015 budget includes an OIG proposal to expand MFCUs' authority with regard to cases of patient abuse and neglect.[27] Under current law, MFCUs can investigate such cases only when the complaints involve Medicaid-funded facilities (such as hospitals or nursing homes) or "board and care" facilities (such as assisted living facilities). As Medicaid has been increasingly relying on home and community-based services, the proposal would permit the investigation and prosecution of patient abuse and neglect arising when Medicaid services are provided in either of those settings. The proposal would give MFCUs the same authority in the areas of patient abuse and neglect that they already have in the area of fraud; MFCUs already investigate a large number of cases of fraud in personal care services and other fraud cases that arise in the home or community.

APPENDIXES

Appendix A: Methodology

We based the information in this report on an analysis of data from six sources: (1) QSRs; (2) supplemental data collected specifically for this FY 2014 MFCU Annual Report; (3) OIG exclusion data; (4) information gathered through onsite reviews; (5) the annual reports of individual MFCUs; and (6) recertification questionnaires. We analyzed data from all six sources to describe the outcomes of the MFCUs' criminal and civil cases during FY 2014 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 30, 2015, except where otherwise noted.

Data Collection and Analysis

Review of QSRs. In 2014 and in prior years, MFCUs submitted statistical data to OIG each quarter. In these QSRs, the MFCUs 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 amounts of criminal and civil recoveries; and the number of staff employed. We reviewed QSRs for FYs 2010 through 2014 to determine the number of convictions for fraud and for patient abuse and neglect; the amounts of recoveries associated with those convictions; the number of civil settlements and judgments; and the amounts of recoveries associated with those civil outcomes.

Supplemental data collection. We requested additional data from all MFCUs in October 2014. We received responses from all 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 2014. We determined the number of global and nonglobal civil settlements and judgments and the recoveries associated with those civil outcomes. We also used this supplemental data to assess the relationship between MFCUs and PI units.

OIG exclusion data. We reviewed 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 managed care organizations and the extent to which the new rules on payment suspension require more coordination between MFCUs and State Medicaid agencies.

MFCU Annual Reports. As a grant requirement, each MFCU must submit to OIG an annual report that highlights its activities.[28] We reviewed the most recent annual report from each MFCU for case examples of types of providers that were frequently convicted (such as home health care agencies) and types of providers with which MFCUs were frequently involved in civil settlements and judgments (such as pharmaceutical manufacturers).

Recertification Questionnaires. As part of the MFCU recertification process, each MFCU completes a recertification questionnaire that OIG uses to assess whether the MFCU is adhering to the performance standards. As part of this process, each State Medicaid program's PI unit is asked to complete a questionnaire that assesses its relationship with its State MFCU. We examined the most recent PI unit questionnaire and MFCU recertification questionnaires. We reviewed responses regarding the relationship between the MFCU and the PI unit including staff, trainings, and the frequency and purpose of meetings.

Limitations

Where possible, we report information from QSRs. However, when the QSRs did not offer the desired level of specificity, we report information from the supplemental data collection instrument. The information collected from the supplemental data collection instrument differs slightly from that reported in the QSRs for some data elements.

Appendix B: FY 2014 MFCU Criminal and Civil Outcomes by Provider Type

Table B1: FY 2014 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	1,381	$293,949,816	889	$1,961,805,005
ABUSE AND NEGLECT				
Certified Nursing Aides	101	$32,049	1	$150,000
Home/Personal Care Aides	0	$0	1	$0
Nursing Facilities	30	$11,381	5	$374,611
Registered/Licensed Nurses, Physician Assistants, and Nurse Practitioners	52	$31,472	3	$30,634
Other Long-Term Care	12	$10,251	0	$0
Other	80	$273,244	0	$0
THEFT OF PATIENT FUNDS				
Certified Nursing Aides	28	$91,523	0	$0
Nondirect Care	25	$320,487	2	$156,407
Nurses, Physician Assistants, and Nurse Practitioners	7	$62,300	0	$0
Other	53	$2,014,273	0	$0
FRAUD: Facilities				
Hospitals	10	$6,293,981	19	$14,067,261
Nursing Facilities	9	$8,119,201	14	$4,111,001
Substance Abuse Treatment Centers	0	$0	2	$26,118,710
Other Long-Term Care	12	$1,097,246	1	$446,135
Other	12	$3,909,683	12	$9,716,501
FRAUD: Medical Support				
Suppliers of Durable Medical Equipment	33	$26,641,609	67	$3,226,887
Home Health Care Agencies	48	$7,120,440	27	$186,651,599
Home Health Care Aides	413	$12,533,282	21	$546,790
Laboratories	0	$0	21	$12,919,426
Nurses, Physician Assistants, and Nurse Practitioners	78	$1,718,242	9	$892,798
Pharmacies	37	$3,754,868	86	$22,482,173
Pharmaceutical Manufacturers	0	$0	462	$1,285,025,189

continued on the next page

APPENDIXES

Table B1: FY 2014 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: Medical Support (continued)				
Radiologists	2	$16,879	4	$3,368,733
Transportation Providers	25	$9,021,762	10	$1,837,856
Other	95	$113,056,555	25	$2,954,400
FRAUD: Practitioners				
Chiropractors	3	$1,421,745	2	$48,000
Counselors/Psychologists	56	$21,794,328	10	$2,704,387
Dentists	19	$4,163,020	18	$7,824,268
Optometrists/Opticians	2	$229,455	3	$1,494,214
Physicians or Doctors of Osteopathy	64	$52,400,623	44	$67,195,597
Podiatrists	1	$132,876	1	$51,200
Other	20	$1,451,598	5	$1,263,644
FRAUD: Program Related				
Billing Companies	3	$4,378	0	$0
Managed Care Organizations	4	$61,000	2	$2,327,088
Medicaid Program Administration	1	$311	2	$2,047,000
Other	46	$16,159,754	10	$301,772,496

Source: OIG analysis of supplemental data collection for the FY 2014 MFCU Annual Report, 2015.
*This information differs slightly from that reported in the QSRs, through which Units reported 1,318 criminal convictions, $293,366,189 in criminal recoveries, 874 civil settlements and judgments, and $1,710,879,440 in civil recoveries.

APPENDIX C: Selected FY 2014 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	16	28	7	4	4	2	10
Alaska	160	13	35	0	44	0	4
Arizona	228	81	36	18	28	12	4
Arkansas	24	84	6	9	5	17	15
California	671	523	53	61	59	38	20
Colorado	255	5	6	0	9	1	26
Connecticut	59	3	12	0	8	0	18
Delaware	538	86	1	15	0	11	21
District of Columbia	170	78	25	2	2	1	12
Florida	600	65	55	26	42	18	34
Georgia	410	4	4	0	9	0	23
Hawaii	20	48	0	9	4	6	8
Idaho	118	6	7	2	11	0	10
Illinois	230	81	42	14	53	23	23
Indiana	941	331	55	11	22	7	30
Iowa	249	21	33	15	28	16	16
Kansas	95	6	25	3	13	3	22
Kentucky	118	27	14	13	14	4	18
Louisiana	366	59	118	14	65	11	40
Maine	31	8	6	4	5	2	12
Maryland	283	31	6	7	6	6	22
Massachusetts	500	112	7	0	19	3	21
Michigan	483	48	32	7	17	8	16
Minnesota	170	3	23	2	20	0	19
Mississippi	79	589	3	31	5	36	11
Missouri	207	23	9	1	8	0	23
Montana	26	2	5	2	1	0	12
Nebraska	104	26	8	8	4	3	15
Nevada	21	2	8	0	12	2	15
New Hampshire	33	7	1	1	0	3	4
New Jersey	395	23	15	5	7	3	13
New Mexico	192	3	4	0	4	0	21
New York	618	128	62	80	53	65	66

continued on the next page

APPENDIXES

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	439	16	5	3	8	2	8
Ohio	903	287	124	25	88	14	32
Oklahoma	186	67	14	8	9	8	15
Oregon	69	13	29	5	26	2	13
Pennsylvania	315	13	66	0	46	0	12
Rhode Island	32	19	5	7	13	7	7
South Carolina	146	34	8	3	11	7	16
South Dakota	46	3	1	0	1	0	6
Tennessee	198	43	15	16	14	5	22
Texas	1,177	126	100	22	85	5	17
Utah	115	17	3	2	3	2	18
Vermont	82	18	18	0	12	0	10
Virginia	373	16	45	6	30	4	23
Washington	167	8	13	1	10	1	14
West Virginia	96	29	8	12	7	2	17
Wisconsin	383	7	5	0	7	1	10
Wyoming	55	2	3	0	5	1	10
Total	**13,192**	**3,272**	**1,185**	**474**	**956**	**362**	**874**

Source: OIG analysis of QSRs, 2015.

APPENDIXES

Table C2: Recoveries, Expenditures, and Staff by State						
State	Recoveries			Expenditures		Staff
	Total	Criminal	Civil	MFCU Grant	Total Medicaid	
Alabama	$17,988,911	$249,299	$17,739,613	$1,253,193	$5,454,050,260	10
Alaska	$644,326	$535,433	$108,892	$1,105,990	$1,546,569,264	8
Arizona	$538,729	$209,277	$329,453	$2,316,274	$9,452,683,998	20
Arkansas	$2,228,765	$127,656	$2,101,109	$2,454,100	$5,154,278,818	22
California	$77,622,975	$22,713,170	$54,909,804	$26,158,835	$68,248,444,914	193
Colorado	$9,999,945	$84,090	$9,915,855	$1,615,525	$6,265,152,763	17
Connecticut	$3,030,886	$17,599	$3,013,287	$1,989,924	$7,167,946,629	13
Delaware	$1,949,634	$106,816	$1,842,817	$1,944,099	$1,805,108,123	17
District of Columbia	$3,973,338	$7,672	$3,965,666	$2,708,824	$2,524,458,778	21
Florida	$91,867,057	$3,989,921	$87,877,136	$15,506,674	$20,818,233,200	161
Georgia	$48,703,251	$7,776,456	$40,926,795	$4,523,320	$9,858,134,878	46
Hawaii	$3,079,615	$61,241	$3,018,374	$1,301,425	$2,049,769,576	13
Idaho	$801,858	$104,933	$696,924	$656,937	$1,692,361,521	8
Illinois	$90,872,897	$1,202,160	$89,670,737	$7,719,034	$17,726,308,920	45
Indiana	$54,591,557	$2,324,001	$52,267,556	$6,119,574	$9,600,134,668	55
Iowa	$24,403,658	$987,348	$23,416,309	$1,020,053	$4,110,153,654	8
Kansas	$27,437,135	$150,269	$27,286,866	$1,330,522	$2,933,837,600	14
Kentucky	$66,222,772	$1,141,643	$65,081,129	$2,989,940	$8,017,227,454	28
Louisiana	$245,305,060	$118,815,109	$126,489,951	$5,134,744	$7,337,796,633	52
Maine	$9,776,295	$19,168	$9,757,127	$728,262	$2,528,826,380	8
Maryland	$41,493,941	$48,049	$41,445,892	$3,510,342	$9,625,821,402	31
Massachusetts	$59,771,098	$4,658,134	$55,112,964	$5,470,721	$14,952,760,958	41
Michigan	$46,562,341	$116,479	$46,445,862	$5,392,509	$14,147,522,772	33
Minnesota	$18,518,275	$806,716	$17,711,559	$1,539,617	$10,429,856,324	16
Mississippi	$17,314,766	$299,775	$17,014,991	$3,318,064	$5,016,224,369	33
Missouri	$8,224,673	$176,421	$8,048,253	$2,047,671	$9,238,680,706	21
Montana	$438,209	$26,746	$411,463	$721,553	$1,146,046,567	8
Nebraska	$10,058,620	$19,542	$10,039,078	$881,049	$1,907,477,721	9
Nevada	$11,292,357	$1,080,007	$10,212,350	$1,887,577	$2,431,932,881	18
New Hampshire	$4,409,810	$22,780	$4,387,030	$724,113	$1,420,746,975	7
New Jersey	$45,632,566	$1,105,245	$44,527,321	$4,442,400	$13,193,930,655	31
New Mexico	$9,389,208	$29,693	$9,359,515	$1,851,073	$4,349,892,086	18
New York	$378,434,543	$2,452,239	$375,982,304	$45,814,464	$53,915,930,694	294
North Carolina	$72,432,177	$20,362,133	$52,070,044	$5,190,481	$12,655,046,228	44
Ohio	$71,166,459	$4,777,300	$66,389,159	$8,830,153	$20,223,303,745	89
Oklahoma	$18,368,761	$395,659	$17,973,102	$2,391,463	$4,925,190,754	22
Oregon	$17,025,308	$710,317	$16,314,992	$2,067,044	$7,291,147,501	15.5

APPENDIXES

Table C2: Recoveries, Expenditures, and Staff by State						
State	Recoveries			Expenditures		Staff
	Total	Criminal	Civil	MFCU Grant	Total Medicaid	
Pennsylvania	$5,707,431	$1,354,491	$4,352,940	$5,352,554	$24,414,853,435	44
Rhode Island	$3,677,355	$18,417	$3,658,938	$1,192,428	$2,566,378,392	11
South Carolina	$27,403,805	$519,381	$26,884,424	$1,426,803	$5,596,632,601	16
South Dakota	$3,853,756	$566	$3,853,190	$409,564	$840,849,947	5
Tennessee	$62,298,837	$3,979,298	$58,319,539	$4,053,211	$9,654,242,145	35
Texas	$106,075,376	$82,758,688	$23,316,688	$16,502,689	$32,831,310,090	175
Utah	$23,725,403	$116,355	$23,609,048	$1,830,431	$2,234,539,587	13
Vermont	$976,626	$145,457	$831,169	$850,206	$1,570,053,514	7
Virginia	$64,755,506	$1,758,645	$62,996,861	$11,757,418	$7,980,183,305	93
Washington	$24,063,858	$245,904	$23,817,953	$3,905,815	$7,522,374,478	32
West Virginia	$19,608,914	$4,160,695	$15,448,219	$1,267,132	$3,488,266,696	21
Wisconsin	$49,010,312	$550,803	$48,459,509	$1,359,679	$7,783,215,463	12
Wyoming	$1,516,673	$46,989	$1,469,685	$485,829	$594,519,949	4
Total	**$2,004,245,629**	**$293,366,189**	**$1,710,879,440**	**$235,051,299**	**$488,240,409,971**	**1,957.5**

Source: OIG analysis of QSRs, 2015.
*Expenditures (combined Federal and State) for MFCU operations of $235 million and MFCU reported recoveries of over $2 billion translate to a return on investment (ROI) of $8.53 per $1 expended by the Federal and State Governments for MFCU operations. 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 2014 statistical data, please see http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/.

APPENDIXES

Appendix D: Onsite Reviews Conducted and Reports Published in FY 2014

Onsite Reviews Conducted, FY 2014	
MFCU Reviewed	**Onsite Review Date**
Connecticut Medicaid Fraud Control Unit	October 2013
Alabama Medicaid Fraud Control Unit	January 2014
Mississippi Medicaid Fraud Control Unit	January 2014
Nebraska Medicaid Fraud Control Unit	February 2014
Iowa Medicaid Fraud Control Unit	April 2014
New Mexico Medicaid Fraud Control Unit	April 2014
Ohio Medicaid Fraud Control Unit	April 2014

Source: OIG, *Work Plan for Fiscal Year 2014*. Accessed at http://oig.hhs.gov/reports-and-publications/archives/workplan/2014/Work-Plan-2014.pdf on April 3, 2015.

FY 2014 Reports on Onsite Reviews		
Report Title	**Release Date**	**OIG Report Number**
West Virginia State Medicaid Fraud Control Unit: 2013 Onsite Review	10/4/2013	OEI-07-13-00080
Montana State Medicaid Fraud Control Unit: 2012 Onsite Review	10/17/2013	OEI-09-12-00700
Nevada State Medicaid Fraud Control Unit: 2012 Onsite Review	10/22/2013	OEI-09-12-00450
Vermont State Medicaid Fraud Control Unit: 2013 Onsite Review	12/26/2013	OEI-02-13-00360
Michigan State Medicaid Fraud Control Unit: 2013 Onsite Review	1/29/2014	OEI-09-13-00070
Minnesota State Medicaid Fraud Control Unit: 2013 Onsite Review	3/18/2014	OEI-06-13-00200
Texas State Medicaid Fraud Control Unit: 2013 Onsite Review	4/11/2014	OEI-06-13-00300
Utah State Medicaid Fraud Control Unit: 2013 Onsite Review	4/16/2014	OEI-09-13-00490
Nebraska State Medicaid Fraud Control Unit: 2014 Onsite Review	6/13/2014	OEI-07-14-00060
Indiana State Medicaid Fraud Control Unit: 2013 Onsite Review	7/28/2014	OEI-07-13-00250
Mississippi State Medicaid Fraud Control Unit: 2014 Onsite Review	8/25/2014	OEI-09-13-00700
Connecticut State Medicaid Fraud Control Unit: 2014 Onsite Review	9/30/2014	OEI-07-13-00540

Source: OIG, *Office of Evaluation and Inspections--Reports and Publications--Medicaid Fraud Control Units.* Accessed at http://oig.hhs.gov/reports-and-publications/oei/m.asp#mfcu on April 3, 2015.

ACKNOWLEDGEMENTS

This report was prepared under the direction of Richard Stern, Director of Medicaid Fraud Policy and Oversight in Washington, D.C.; Kevin Golladay, Regional Inspector General for Evaluation and Inspections in the Dallas regional office; and Blaine Collins and Ruth Ann Dorrill, Deputy Regional Inspectors General in the Dallas regional office.

Lyndsay Patty served as team leader for this study. Other Office of Evaluation and Inspections staff who provided support include Maria Balderas, Susan Burbach, Jordan Clementi, and Christine Moritz. Office of Management and Policy staff who provided support include Alexis Crowley. Office of Investigations staff provided support. Office of Counsel to the Inspector General staff who provided support include Andrew VanLandingham.

ENDNOTES

[1] Social Security Act (SSA) § 1903(q).
[2] One State—North Dakota—maintains a waiver under SSA § 1902(a)(61) which requires the State to demonstrate to the satisfaction of the Secretary that operating a MFCU would not be cost effective because minimal fraud exists and that beneficiaries will be protected from abuse and neglect without the existence of a MFCU. Additionally, U.S. territories do not currently operate MFCUs.
[3] SSA § 1903(a)(61).
[4] SSA § 1903(a)(6)(B).
[5] OIG, *State Medicaid Fraud Control Units Fiscal Year 2014 Statistical Chart*.
[6] Ibid.
[7] SSA §§ 1903(q) & (q)(2); 42 CFR §§ 1007.5 and 1007.9(d).
[8] SSA § 1903(q)(1).
[9] OIG, *Medicaid Fraud Control Units*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp on December 9, 2014
[10] SSA § 1903(q)(4).
[11] Cases may involve participation by other Federal and State law enforcement agencies.
[12] 42 CFR § 1007.11(b)(1) allows Units to receive Federal financial participation for reviewing complaints of the misappropriation of patient's private funds. This authority falls under the Units' general duties regarding cases of patient abuse and neglect.
[13] In 2014—as in other years—the total number of settlements exceeded the total number of cases finalized by MFCUs. 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.
[14] Taxpayers Against Fraud. *States With False Claims Acts*. Accessed at http://www.taf.org/states-false-claims-acts on February 25, 2015.
[15] SSA § 1909.
[16] OIG, *State False Claims Act Reviews*. Accessed at https://oig.hhs.gov/fraud/state-false-claims-act-reviews/index.asp on February 25, 2015.
[17] According to SSA § 1128, 42 USC § 1320a-7, OIG is required to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses: Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare, Medicaid, the Children's Health Insurance Program, or other State health care programs; patient abuse or neglect; felony convictions for other health care-related fraud, theft, or other financial misconduct; and felony convictions relating to unlawful manufacture, distribution, prescription, or dispensing of controlled substances. *OIG Exclusions Background Information*. Accessed at http://oig.hhs.gov/exclusions/background.asp on April 3, 2015. Accessed at http://oig.hhs.gov/exclusions/background.asp on April 3, 2015.
[18] 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 December 9, 2014.
[19] SSA § 1936(b)(1), 42 U.S.C. § 1396u-6.
[20] CMS, *Comprehensive Medicaid Integrity Plan: Fiscal Years 2014–2018*, p. 3. Accessed at http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf on January 20, 2015.
[21] A Medicaid agency's mere consultation with a MFCU to discuss an allegation of fraud, or to help the State determine whether an allegation is credible, does not in itself constitute a credible allegation of fraud. CMS, *Guidance to States on Section 6402(h)(2) of ACA Program Integrity Provisions*, CPI-B 11-04, March 25, 2011.
[22] In States without a MFCU, the Medicaid agency must refer the case to an appropriate law enforcement agency, such as the Medicaid Inspector General. 42 CFR § 455.23(d).
[23] Despite this perception, MFCUs reported through their QSRs that referrals from PI units continually increased over the past 4 years.
[24] OIG, *FY 2015 Work Plan*, p. 38. Accessed at https://oig.hhs.gov/reports-and-publications/workplan/ on January 14, 2015. See p. 38 for OIG work regarding provider payment suspensions during pending investigations of credible allegations of fraud.
[25] Kaiser Family Foundation, *Medicaid Moving Forward*. Accessed at http://kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update/ on January 22, 2015.
[26] *2015 Fiscal Year 2014 Budget in Brief, Strengthening Health and Opportunity for all Americans*, p. 73. Accessed at http://www.hhs.gov/budget/fy2015/fy-2015-budget-in-brief.pdf on January 14, 2015.
[27] Ibid.
[28] 42 CFR 1007.17.