U.S. Department of Health and Human Services

Office of Inspector General

Medicaid Fraud Control Units Fiscal Year 2023 Annual Report

Ann Maxwell

Deputy Inspector General for Evaluation and Inspections

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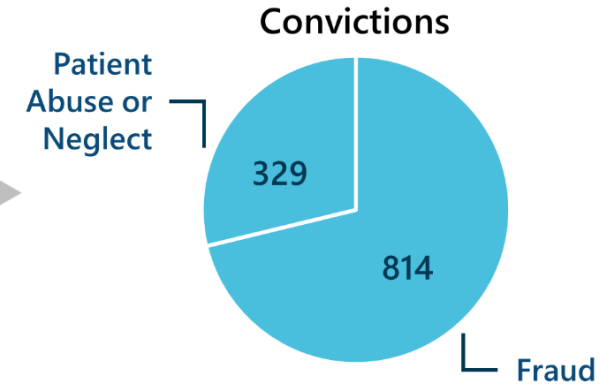
HHS Office of Inspector General

REPORT HIGHLIGHTS

March 2024 | OEI-09-24-00200

Medicaid Fraud Control Units Fiscal Year 2023 Annual Report

1,143 Convictions

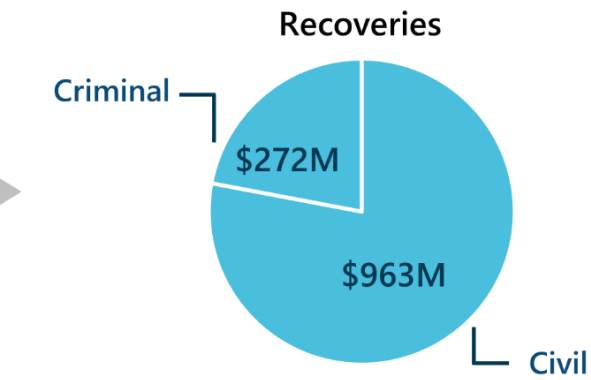


795 individuals or entities excluded from federally funded programs

436 Civil Settlements and Judgments

$1.2 Billion Recovered

MFCUs recovered $3.35 for every $1 spent



Medicaid Fraud Control Units (MFCUs) investigate and prosecute Medicaid provider fraud and patient abuse or neglect. The Department of Health and Human Services Office of Inspector General (OIG) is the designated Federal agency that oversees and annually recertifies and approves Federal funding for each MFCU. For this report, OIG analyzed the annual statistical data on case outcomes (such as convictions; civil settlements and judgments; and recoveries) that 53 MFCUs submitted to OIG for fiscal year 2023, as well as other historical data. Those MFCUs operated in all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

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BACKGROUND

Medicaid Fraud Control Units (MFCUs or Units) investigate and prosecute Medicaid provider fraud and patient abuse or neglect.[1] The Social Security Act (SSA) requires each State to effectively operate a MFCU, unless the Secretary of Health and Human Services (HHS) determines that (1) the operation of a Unit would not be cost-effective because minimal Medicaid fraud exists in a particular State; and (2) the State has other adequate safeguards to protect enrollees from abuse or neglect.[2] In fiscal year (FY) 2023, all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operated MFCUs.[3, 4]

MFCUs are funded jointly by the Federal and State Governments. Each Unit receives a Federal grant award equivalent to 90 percent of total expenditures for new Units and 75 percent for all other Units.[5] In FY 2023, combined Federal and State expenditures for the Units totaled approximately $369 million, of which approximately $277 million represented Federal funds.[6]

As illustrated in Exhibit 1, MFCU cases typically begin as referrals from external sources or are generated internally from data mining.[7] MFCU staff review referrals of possible fraud and patient abuse or neglect to determine the potential for criminal prosecution and/or civil action. If the Unit accepts a referral for investigation, the case may result in various possible outcomes. Criminal prosecutions may result in convictions; civil actions may result in civil settlements or judgments. Both criminal prosecutions and civil actions may include the assessment of monetary recoveries.

Exhibit 1: The typical life cycle of a MFCU case

MFCUs investigate and prosecute a wide variety of case types. Some cases may be resolved in a relatively short period of time. Others are more complex, may involve multiple suspects, and may take years to resolve. The Office of Inspector General

(OIG) has the authority to exclude convicted individuals and entities from federally funded health care programs on the basis of convictions referred from MFCUs.[8] When it is appropriate, Units also coordinate with OIG and other Federal and State agencies in the joint investigation and prosecution of Medicaid and other health care fraud cases.

Oversight of the MFCU Program

Reducing Medicaid fraud is a top priority for OIG, and its role in overseeing MFCUs helps achieve that priority. OIG oversees the MFCU grant program by recertifying Units; conducting reviews and inspections (hereinafter referred to as inspections) of Units; providing technical assistance to Units; and monitoring key statistical data about Unit caseloads and outcomes.[9]

Annually, OIG reviews each Unit's application for recertification; approval of this application is necessary for the Unit to receive Federal reimbursement.[10] To recertify a Unit, OIG performs a desk review to assess the Unit's compliance with the Federal requirements for MFCUs contained in statute, regulations, and OIG policy transmittals. OIG also examines the Unit's adherence to 12 performance standards, such as those regarding staffing, maintaining adequate referrals, and cooperating with Federal authorities.[11]

OIG further assesses a Unit's performance by conducting inspections of Units that may result in findings and lead to OIG making recommendations for improvement. During an inspection, OIG also makes observations regarding Unit operations and practices, and may identify beneficial practices that could be useful to other Units. Finally, OIG provides training and technical assistance to Units, as appropriate.

OIG also provides ongoing technical assistance and guidance to Units. These activities may include outreach, responding to questions from the Units, providing training to Units, and issuing policy transmittals to all Units. OIG also collects and presents statistical data reported by each MFCU annually, such as the numbers of open cases; indictments; and convictions and amounts of recoveries. These data can be accessed on the OIG website in two formats: a statistical chart and an interactive map.

Methodology

For this report, we analyzed the statistical data on case outcomes that the 53 MFCUs submitted to OIG for the 10-year period ending with FY 2023.[12] We aggregated case outcomes across all Units for each fiscal year. These outcomes include convictions; civil settlements and judgments; and criminal and civil recoveries. We present historical trends on case outcome data and, although identifying causes of changes in case outcomes over time is outside the scope of this analysis, we provide context where available and appropriate. We identified the provider types with the highest numbers of criminal and civil outcomes and calculated the return on investment (ROI)

for all MFCUs as a group.[13] We also identified the number of exclusions that OIG imposed in FY 2023 on individuals and entities associated with convictions reported by MFCUs. We also analyzed data associated with referrals of potential fraud that MFCUs reported receiving from Medicaid managed care organizations (MCO).[14, 15] Additionally, we included the beneficial practices described in previous OIG reports on Units, as described in Appendix A.

Standards

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

OIG inspections of the MFCUs and this annual report differ from other OIG evaluations in that they support OIG's direct administration of the MFCU grant program. They are subject to the same internal quality controls as are other OIG evaluations, including internal and external peer review.

Inspector General's Award for Excellence in Fighting Fraud, Waste, and Abuse

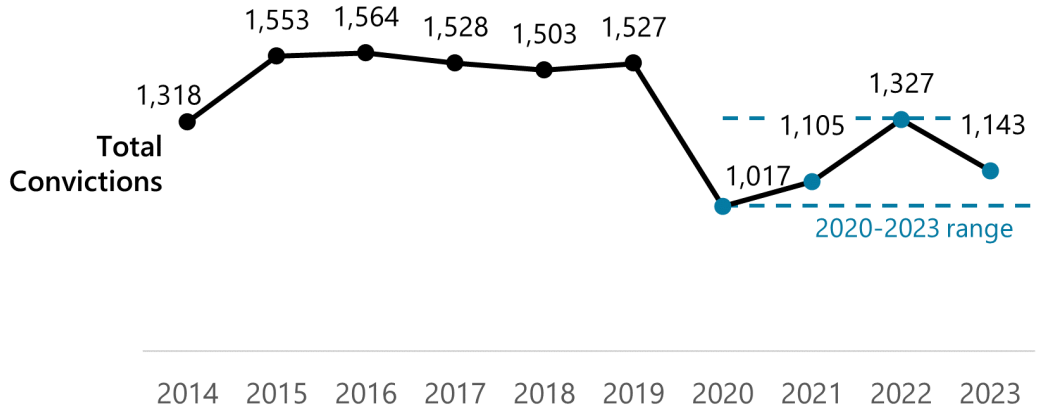
OIG annually recognizes the accomplishments of one MFCU with the Inspector General's Award for Excellence in Fighting Fraud, Waste, and Abuse. For this year's award, OIG recognizes the Missouri MFCU on the basis of several achievements. The MFCU, in FY 2023, reported especially high case outcomes for a Unit of its size. The MFCU also had excellent partnerships with OIG and other Federal law enforcement agencies, such as the U.S. Attorney's Office, resulting in several successful joint cases. One example was a multi-year investigation, in collaboration with Federal and local partners, of a residential treatment facility that resulted in a civil settlement of more than $1.8 million. Finally, the MFCU built strong and successful partnerships with State partners, including the State Medicaid agency's program integrity unit, and MCOs, which led to a consistently high number of fraud referrals from these partners.

CASE OUTCOMES

The number of convictions in FY 2023 remained in a lower range compared to the years before FY 2020

MFCUs reported 1,143 convictions in FY 2023. As shown in Exhibit 2, after remaining steady for several years, the number of MFCU convictions decreased significantly during FY 2020, which coincided with the first year of the COVID-19 public health emergency. Although the 1,143 convictions in FY 2023 were more than in FY 2020, the number of convictions remained lower than in the years before the pandemic.

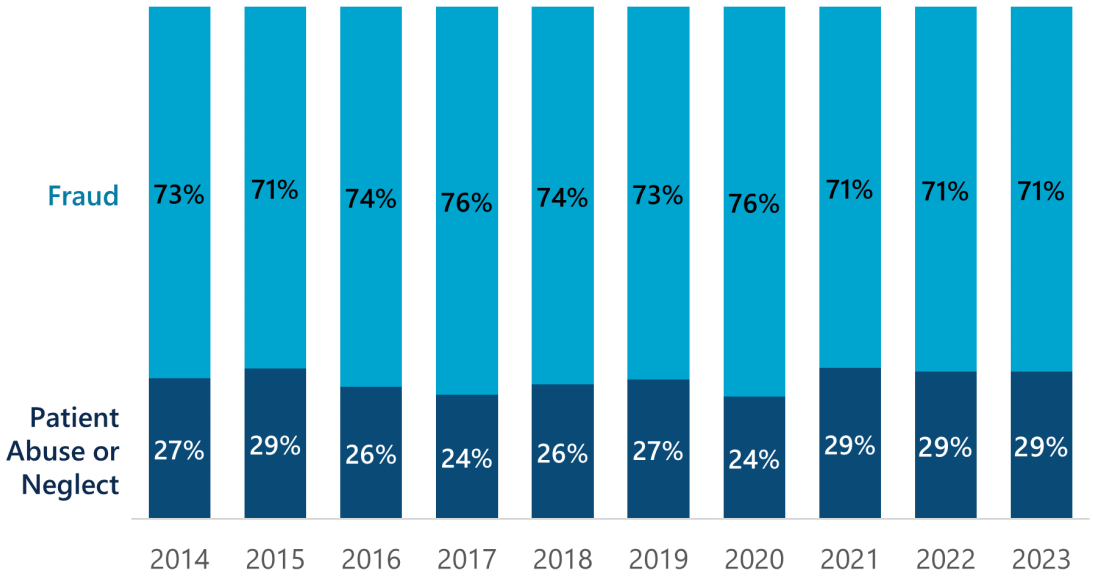
Exhibit 2: The number of annual convictions in recent years has shown more variability than in the 5 years preceding FY 2020



Source: OIG analysis of Quarterly and Annual Statistical Reports for FYs 2014 through 2023.

As shown in Exhibit 3, the proportion of total convictions involving fraud charges has remained steady over the 10-year period, ranging from 71 to 76 percent. In FY 2023, MFCUs reported 814 fraud convictions, or 71 percent of the total convictions, and 329 patient abuse or neglect convictions (29 percent of the total).

Exhibit 3: The proportion of fraud convictions compared to patient abuse or neglect convictions has remained relatively consistent through the 10-year period



Source: OIG analysis of Quarterly and Annual Statistical Reports for FYs 2014 through 2023.

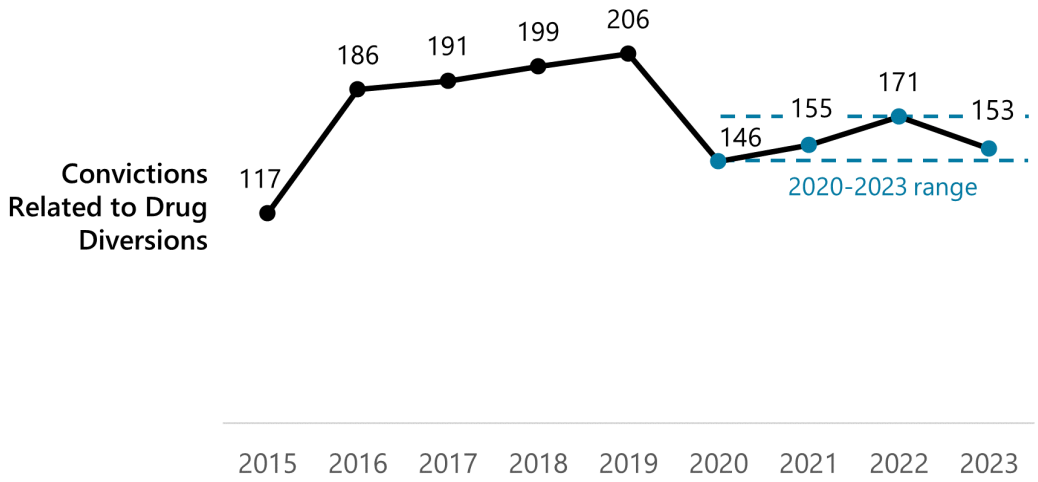
In FY 2023, OIG imposed a total of 2,112 exclusions on individuals and entities.[16] MFCU cases were responsible for 795 (38 percent) of those exclusions. In addition to these 795 MFCU-generated exclusions, MFCUs participated in joint cases with the OIG Office of Investigations that also may have resulted in exclusions.

Exclusions

MFCU convictions lead to the exclusion of individuals and entities from participation in federally funded health care programs, broadening the impact of those convictions. When MFCUs inform OIG about convictions for fraud and patient abuse or neglect in their respective States, OIG has the authority to exclude the convicted individuals and entities from federally funded health care programs. By submitting this information to OIG, MFCUs help ensure that individuals and entities convicted in one State are excluded from Medicaid programs in other States, as well as from other Federal programs related to health care.

The number of annual drug diversion convictions reported by MFCUs declined in FY 2020 and has remained in a lower range

Exhibit 4: The number of convictions from drug diversion cases in FY 2023 remained similar to those for the previous 3 years*



*OIG did not collect data specific to drug diversion cases for FY 2014.
Source: OIG analysis of Annual Statistical Reports for FYs 2015 through 2023.

Associated criminal recoveries from drug diversion cases totaled $7.2 million in FY 2023. Two States, Tennessee and Pennsylvania, accounted for 86 percent of this total and those States recovered $5.2 million and $1 million, respectively.[17]

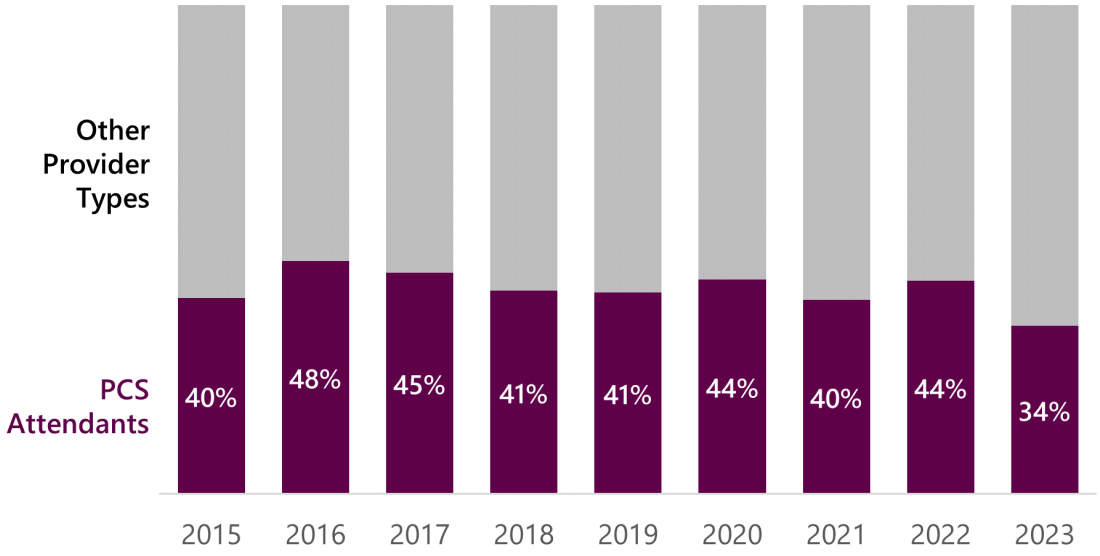
Drug Diversion Cases

In Medicaid, drug diversion cases generally involve (a) the fraudulent billing of Medicaid for medically unnecessary prescription drugs intended for illegal use, or (b) fraudulent activities of Medicaid providers involving drugs diverted from legal and medically necessary uses, regardless of whether Medicaid itself was billed. MFCUs may conduct drug diversion investigations jointly with other State or Federal agencies, such as OIG or the U.S. Attorney's Office.

A significant proportion of fraud convictions involved personal care services (PCS) attendants over the 10-year period

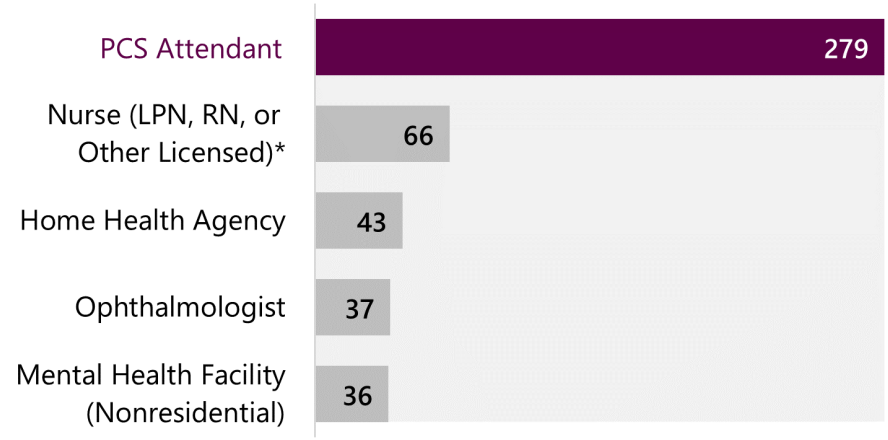
As shown in Exhibits 5 and 6, respectively, PCS attendants accounted for a large proportion of all fraud convictions during FYs 2014 through 2023 and were by far the most prominent provider type for fraud convictions in 2023. See Appendix B for detailed outcome statistics by provider type.

Exhibit 5: **PCS attendants** accounted for a significant proportion of total fraud convictions among provider types during FYs 2015-2023*



*OIG did not collect data specific to PCS attendant fraud cases for FY 2014.
Source: OIG analysis of Annual Statistical Reports for FYs 2015 through 2023.

Exhibit 6: Convictions of **PCS attendants** for fraud were **significantly higher** than for any other provider type in FY 2023

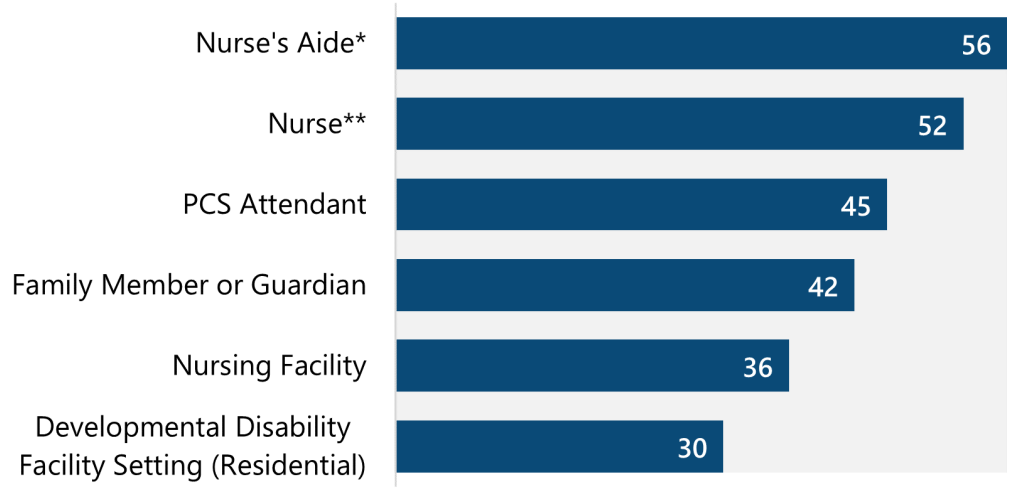


* Licensed Practical Nurse (LPN) and Registered Nurse (RN).
This chart shows the top five provider types based on the number of fraud convictions in FY 2023.
Source: OIG analysis of FY 2023 Annual Statistical Reports.

Convictions for patient abuse or neglect involved nurse's aides or nurses more than for any other provider type in FY 2023

For the second year in a row, nurse's aides and nurses were the top two provider types for patient abuse or neglect convictions.

Exhibit 7: Six provider types had more patient abuse or neglect convictions than any other provider types



*Certified Nurse Assistant or other.
** LPN, RN, or other licensed nurse.
This chart shows the top six provider types based on the number of convictions for patient abuse and neglect in FY 2023.
Source: OIG analysis of FY 2023 Annual Statistical Reports.

Patient Abuse Case Example

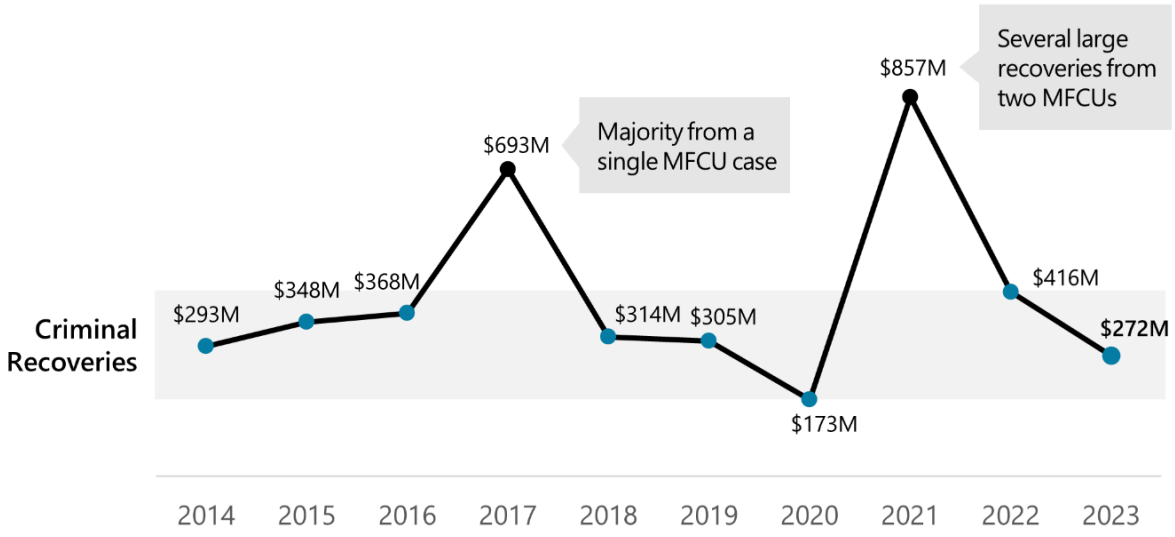
In FY 2023, the California MFCU investigated and prosecuted three providers working at an unlicensed care facility. Six disabled residents of the facility were found malnourished and living in filth, without basic care, in the facility, which lacked the staff or equipment needed to care for the residents. The providers were convicted of a total of 10 counts of felony elder abuse and 1 count of misdemeanor elder abuse.

Source: California Office of the Attorney General, *Attorney General Bonta Secures Convictions in "Horrific" Abuse Case in Riverside*, https://oag.ca.gov/news/press-releases/attorney-general-bonta-secures-convictions-%E2%80%98horrific%E2%80%99-abuse-case-riverside. Accessed on February 28, 2024.

The amount of annual criminal recoveries during most years over the 10-year period ranged between $173 million and $416 million

As shown in Exhibit 8, the amount of annual criminal recoveries has varied significantly. The criminal recovery spikes in FY 2017 and FY 2021 were primarily the result of large cases prosecuted by several MFCUs.

Exhibit 8: In FY 2023, MFCUs reported the second-lowest amount of total criminal recoveries over the 10-year period



Source: OIG analysis of Quarterly and Annual Statistical Reports for FYs 2014 through 2023.

Criminal Fraud Case Example

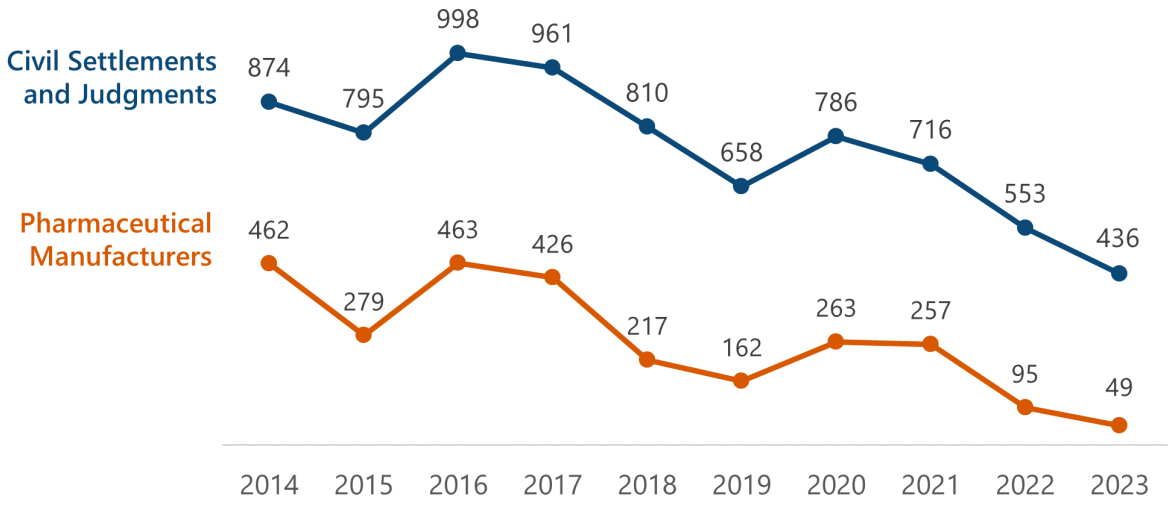
One case in FY 2023 with significant criminal recoveries involved an investigation by the North Carolina MFCU and Federal partners. In that case, the MFCU investigated the owner of a laboratory for defrauding the Medicaid program and violating the Anti-Kickback Statute. Among other actions, the defendants billed Medicaid for urine testing services that were not medically necessary and provided illegal kickbacks in exchange for the testing. The defendants were convicted of defrauding the North Carolina Medicaid program of more than $11 million.

Source: North Carolina Department of Justice, *Attorney General Josh Stein Wins Conviction in $11 Million Medicaid Fraud Scheme*, https://ncdoj.gov/attorney-general-josh-stein-wins-conviction-in-11-million-medicaid-fraud-scheme/. Accessed on January 24, 2024.

Despite a decreasing number of civil settlements and judgments, total civil recoveries in FY 2023 reached a 4-year high

As shown in Exhibit 9, coinciding with the decrease in the number of total civil settlements and judgments, the number of civil settlements and judgments associated with pharmaceutical manufacturers also significantly decreased.[18, 19]

Exhibit 9: The number of annual civil settlements and judgments has decreased over the 10-year period



Source: OIG analysis of Quarterly and Annual Statistical Reports for FYs 2014 through 2023.

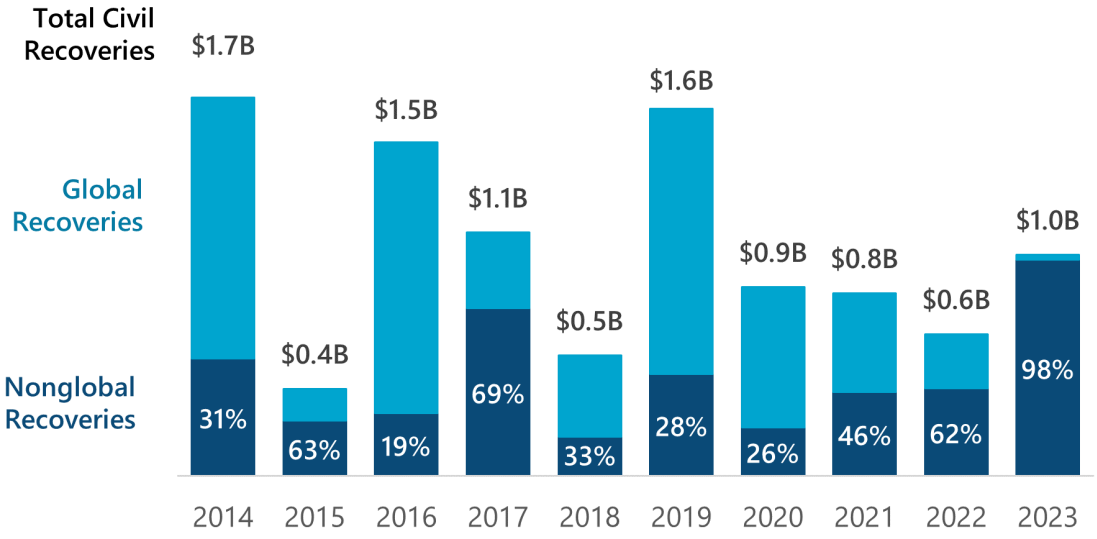
Civil Case Example

In one civil case, the California MFCU partnered with other State agencies to pursue allegations that a national managed care company overcharged the California Medicaid program by falsely reporting higher prescription drug costs. As a result of the investigation and ensuing settlement, the company agreed to pay a total of more than $215 million.

Source: State of California Department of Justice, *Attorney General Bonta Announces $215 Million Settlement Against Healthcare Company Centene,* https://oag.ca.gov/news/press-releases/attorney-general-bonta-announces-215-million-settlement-against-healthcare. Accessed on January 24, 2024.

As shown in Exhibit 10, the amount of total civil recoveries varied significantly during the 10-year period. In FY 2023, MFCUs reported almost $1 billion in total civil recoveries—the vast majority from nonglobal cases ($939 million). MFCUs in two States—California and Texas—accounted for over half of these nonglobal civil recoveries ($568 million).

Exhibit 10: Nonglobal cases accounted for almost all civil recoveries in FY 2023



Source: OIG analysis of Quarterly and Annual Statistical Reports for FYs 2014 through 2023.

FY 2023 marked the highest amount of civil recoveries from nonglobal cases during the 10-year period

Beginning in FY 2021, the percentage of total civil recoveries resulting from nonglobal cases (see dark blue segments in Exhibit 10) rose each year, from 26 percent in FY 2020 to 98 percent in FY 2023. FY 2023 also marked the lowest amount of global recoveries ($23 million) during the 10-year period. For the 3 years representing the highest civil recovery amounts (FYs 2014, 2016, and 2019), the totals were primarily derived from large global pharmaceutical cases.

Types of Civil Cases

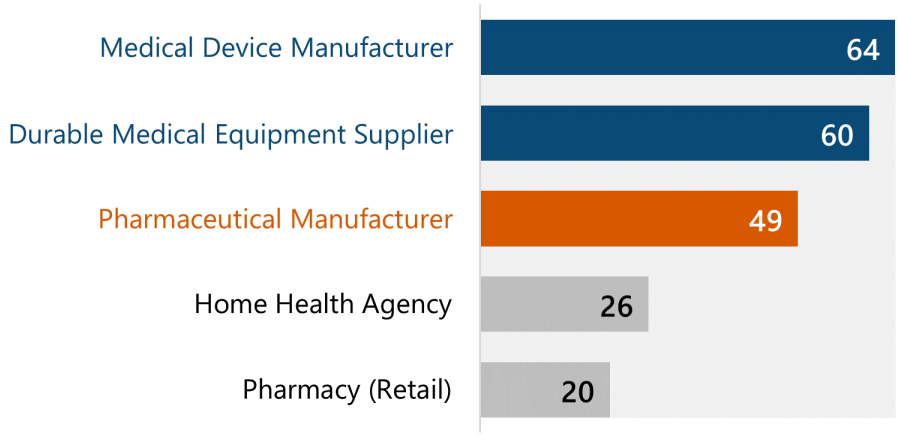
A **global case** involves both the Federal Government and a group of States and is coordinated by the National Association of Medicaid Fraud Control Units.

A **nonglobal case** is conducted by a Unit—individually or with other law enforcement partners—and is not coordinated by the National Association of Medicaid Fraud Control Units.

Medical device manufacturers and durable medical equipment suppliers were associated with the most civil settlements and judgments in FY 2023

As shown in Exhibit 11, two provider types (medical device manufacturers and durable medical equipment suppliers) accounted for more civil settlements and judgments than did other provider types in FY 2023. As previously mentioned, the number of settlements and judgments involving pharmaceutical manufacturers have declined since FY 2016.

Exhibit 11: More FY 2023 civil settlements and judgments involved medical device manufacturers and durable medical equipment suppliers than pharmaceutical manufacturers



This chart shows the top five provider types based on the number of civil settlements and judgments in FY 2023.
Source: OIG analysis of FY 2023 Annual Statistical Reports.

Medical Device Manufacturer Case Example

In a case involving a medical device manufacturer, the National Association of Medicaid Fraud Control Units partnered with OIG, the U.S. Department of Justice, and other Federal agencies to pursue allegations that the company misled Federal health care programs regarding its medical devices—cochlear implant processors. As a result of the investigation and ensuing settlement, the company agreed to pay a total of more than $12 million to the Federal government and participating States and was required to enter into a Corporate Integrity Agreement with OIG.

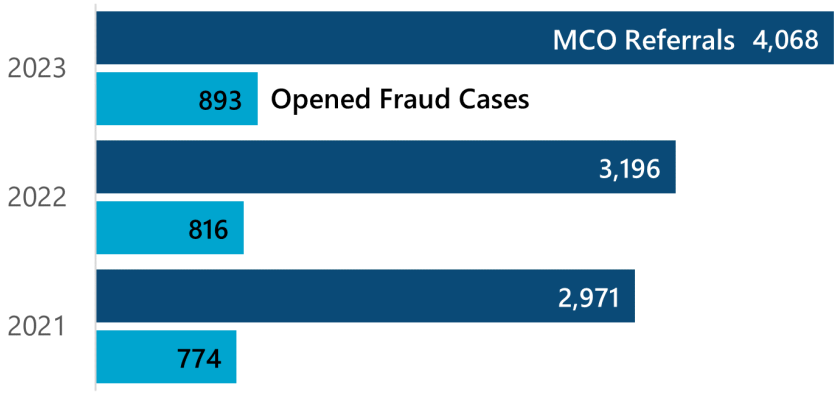
Source: United States Department of Justice, *Advanced Bionics LLC to Pay Over $12 Million for Alleged False Claims for Cochlear Implant Processors,* https://www.justice.gov/opa/pr/advanced-bionics-llc-pay-over-12-million-alleged-false-claims-cochlear-implant-processors. Accessed on February 29, 2024.

MCO FRAUD REFERRALS RECEIVED BY UNITS

The number of fraud referrals that MFCUs reported receiving from MCOs has increased since FY 2021

As one effort to identify and prevent fraud in managed care plans, OIG expanded its engagement with MCOs and their special investigation units in coordination with Federal and State law enforcement partners to help increase actionable referrals of potential Medicaid fraud to law enforcement.[20, 21] As shown in Exhibit 12, the total number of fraud referrals that MFCUs reported receiving from MCOs that cover Medicaid enrollees increased from FY 2021 to FY 2023. The number of cases opened by MFCUs from those referrals also increased each year.

Exhibit 12: MFCUs received more fraud referrals from MCOs and opened more cases based on those referrals each year



CONCLUSION

MFCUs play a vital role in holding wrongdoers accountable for Medicaid provider fraud and protecting patients from abuse or neglect. Medicaid, as a Federal-State partnership that provides health insurance for nearly 80 million individuals, requires skilled and effective oversight from both the Federal and State governments. MFCUs, which report to or work closely with the State Attorney General, and which receive funding and oversight from OIG, are uniquely positioned to investigate and prosecute provider fraud and patient abuse or neglect in coordination with Federal and State law enforcement and oversight agencies.

This report generally shows that results from MFCU activities are picking back up after slumping in FY 2020 but have not gone back to pre-pandemic levels. Some MFCU case outcomes, such as criminal convictions, remained lower in FY 2023 than before the COVID-19 outbreak. The amount of civil recoveries reached a 4-year high in FY 2023, and combined criminal and civil recoveries were $1.2 billion, resulting in an ROI of $3.35 for every $1 spent. Also in FY 2023, civil recoveries from nonglobal cases accounted for almost all civil recoveries, a significant shift from past years when recoveries from global cases were more prominent. This shift from global to nonglobal recoveries coincided with the continued, steady drop in cases involving pharmaceutical manufacturers.

As in past MFCU annual reports, OIG has identified beneficial practices implemented by the MFCUs (see Appendix A), which other MFCUs may want to consider for adoption.

APPENDICES

Appendix A: Beneficial Practices Described in Office of Inspector General Inspection Reports

This appendix summarizes MFCU practices that OIG has highlighted as beneficial to Unit operations, which other Units may wish to consider adopting in their States.

All of OIG's MFCU reports are available at https://oig.hhs.gov/reports-and-publications/oei/m.asp#mfcu.

STANDARD 4	A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.
Kansas OEI-12-18-00210 July 2019	**Supplementing reviews of referrals of patient abuse or neglect and enhancing referral coordination:** The Unit's nurse investigator reviewed complaints about patient abuse or neglect that had been previously closed by the State's survey and certification agency to determine whether the complaints warranted further investigation. In addition, the nurse investigator arranged for the Unit to receive complaints of patient abuse or neglect at the same time the State's survey and certification agency sent the complaints to local law enforcement agencies. After reviewing the complaints, the nurse investigator contacted local law enforcement agencies. If those agencies did not plan to take any action on the complaints, the Unit's Special Agent in Charge reviewed the complaints to determine whether to open a formal investigation.
Louisiana OEI-12-20-00650 August 2021	**Hiring an outreach coordinator to promote the Unit's mission among its stakeholders:** The outreach coordinator's responsibilities were to promote the Unit's mission among nursing homes, rehabilitation facilities, local law enforcement agencies, and other State agencies. The outreach coordinator was responsible for (1) developing training regarding the Unit's mission and presenting that training to Unit stakeholders; (2) coordinating with the Louisiana Department of Justice on press releases; and (3) acting as a liaison to receive referrals from stakeholders.
Montana OEI-12-19-00170 March 2020	**Participating in an Elder Abuse Task Force to provide training to law enforcement and first responders:** To encourage referrals, the Unit regularly trained cadets at the Montana Law Enforcement Academy and trained other law enforcement and first responder personnel through its participation in the Montana Elder Abuse Task Force. The training focused on the Unit's mission and how the Unit can assist with crimes that law enforcement personnel and first responders may encounter.

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Beneficial Practices Described in Office of Inspector General Inspection Reports

STANDARD 4	A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.
New York OEI-12-17-00340 September 2018	**Establishing data analytics working groups to improve the Unit's ability to data mine to find potential cases:** The Unit established data analytics working groups to provide guidance, training, and an assessment of the Unit's data mining efforts. The groups include the Data Analytics Tool group, the Data Sources group, the Fraud and Abuse group, and the Governance group.
Ohio OEI-07-14-00290 April 2015	**Establishing a program integrity group composed of personnel from other Medicaid program integrity entities:** To improve the quantity and quality of referrals, the Unit established the Ohio Program Integrity Group, which combines the knowledge and resources of all of the State agencies that are responsible for Medicaid program integrity. In addition, the Unit spearheaded the Managed Care Program Integrity Group, which meets quarterly.
South Carolina OEI-12-20-00610 September 2021	**Notifying referral sources of the Unit's decision whether to open formal investigations of incoming referrals:** Through secure electronic channels, the Unit communicated with the State Medicaid agency and other referral sources regarding the Unit's decision to accept or decline referrals. In response, State officials lauded the responsiveness of the Unit's communications. The Unit followed a similar practice, where appropriate, regarding referrals received from private citizens.
STANDARD 5	**A Unit takes steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases.**
Arkansas OEI-12-19-00450 September 2020	**Designating staff as subject matter experts:** The Unit director designated Unit investigators as subject matter experts on specific, common provider types for efficient assignment and improved investigation of cases.
New York OEI-12-17-00340 September 2018	**Developing a strategic plan to optimize and prioritize resources:** The Unit developed a written strategic plan to help Unit staff make informed decisions regarding the optimal use of resources. The plan provides guidance to prioritize certain types of investigations, such as criminal investigations that are related to systematic patient abuse and neglect; investigations of fraud allegations against MCOs; and fraud investigations of large providers. The plan also establishes a priority for false claims investigations with higher potential for monetary recoveries or risk of patient harm.

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Beneficial Practices Described in Office of Inspector General Inspection Reports

STANDARD 8	A Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health care fraud.
Florida OEI-07-15-00340 June 2016	**Co-locating Unit and OIG staff to improve cooperation on joint cases:** Unit staff have workstations at an OIG field office—this improved communication and cooperation with OIG on joint cases, including fraud cases generated through the U.S. Department of Justice Medicare Strike Force.
Idaho OEI-12-18-00320 August 2019	**Monitoring media sources to report convictions of providers to OIG:** The Unit's legal secretary monitored media sources for convictions in patient abuse and neglect cases. Although the convictions were a result of investigations by local authorities and not the Unit, the legal secretary obtained the conviction information, and after the Unit Director's review and approval, the legal secretary submitted the police reports and court documents to OIG. As a result of those efforts, OIG has excluded individuals from federally funded health programs.

STANDARD 9	A Unit makes statutory or programmatic recommendations, when warranted, to the State government.
Minnesota OEI-06-13-00200 March 2014	**Developing legislation to protect Medicaid enrollees from abuse:** The Unit helped develop legislation to protect Medicaid enrollees by strengthening background checks for individuals who serve as guardians and conservators of Medicaid enrollees.
Washington OEI-09-16-00010 September 2016	**Using information from a case closure form to make program integrity recommendations to State agencies:** The Unit used a case closure form to make numerous program integrity recommendations to State agencies and tracked the responses to these recommendations in a database.

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Beneficial Practices Described in Office of Inspector General Inspection Reports

STANDARD 12	A Unit conducts training that aids in the mission of the Unit.
Kentucky OEI-06-17-00030 September 2017	**Implementing a mentoring program to develop Unit attorneys:** The Unit created an executive advisor position to help Unit attorneys develop litigation skills. The executive advisor also mentored new attorneys and served as a co-chair on Unit prosecutions.
Louisiana OEI-12-20-00650 August 2021	**Sponsoring combined training events with a neighboring Unit:** The Unit and a neighboring Unit alternated hosting a combined training for employees of both Units. Training events included case studies, statistical trends, and roundtable discussions.
Maryland OEI-07-16-00140 September 2016	**Developing an internal boot camp to train new staff:** The Unit developed an internal "boot camp" training program that helped new staff develop a full understanding of the Unit's work. Experienced MFCU staff gave 1- to 2-hour lectures on topics such as civil and criminal investigation procedures; interviewing techniques; and understanding medical codes.
Missouri OEI-12-18-00490 January 2020	**Creating in-house training videos:** The Unit's Chief Auditor created in-house training videos for Unit investigators and attorneys. The videos contained step-by-step tutorials for creating and using investigative and trial tools.
New York OEI-12-17-00340 September 2018	**Using a moot-court approach for training attorneys:** The Unit used moot-court training to train Unit attorneys. This training helped the Unit attorneys practice opening arguments to prepare for trial.

OTHER	Beneficial practices not relating directly to a specific performance standard.
South Dakota OEI-07-16-00170 September 2016	**Having providers teach their peers about implications of Medicaid fraud:** The Unit used providers who had previously been investigated for Medicaid fraud to educate their peers. These providers gave presentations alongside Unit staff at training conferences—this helped to highlight Medicaid billing issues and the implications of Medicaid fraud.
Virginia OEI-07-15-00290 August 2016	**Using specialty software to better analyze, maintain, and share documentary evidence:** The Unit used specialty software designed to read the text in a document, analyze it for keywords, and systematically code it according to criteria established by an analyst. This improved the Unit's abilities to process and track evidence collected during investigations and to share that evidence with Federal and State partners working on joint cases.

Appendix B: Medicaid Fraud Control Unit Case Outcomes and Open Investigations by Provider Type and Case Type for Fiscal Year 2023

Exhibit B1: Number of convictions; settlements and judgments; and recoveries by provider type and case type

PROVIDER TYPE	CRIMINAL		CIVIL	
	Convictions	Amount of Recoveries	Settlements and Judgments	Amount of Recoveries
Patient Abuse or Neglect				
Assisted Living Facility	16	$9,407,015	0	$0
Developmental Disability Facility (Nonresidential)	1	$56,695	1	$112,000
Developmental Disability Facility (Residential)	30	$42,312	1	$1,866,000
Family Member or Guardian	42	$2,464,334	1	$8,168
Inpatient Psychiatric Services for Individuals Under Age 21	1	$690	0	$0
Internal Medicine	1	$670	0	$0
Marketer or Telemarketer	0	$38,125	0	$0
Nurse (LPN, RN, or Other Licensed)	52	$28,585	0	$0
Nurse's Aide (Certified Nurse Assistant or Other)	56	$67,004	0	$0
Nursing Facility	36	$1,430,028	11	$9,338,908
Obstetrician/Gynecologist	1	$4,694	0	$0
Personal Care Services Attendant	45	$131,731	0	$0
Radiologist	0	$0	1	$0
Other Individual Provider	25	$171,207	0	$0
Other Long-Term Care Facility	2	$963	0	$0
Other Therapist/Counselor (Mental Health) Licensed	1	$0	0	$0
Other Perpetrator	20	$148,567	0	$0
Fraud—Facility-Based Medicaid Providers and Programs—Inpatient and/or Residential				
Assisted Living Facility	4	$1,841	1	$89,944
Developmental Disability Facility (Residential)	0	$42,273	4	$1,264,307
Hospital	1	$0	10	$9,429,706
Inpatient Psychiatric Services for Individuals Under Age 21	0	$0	0	$0

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Exhibit B1: Number of convictions; settlements and judgments; and recoveries by provider type and case type (continued)

PROVIDER TYPE	CRIMINAL		CIVIL	
	Convictions	Amount of Recoveries	Settlements and Judgments	Amount of Recoveries
Fraud—Facility-Based Medicaid Providers and Programs—Inpatient and/or Residential				
Nursing Facility	7	$10,487	0	$0
Other Inpatient Mental Health Facility	1	$153,969	2	$93,784
Other Long-Term Care Facility	0	$0	2	$29,495,268
Fraud—Facility-Based Medicaid Providers and Programs—Outpatient and/or Day Services				
Adult Day Center	0	$114,541	0	$0
Ambulatory Surgical Center	0	$0	0	$0
Developmental Disability Facility (Nonresidential)	3	$1,726,794	1	$922
Dialysis Center	0	$0	0	$0
Mental Health Facility (Nonresidential)	36	$32,399,225	12	$10,742,245
Substance Abuse Treatment Center	6	$8,328,106	6	$1,087,368
Other Facility (Nonresidential)	6	$258,338	2	$1,299,576
Fraud—Licensed Practitioners				
Audiologist	0	$0	0	$0
Chiropractor	2	$50,944	4	$584,495
Clinical Social Worker	8	$499,641	0	$0
Dental Hygienist	0	$0	0	$0
Dentist	6	$3,716,710	8	$2,223,254
Nurse (LPN, RN, or Other Licensed)	66	$1,159,431	3	$298,527
Nurse Practitioner	7	$1,721,615	1	$315,000
Optometrist	2	$239,875	2	$592,549
Pharmacist	6	$4,019,978	1	$0
Physician Assistant	4	$277,401	0	$0
Podiatrist	1	$144,795	0	$0
Psychologist	2	$3,688,009	2	$1,262,880

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PROVIDER TYPE	CRIMINAL		CIVIL	
	Convictions	Amount of Recoveries	Settlements and Judgments	Amount of Recoveries
Fraud—Licensed Practitioners				
Therapist (Non-Mental Health, Physical Therapist (PT), Speech Therapist (ST), Occupational Therapist (OT), or Radiation Therapist (RT))	5	$1,426,385	3	$50,697
Other Licensed Therapist/Counselor (Mental Health)	17	$6,586,134	1	$200,000
Other Licensed Practitioner	1	$520	1	$1,498,363
Fraud—Medical and Other Support Services				
Ambulance	5	$2,640,704	3	$4,175,873
Billing Services	4	$123,383	3	$72,801
Home Health Agency	43	$34,625,806	26	$15,656,773
Hospice	1	$15,454,117	2	$718,463
Lab (Clinical)	3	$5,435,061	13	$26,336,282
Lab (Radiology and Physiology)	0	$0	3	$2,524,413
Lab (Other)	0	$0	4	$2,017,951
Medical Device Manufacturer	0	$0	64	$10,150,832
Pain Management Clinic	0	$4,894,904	5	$13,717,974
Personal Care Services Agency	22	$26,400,167	3	$842,996
Pharmaceutical Manufacturer	0	$0	49	$139,962,829
Pharmacy (Hospital)	0	$0	1	$7,000,000
Pharmacy (Institutional Wholesale)	1	$22,000	0	$0
Pharmacy (Retail)	10	$5,245,873	20	$20,262,838
Supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	15	$23,586,165	60	$24,617,316
Targeted Case Management and Case Management	3	$1,091,354	0	$0
Transportation (Nonemergency)	12	$159,646	2	$1,007,913
Other Medical and Other Support Services	2	$483,428	13	$9,384,919

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PROVIDER TYPE	CRIMINAL		CIVIL	
	Convictions	Amount of Recoveries	Settlements and Judgments	Amount of Recoveries
Fraud—Other Individual Providers				
Emergency Medical Technician or Paramedic	0	$0	0	$0
Nurse's Aide (CNA or Other)	10	$76,699	2	$9,048
Optician	0	$0	0	$0
Personal Care Services Attendant	279	$10,583,638	16	$49,882
Pharmacy Technician	4	$3,501,857	1	$0
Unlicensed Counselor (Mental Health)	22	$5,954,566	2	$2,824
Unlicensed Therapist (Non-Mental Health)	0	$0	0	$0
Other Individual Provider Not Listed Above	31	$5,566,861	1	$3,827,403
Fraud—Physicians (Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO)) by Medical Specialty				
Allergist/Immunologist	0	$0	0	$0
Anesthesiologist	2	$28,276	0	$0
Cardiologist	0	$0	4	$11,881,054
Dermatologist	0	$0	2	$6,785,000
Emergency Medicine	3	$22,596	1	$3,360,000
Family Practice	18	$3,245,136	7	$3,919,217
Gastroenterologist	0	$0	0	$0
Geriatrician	2	$1,330	0	$0
Internal Medicine	8	$5,049,557	8	$6,971,408
Neurologist	4	$2,219,296	1	$56,381
Obstetrician/Gynecologist	5	$451,180	3	$485,000
Oncologist	0	$0	1	$76,949
Ophthalmologist	37	$278,643	1	$17,000,000
Orthopedist	1	$418,500	0	$0
Pediatrician	1	$0	2	$193,025
Physical Medicine and Rehabilitation	3	$917,588	0	$0
Psychiatrist	5	$705,078	3	$832,350
Radiologist	0	$0	0	$5,190
Surgeon	4	$26,792,941	7	$3,656,665

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PROVIDER TYPE	CRIMINAL		CIVIL	
	Convictions	Amount of Recoveries	Settlements and Judgments	Amount of Recoveries
Fraud—Physicians (Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO)) by Medical Specialty				
Urologist	0	$0	1	$2,400,000
Other Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO)	12	$4,287,663	9	$5,431,757
Fraud—Program-Related				
Managed Care Organization (MCO)	1	$4,032	7	$519,759,204
Medicaid Program Administration	11	$49,954	2	$10,021,592
Other Program-Related	10	$424,703	2	$15,492,065
Fraud—Other Perpetrators				
Family Member or Guardian	3	$545,451	0	$0
Marketer or Telemarketer	2	$0	0	$0
Other Perpetrator Not Listed Above	24	$379,798	1	$0
TOTAL	**1,143**	**$272,227,587**	**436**	**$962,520,150**

Note: Criminal and civil recovery amounts do not add up to the totals shown because of rounding.

Exhibit B2: Number of open investigations at the end of FY 2023 by provider type and case type

PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Patient Abuse or Neglect			
Adult Day Center	3	0	3
Anesthesiologist	1	0	1
Assisted Living Facility	286	24	310
Billing Services	1	0	1
Chiropractor	2	0	2
Clinical Social Worker	6	0	6
Dentist	17	0	17
Developmental Disability Facility (Nonresidential)	10	0	10
Developmental Disability Facility (Residential)	223	8	231

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PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Patient Abuse or Neglect			
Emergency Medicine	5	0	5
EMTs or Paramedics	1	0	1
Family Member or Guardian	255	0	255
Family Practice	19	1	20
Gastroenterologist	1	0	1
Home Health Agency (Excluding PCS)	7	0	7
Hospice	6	0	6
Hospital	19	4	23
Inpatient Psychiatric Services for Individuals Under Age 21	1	0	1
Internal Medicine	13	0	13
Marketer or Telemarketer	1	0	1
Mental Health Facility (Nonresidential)	1	0	1
Neurologist	7	0	7
Nurse (RN, LPN, or Other Licensed)	290	0	290
Nurse Practitioner	15	0	15
Nurse's Aide (CNA or Other)	321	2	323
Nursing Facility	756	85	841
Obstetrician/Gynecologist	2	0	2
Ophthalmologist	3	0	3
Optometrist	1	0	1
Orthopedist	2	0	2
Pediatrician	9	0	9
Personal Care Services Agency	4	0	4
Personal Care Services Attendant	214	3	217
Pharmaceutical Manufacturer	1	0	1
Pharmacist	2	0	2
Pharmacy (Retail)	9	0	9
Physician Assistant	4	0	4
Psychiatrist	9	1	10
Radiologist	1	0	1
Substance Abuse Treatment Center	3	0	3
Surgeon	5	0	5

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PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Patient Abuse or Neglect			
Therapist (Non-Mental Health, PT, ST, OT, or RT)	2	0	2
Transportation (Nonemergency)	6	1	7
Unlicensed Counselor (Mental Health)	3	0	3
Unlicensed Therapist (Non-Mental Health)	1	0	1
Other Facility (Nonresidential)	3	1	4
Other Individual Provider	105	1	106
Other Inpatient Mental Health Facility	21	0	21
Other Licensed Practitioner	30	0	30
Other Long-Term Care Facility	36	0	36
Other MD/DO	4	0	4
Other Mental Health Therapist/Counselor, Licensed	1	0	1
Other Medical and Support Services	1	0	1
Other Program-Related	35	9	44
Other Perpetrator Not Listed Above	169	1	170
Fraud—Facility-Based Medicaid Providers and Programs—Inpatient and/or Residential			
Assisted Living Facility	46	21	67
Developmental Disability Facility (Residential)	39	14	53
Hospital	55	187	242
Inpatient Psychiatric Services for Individuals Under Age 21	9	15	24
Nursing Facility	87	151	238
Other Inpatient Mental Health Facility	11	28	39
Other Long-Term Care Facility	16	21	37
Fraud—Facility-Based Medicaid Providers and Programs—Outpatient and/or Day Services			
Adult Day Center	69	8	77
Ambulatory Surgical Center	2	12	14
Developmental Disability Facility (Nonresidential)	26	14	40
Dialysis Center	0	23	23
Mental Health Facility (Nonresidential)	485	77	562
Substance Abuse Treatment Center	185	69	254
Other Facility (Nonresidential)	38	78	116

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PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Fraud—Licensed Practitioners			
Audiologist	5	2	7
Chiropractor	17	5	22
Clinical Social Worker	75	3	78
Dental Hygienist	2	1	3
Dentist	209	40	249
Nurse (LPN, RN, or Other Licensed)	412	9	421
Nurse Practitioner	73	10	83
Optometrist	25	6	31
Pharmacist	55	24	79
Physician Assistant	21	1	22
Podiatrist	20	10	30
Psychologist	60	8	68
Therapist (Non-Mental Health, PT, ST, OT, or RT)	79	22	101
Other Licensed Therapist/Counselor (Mental Health)	157	13	170
Other Licensed Practitioner	25	14	39
Fraud—Medical and Other Support Services			
Ambulance	25	55	80
Billing Services	38	62	100
Home Health Agency	480	76	556
Hospice	63	26	89
Lab (Clinical)	150	574	724
Lab (Radiology and Physiology)	17	50	67
Lab (Other)	26	171	197
Medical Device Manufacturer	3	646	649
Pain Management Clinic	40	23	63
Personal Care Services Agency	205	12	217
Pharmaceutical Manufacturer	87	1,542	1,629
Pharmacy (Hospital)	1	5	6
Pharmacy (Institutional Wholesale)	10	156	166
Pharmacy (Retail)	276	788	1,064
Supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	141	579	720
Targeted Case Management and Case Management	13	2	15

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PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Fraud—Medical and Other Support Services			
Transportation (Nonemergency)	244	30	274
Other Medical and Support Services	72	289	361
Fraud—Other Individual Providers			
Emergency Medical Technician or Paramedic	0	2	2
Nurse's Aide (CNA or Other)	57	0	57
Optician	1	1	2
Personal Care Services Attendant	1,692	31	1,723
Pharmacy Technician	15	1	16
Unlicensed Counselor (Mental Health)	66	4	70
Unlicensed Therapist (Non-Mental Health)	3	0	3
Other Individual Provider	206	30	236
Fraud—Physicians (MD/DO) by Medical Specialty			
Allergist/Immunologist	6	4	10
Anesthesiologist	28	5	33
Cardiologist	17	20	37
Dermatologist	4	8	12
Emergency Medicine	16	22	38
Family Practice	213	44	257
Gastroenterologist	0	1	1
Geriatrician	2	2	4
Internal Medicine	109	31	140
Neurologist	14	4	18
Obstetrician/Gynecologist	21	4	25
Oncologist	5	1	6
Ophthalmologist	11	14	25
Orthopedist	5	2	7
Pediatrician	45	15	60
Physical Medicine and Rehabilitation	21	9	30
Psychiatrist	66	22	88
Radiologist	7	24	31
Surgeon	20	15	35
Urologist	2	2	4
Other MD/DO	106	69	175

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PROVIDER TYPE	OPEN INVESTIGATIONS		
	Criminal	Civil	Total
Fraud—Program-Related			
Managed Care Organization (MCO)	8	76	84
Medicaid Program Administration	5	11	16
Other Program-Related	54	90	144
Fraud—Other Perpetrators			
Family Member or Guardian	23	0	23
Marketer or Telemarketer	36	1	37
Other Perpetrator Not Listed Above	104	20	124
TOTAL	**10,135**	**6,698**	**16,833**

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

Contact

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

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

ABOUT THE OFFICE OF INSPECTOR GENERAL

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

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

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

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ENDNOTES

[1] Social Security Act (SSA) § 1903(q)(3)–(4). Regulations at 42 CFR § 1007.11(b)(1) add that a Unit's responsibilities may include reviewing complaints of misappropriation of patients' private funds in residential health care facilities. Units may investigate patient abuse and neglect incidents occurring in (1) health care facilities that receive Medicaid payments; and (2) board and care facilities, which are residential settings that receive payments on behalf of two or more unrelated adults who reside in the facility and receive nursing care services or a substantial amount of personal care services (PCS). SSA § 1903(q)(4). Beginning on December 27, 2020, MFCUs may also receive Federal financial participation to investigate and prosecute abuse or neglect of Medicaid enrollees in a noninstitutional or other setting. Consolidated Appropriations Act, 2021, P.L. No. 116-260, Division CC § 207.

[2] SSA § 1902(a)(61).

[3] The SSA authorizes the Secretary of HHS to award grants (SSA § 1903(a)(6)) and to certify and annually recertify Units (SSA § 1903(q)). The Secretary delegated this authority to OIG. See also 42 CFR § 1007.15. Units must meet several requirements established by the SSA and Federal regulations. For example, each Unit must (1) be a single, identifiable entity of State Government, separate and distinct from the State Medicaid agency (SSA § 1903(q)(2); 42 CFR §§ 1007.5(a) and 1007.9(a)); (2) employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney (SSA § 1903(q)(6); 42 CFR § 1007.13); (3) develop a formal agreement, such as a memorandum of understanding, describing the Unit's relationship with the State Medicaid agency (42 CFR § 1007.9(d)); and (4) have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority (SSA § 1903(q)(1); 42 CFR § 1007.7).

[4] The territories of American Samoa, Guam, and the Northern Mariana Islands have not established Units. Puerto Rico and the U.S. Virgin Islands received certification to operate in FY 2019 and North Dakota received certification to operate in FY 2020.

[5] SSA § 1903(a)(6). For a Unit's first 3 years of operation, the Federal Government contributes 90 percent of funding and the State contributes 10 percent. Thereafter, the Federal Government contributes 75 percent and the State contributes 25 percent.

[6] OIG's analysis of MFCU Annual Statistical Reports for FY 2023.

[7] 42 CFR § 1007.20. MFCUs must receive approval from OIG to conduct data mining. As of December 2023, 24 MFCUs were approved for data mining. OIG, *Data Mining Applications*, https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/data-mining.asp. Accessed on December 19, 2023.

[8] SSA § 1128; 42 U.S.C. § 1320a-7. See also OIG, *Background Information*, https://oig.hhs.gov/exclusions/background.asp. Accessed on December 19, 2023.

[9] OIG provides information on MFCU operations and outcomes but does not direct or encourage MFCUs to investigate or prosecute a specific number of cases. MFCU investigators and prosecutors should apply professional judgment and discretion in determining what criminal and civil cases to pursue.

[10] 42 CFR § 1007.15.

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

[12] In FY 2015, OIG changed from requiring MFCUs to report statistics on a quarterly basis (Quarterly Statistical Reporting) to requiring MFCUs to report statistics on an annual basis (Annual Statistical Reporting). Because Quarterly Statistical Reports did not capture outcomes specific to drug diversion or PCS attendant fraud cases, we only have 9 years of data for those cases.

[13] To calculate the ROI for MFCUs, we first calculated the total recoveries by adding the $272 million in criminal case recoveries to the $963 million in civil case recoveries. We then divided the $1.2 billion in total recoveries by the total MFCU grant expenditures of $369 million, resulting in the overall ROI of $3.35 for every $1 spent.

[14] For purposes of this report, we use the acronym MCO to refer to a variety of managed care entities and health care plans that cover Medicaid enrollees, including comprehensive risk-based managed care organizations, managed care entities, prepaid ambulatory health plans, prepaid inpatient health plans, primary care case management systems, and other entities that provide services under capitated payment arrangements.

[15] Federal regulations require MFCUs to enter into a written agreement with the Medicaid agency to establish procedures by which the Unit will receive referrals of potential fraud from MCOs, if applicable, either directly or through the Medicaid agency. See 42 CFR § 1007.9(d)(3)(iv). If an initial review of the complaint indicates substantial potential for criminal prosecution, the Unit is responsible for either investigating the complaint or referring it to an appropriate criminal investigative or prosecutorial authority. See 42 CFR § 1007.11(b)(3).

[16] OIG, *LEIE Downloadable Databases*, https://oig.hhs.gov/exclusions/exclusions_list.asp. Accessed on December 19, 2023. The list of OIG-excluded individuals or entities can be found on the OIG website.

[17] MFCUs may receive Federal financial participation for investigating Medicaid providers for alleged fraudulent activities related to drug diversion regardless of whether the Medicaid program was billed. OIG, *State Fraud Policy Transmittal 2020-3*, *MFCU Authority to Receive Federal Funding to Investigate and Prosecute Diversion and Misuse of Pharmaceuticals*, October 28, 2020. This transmittal describes the situations in which Units may receive Federal financial participation to investigate and prosecute drug diversion cases. Prior to this, OIG had not clarified that MFCUs could receive Federal financial participation for drug diversion investigations where there was no loss to the Medicaid program.

[18] A single settlement or judgment may represent the resolution of a single case or multiple cases packaged together.

[19] The National Association of Medicaid Fraud Control Units reported that the number of MFCU global case filings steadily decreased in recent years, from 89 filings in 2019 to 35 filings in 2023.

[20] OIG's Fiscal Year 2024 *Justification of Estimates for Congress* identifies the Priority Outcome efforts to increase the number and quality of referrals of potential provider fraud from MCOs to MFCUs. https://oig.hhs.gov/documents/budget/1105/FY-2024-HHS-OIG-CJ.pdf. Accessed on March 6, 2024.

[21] In FY 2021, OIG directed MFCUs to annually report the number of fraud referrals they received directly from MCOs, as well as those received indirectly, such as referrals that originated from MCOs but were submitted to MFCUs by the State Medicaid agency. OIG instructs MFCUs to report referrals from MCOs that are associated with "some investigative or legal review or action . . . undertaken by MFCU staff." https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/ASR-Definitions-Instructions.pdf. Accessed on March 6, 2024.