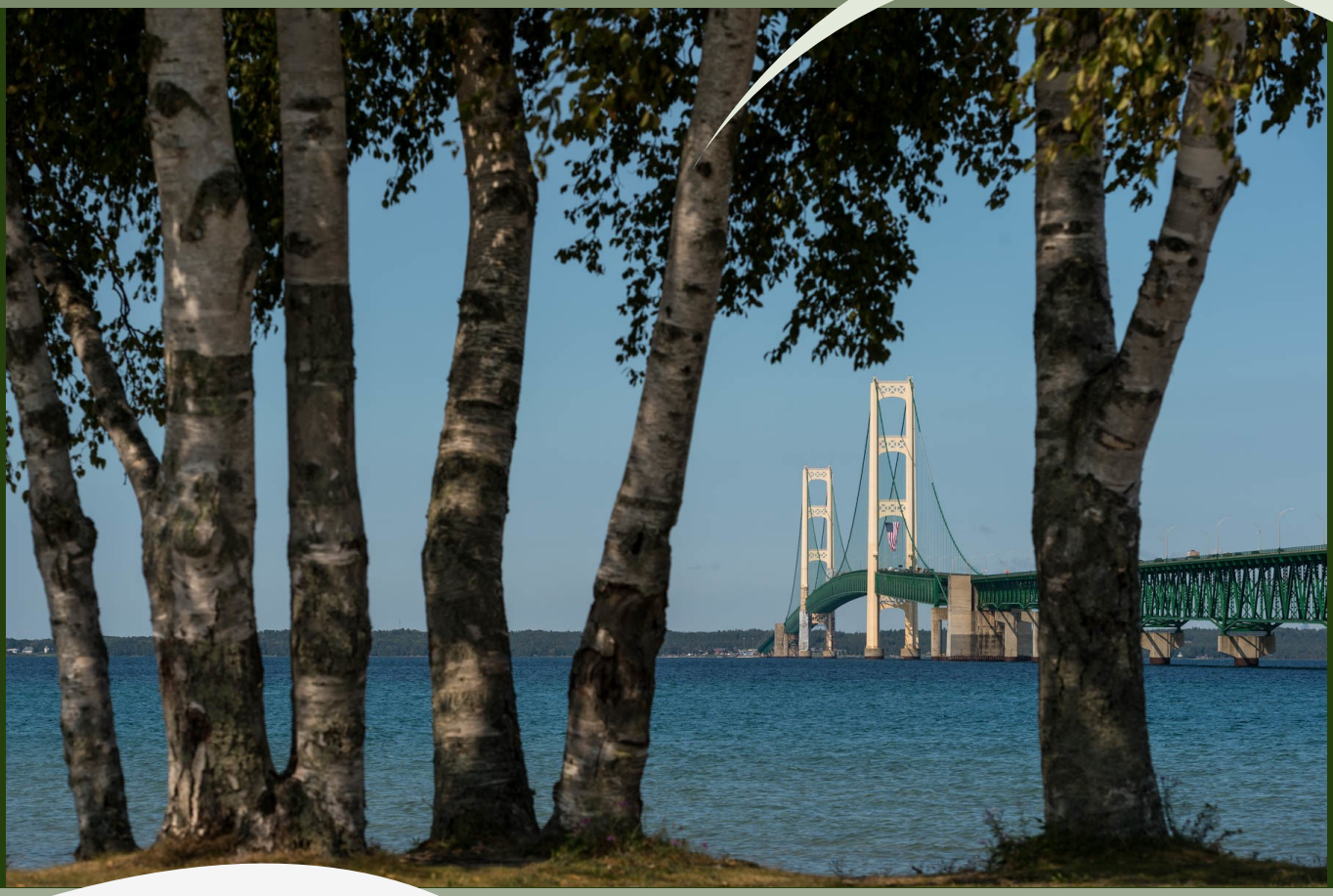
FY 2023 Annual Report



State of Michigan
Department of Health
and Human Services
Office of Inspector General

Alan Kimichik, Inspector General

Contents

Message from the Inspector General

It is with honor that I present to you the Michigan Department of Health and Human Services (MDHHS) Office of Inspector General (OIG) Fiscal Year (FY) 2023 Annual Report.

The OIG is charged with investigating fraud, waste and abuse in programs administered by MDHHS and increasing program integrity and accountability. The landscape of public benefits fraud is a dynamic and ever-changing environment. OIG staff consistently develop innovative and creative ways to identify, prevent and combat fraud, waste and abuse.

This year, OIG's Benefit Trafficking Unit uncovered a nationwide organized criminal scheme where thieves used electronic skimmers to clone Electronic Benefit Transfer (EBT) cards and stole $4 million in food assistance benefits from numerous states. Those benefits were then illegally used in Michigan. The OIG investigation led to 10 arrests, and their criminal cases are pending in court.

The nationwide EBT card-cloning fraud also affected thousands of Michigan EBT card holders. OIG's Investigative Analytics Unit developed algorithms and data tools for early detection of compromised EBT accounts and skimmer locations. These data mining activities have resulted in the detection and confiscation of five skimmers at Michigan EBT retailers and have safeguarded more than 7,300 individual MDHHS EBT accounts and more than $1.1 million of EBT funds.

I am fortunate to lead such a dedicated team and am proud of our ongoing work to improve program integrity in the programs administered by MDHHS.

Due to OIG staff's dedicated work, the following accomplishments were achieved in FY 2023:

- Accounted for approximately $295.1 million in program integrity efforts (fraud detection, cost avoidance and disqualifications).
- Performed 18,108 public assistance application investigations resulting in cost avoidance of more than $81 million.
- Established $161.1 million in Medicaid provider overpayment receivables and cost avoidance.
- Completed 3,286 public assistance fraud investigations.
- Identified $6.8 million of public assistance program fraud.
- Established $2.7 million in cost avoidance from disqualifications of public assistance recipients for intentional program violations.

OIG's actions benefit all citizens by helping ensure that funds for public assistance programs are available to the residents that truly need them, taxpayers' money is spent on its intended purpose and benefit programs are operating as expected.

I want to thank the OIG's staff, fellow state employees and all Michiganders who reported suspected fraud, waste, abuse and misconduct in FY 2023 and encourage them to continue in the future. Together, we can further strengthen the integrity of the programs administered by MDHHS.

Sincerely,

Alan Kimichik, Inspector General

EXECUTIVE SUMMARY

Fraud Detection and Prevention

Enforcement Division

In FY 2023, the Office of Inspector General - Enforcement Division agents:

- Determined $90.5 million of fraud, cost avoidance and established program disqualifications.
- Completed 3,286 fraud investigations.
- Completed 18,108 Front End Eligibility (FEE)[1] investigations.
- Identified $81 million in cost avoidance in FEE investigations.
- Established an additional $2.7 million in cost avoidance from intentional program violation (IPV) disqualifications.
- Identified $6.8 million of program fraud.

Integrity Division

In FY 2023, the Office of Inspector General - Integrity Division agents:

- Sanctioned 98 providers, establishing $18.3 million in fee-for-service and $19.9 million in managed care encounter payment cost avoidance.
- Identified $17.5 million in inappropriate Medicaid expenditures, recovering $6.9 million to date.
- Performed program integrity oversight of Michigan Medicaid's 41 Managed Care Organizations (MCO). These MCOs performed a total of 1,180 provider audits and/or reviews, resulting in a total reduction of MCO encounter payments of $18.4 million.
- Referred 49 Medicaid providers to the Michigan Department of Attorney General's Health Care Fraud Division for credible allegation of fraud investigations.
- Completed 1,189 fraud investigations.

[1]**Front End Eligibility (FEE):** MDHHS caseworkers may request an investigation by an OIG agent when applications or re-certifications for public assistance contain suspicious or error-prone information. OIG agents investigate, substantiate or refute discrepancies and suspicious activities; the results may involve an assistance case not being opened, reduced benefits issued and/or case closure.

EXECUTIVE SUMMARY

Fraud Detection and Prevention

Enforcement Division
Specialized Investigative Units:

In FY 2023, the Special Investigations Unit (SIU) agents:

- Completed 118 investigations.
- Determined $764,321 of provider, contractor, recipient and employee fraud.

In FY 2023, the Benefit Trafficking Unit (BTU) agents:

- Completed 720 benefit trafficking investigations.
- Determined $586,131 in fraud.

In FY 2023, the Identity Theft Unit (ITU) agents:

- Investigated 62 criminal entities utilizing 1,009 stolen and fraudulent identities to illegally obtain and traffic Food Assistance Program (FAP) benefits.
- Determined $321,391 in fraud from identity theft and established more than $4 million in cost avoidance.

In FY 2023, the High Risk Medicaid Unit (HRMU) agents:

- Completed 1,899 high-risk Medicaid investigations.
- HRMU investigations resulted in 451 beneficiaries being confined to a specified pharmacy and/or health care provider.
- Investigations resulted in $8.8 million in Medicaid cost avoidance.
- Determined $620,754 in fraud.

In FY 2023, the Cooperative Disability Investigation Unit (CDI) agents:

- Completed 34 cooperative disability investigations.
- Established $4 million in cost avoidance.

Operations Division
In FY 2023, the Investigative Analytics Section of the Office of Inspector General's Operations Division:

- Safeguarded more than 7,300 MDHHS EBT accounts and more than $1.1 million of EBT funds by developing algorithms that allowed for the early detection of cloned EBT accounts and skimmer locations.

OIG Authority

The Office of Inspector General (OIG), created in 1972, is a criminal justice agency in the Michigan Department of Health and Human Services (MDHHS) under Michigan Compiled Law (MCL) 400.43b and Executive Orders No. 2010-1 and No. 2015-4. The primary duty of the OIG is to investigate cases of suspected fraud involving MDHHS assistance programs. In addition, OIG conducts the following activities as required by state and federal laws:

- Makes referrals for prosecution and disposition of appropriate cases as determined by the Inspector General.
- Fulfills the program integrity functions required by the Centers for Medicare and Medicaid Services (CMS) under 42 CFR §455.13-17, 42 CFR §455.21-23 and 42 CFR §455.500-518.
- Conducts and supervises activities to prevent, detect and investigate provider fraud, waste and abuse in Michigan's health services programs.
- Reviews administrative policies, practices and procedures.
- Makes recommendations to improve program integrity and accountability.

OIG Mission Statement

The mission of the OIG is to assist MDHHS in maintaining integrity and accountability in the administration of its human services programs. The OIG provides investigation and advisory services to ensure appropriate and efficient use of available public resources. The office shall serve as an independent and autonomous entity within the department to lead the integrity efforts of health services programs by seeking out, detecting and investigating provider and recipient fraud, waste and abuse.

OIG VALUES

The Office of Inspector General (OIG) is accountable to the people of the State of Michigan for maintaining the highest standards of integrity and good moral character.

As members of the OIG, we must work together as a team to plan and strive for excellence, realizing that the daily decisions that are made will reflect on the future of the people we investigate as well as our organization as a whole.

Recognition

- OIG employees shall recognize the accomplishments of those who make significant contributions toward our mission, values, goals and objectives.

Dignity

- OIG employees shall dedicate themselves to treat all people with respect, fairness and compassion.

Innovation

- OIG employees will strive to identify new activities to produce a greater impact on fraud, waste and abuse in programs administered by the Michigan Department of Health and Human Services.

Teamwork

- OIG employees shall recognize that the cooperation of all criminal justice and public agencies is essential for effective, efficient and responsive investigations and enforcement.
- Lead by example and be willing and able to assist any other investigative or public agency when requested.
- Understand the importance of creating a work environment that encourages innovation, input and participation.

Integrity

- OIG employees will display the highest possible standards of professional and ethical conduct.
- Understand that the integrity of the OIG must never be compromised. The public demands, and we must accept, that the integrity of an OIG employee must be above reproach. Strive to reach the highest standards of honesty and integrity.
- Conduct themselves in a manner that does not discredit the criminal justice profession or the OIG. Maintain the integrity of their profession through complete disclosure of those who violate laws, those who violate rules of conduct or those who conduct themselves in a manner which discredits the criminal justice profession.
- Never consider the badge of office as a license designed to provide them with special favor or consideration.

Excellence

- OIG employees are expected to meet the responsibilities of their assigned job duties, be responsible for their actions and be accountable to their supervisors, co-workers and to the citizens they serve.
- Perform the duties of the OIG Mission to their utmost ability.
- Know the laws, rules and policies that will aid them in performing their duties. Be aware of and meticulously adhere to all legal requirements on the release and dissemination of information.
- Understand that when trust and confidence are established within our organization, our stakeholders and the public will support us in fulfilling our duties.
- Take pride in themselves and their organization, take ownership of their work and be leaders in their areas of responsibility.

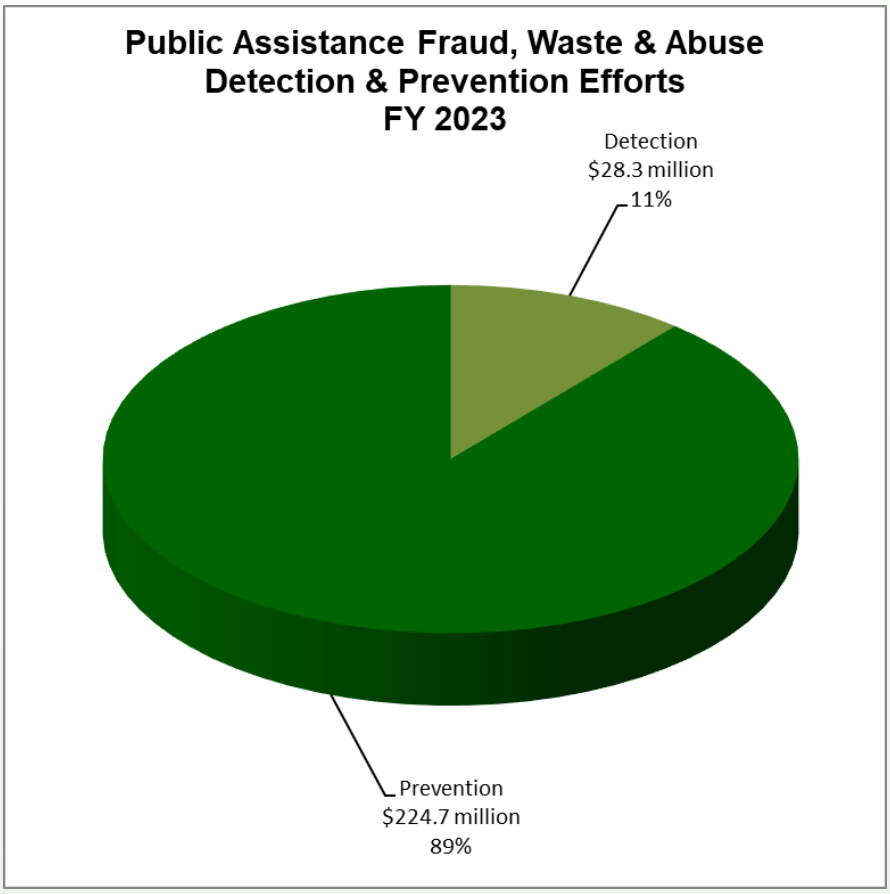
INSPECTOR GENERAL OVERVIEW

The OIG is the criminal justice agency within the MDHHS providing program integrity services. OIG agents provide investigation and advisory services to ensure appropriate and efficient use of available public resources in the State of Michigan.

Within the OIG there are three divisions: Integrity (Medicaid providers), Enforcement (recipients/vendors and non-Medicaid providers) and Operations (Administrative, Investigative Analytics and Policy & Training). OIG agents and their managers are strategically located throughout Michigan to assist MDHHS in maintaining integrity and accountability in the administration of all its programs.

OIG IMPACT ON PUBLIC ASSISTANCE PROGRAMS

Fraud detection in public assistance - $28.3 million
Fraud prevention in public assistance - $224.7 million



Notes: Represents FIP (Family Independence Program), FAP (Food Assistance Program), SDA (State Disability Assistance), SER (State Emergency Relief), CDI (Cooperative Disability Investigations) and FFS (Fee-For-Service) Medicaid.

ENFORCEMENT DIVISION

The Enforcement Division primarily investigates allegations of fraud, waste or abuse by the recipients and the vendors of all public assistance programs, excluding Medicaid providers. In the Enforcement Division, there are several unique programs and units that focus on important aspects of fraud detection and prevention.

FRAUD INVESTIGATIONS

Fraud investigations conducted by the Enforcement Division examine instances of alleged fraud in the programs administered by the MDHHS, as well as reviewing administrative policies and procedures and recommending ways of improving accountability, fraud detection and prevention. For example, OIG investigates fraud in the Family Independence Program (FIP), the Food Assistance Program (FAP), the Child Development and Care program (CDC) and the Medicaid program (MA). In addition, OIG investigates vendor fraud and state employees alleged to be involved in program fraud or certain crimes against MDHHS. All investigations found to have the elements of fraud or criminal activity are sent to the appropriate authority for criminal disposition or are sent to the appropriate area within MDHHS for administrative action.

Fraud Investigation Highlights

Dual Assistance
An OIG investigation revealed that a recipient applied for and received benefits in another state while also receiving Michigan benefits. OIG presented the investigation to the Michigan Department of Attorney General for review of potential criminal charges. The recipient pled guilty to welfare fraud and was ordered to pay $41,897 in restitution and serve 24 months of probation.

Synthetic Identity Fraud
An OIG investigation revealed that a recipient applied for and received benefits using their real identity and a synthetically created identity. OIG presented the investigation to the Michigan Department of Attorney General for review of potential criminal charges. The recipient pled guilty to welfare fraud and was sentenced to pay $87,771 in restitution, serve 24 months of probation and complete community service.

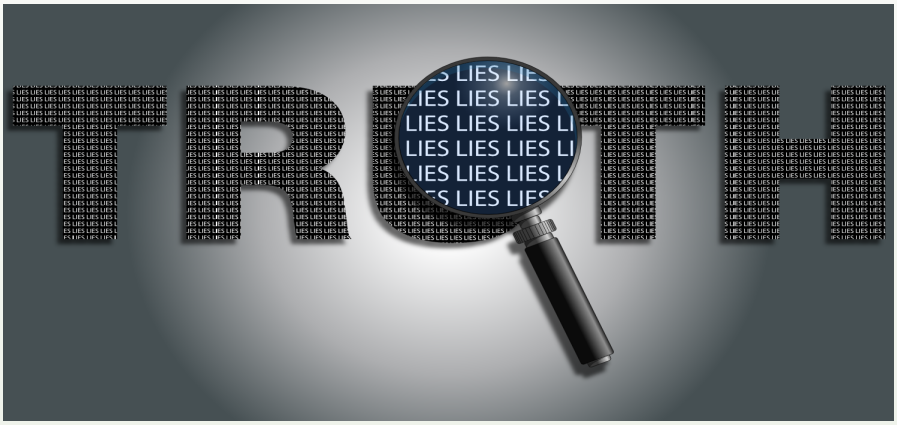
Group Composition
OIG received a fraud referral alleging a recipient did not report their spouse residing in their home. A joint investigation was conducted by OIG and the Social Security Administration. The investigation revealed that the recipient did not properly report their spouse as a member of the household, the group's shared income or assets when applying for benefits. OIG determined the recipients' eligibility for FAP and Social Security benefits was affected by the false information provided to the department. The investigation was referred to the U.S. Attorney's Office for review of potential criminal charges. The recipient pled guilty and was ordered to pay $181,916 in restitution, serve 18 months in federal prison and three years of probation.

Asset Detection
An OIG investigation revealed that a recipient did not report real estate assets when applying for benefits. OIG determined the household exceeded the asset limit, making them ineligible for benefits. The investigation was referred to the Michigan Department of Attorney General for review of potential criminal charges. The recipient pled guilty and was ordered to pay $17,112 in restitution.

Unreported Self-Employment
OIG received a referral indicating that a recipient misrepresented their income when they applied for benefits. An OIG investigation revealed that the recipient had consistently failed to report the self-employment income of their spouse. The investigation was presented to the county prosecutor's office for review of potential criminal charges. The recipient pled guilty to welfare fraud and was ordered to pay $60,723 in restitution and sentenced to serve one year of probation.

FRONT END ELIGIBILITY (FEE)

The FEE program is a fraud prevention initiative established by the Office of Inspector General (OIG) to reduce errors and over-payments in public assistance programs when applications or recertifications for public assistance contain suspicious or error-prone information. OIG agents investigate, substantiate or refute discrepancies and suspicious activities. Agents complete the investigation within 15 workdays and respond to the eligibility staff with their findings. The goal of the FEE program is to support a partnership between OIG and the local office staff early in the eligibility determination process to reduce errors and over-payments, which results in significant cost avoidance savings for the department.



FEE Investigation Highlights

Unreported Assets
OIG received a FEE referral alleging that a recipient did not report a financial asset at application. The investigation showed that the recipient's assets exceeded the asset limit for benefits. The recipient's Michigan benefits were denied, resulting in a cost avoidance of $43,092.

Dual Assistance
OIG received a FEE referral alleging that a recipient no longer lived in Michigan. Evidence gathered during the investigation showed that the recipient in fact did not live in Michigan and received duplicate medical benefits in another state. The recipient's Michigan benefits were denied, resulting in a cost avoidance of $17,820.

Dual Assistance
OIG received a FEE referral alleging that a recipient received dual benefits in Michigan and another state. Evidence gathered during the investigation supported that the recipient's children did not reside with the recipient in Michigan and were not eligible for benefits. The recipient's benefits case was reduced, resulting in a cost avoidance of $17,676.

Unreported Self-Employment
OIG received a FEE referral alleging that a recipient did not report income from self-employment at application. Evidence gathered during the investigation found the recipient to be the owner of a business, drawing substantial income from business profits. The recipient's benefits were denied, resulting in a cost avoidance of $17,060.

Residency
OIG received a FEE referral alleging that a recipient was no longer living in Michigan and was a resident of another state. Evidence gathered during the investigation supported that the recipient in fact did not live in Michigan. The recipient's benefits were denied, resulting in a cost avoidance of $25,308.

BENEFIT TRAFFICKING UNIT (BTU)

BTU agents conduct comprehensive and multifaceted criminal and civil investigations involving the fraudulent acquisition and use of MDHHS program benefits and initiates criminal, civil and administrative action to prosecute offenders and recover program funds. FAP trafficking is a crime that involves the buying, selling or trading of public assistance benefits for cash or other ineligible items, including tobacco, alcohol, firearms, drugs and gambling. The unit also investigates allegations of MA fraud, which includes the sale of a person's MA card to obtain health services.

BTU Investigation Highlights

EBT Card Skimming and Cloning

Electronic Benefit Transfer (EBT) card cloning is the process by which thieves use an electronic device, referred to as a skimmer, to copy the card information and transfer the data to an unauthorized card through which they can steal the food assistance benefits. The Benefit Trafficking Unit uncovered a nationwide organized criminal scheme through which thieves stole $4 million in food assistance benefits from numerous states to illegally use in Michigan. Ten individuals were arrested, and their criminal cases are pending in court.

FAP Trafficking

A BTU agent discovered a FAP trafficking scheme in which an individual paid a reduced amount of cash for the EBT Bridge Card food assistance benefits of several exotic dancers at an adult entertainment club to purchase items for a retail catering operation. The individual was criminally charged and pled guilty to Food Stamp Fraud and paid restitution of $8,000 to the State of Michigan.

IDENTITY THEFT UNIT (ITU)

Identity theft is a pervasive crime that increased during the COVID-19 pandemic. In July 2021, OIG established the ITU to combat the growing trend of public assistance fraud where individuals and criminal enterprises utilize stolen identities to apply for and obtain MDHHS benefits. ITU agents ascertain and identify the existence of sophisticated criminal conspiratorial schemes through field investigations, social media and advanced data analysis. The ITU initiates appropriate criminal charges to prosecute offenders and recover program funds.

ITU Investigation Highlights

FAP Identity Theft

The Identity Theft Unit discovered that an individual used the identity of a deceased person and other stolen identities to apply for food assistance benefits in Michigan and several other states resulting in the theft of more than $100,000 in FAP benefits. The individual was charged with several felony crimes, and the case is pending in court.

Tax Preparer Identity Theft

An ITU agent investigated fraudulent FAP applications submitted with stolen identities and discovered that a tax preparer with access to the personal information of the victims was the perpetrator of the scheme which resulted in the theft of more than $70,000 in FAP benefits. The perpetrator was charged with several felony crimes, and the case is pending in court.

SPECIAL INVESTIGATION UNIT (SIU)

The SIU investigates the most complex criminal and civil complaints of fraud, waste and abuse in the programs administered by the department. The SIU identifies and determines existence of sophisticated criminal conspiratorial schemes by employees, contractors, businesses, vendors and recipients to receive program funds. Agents ascertain the nature of offenses committed and determine and initiate appropriate criminal, civil and administrative action to resolve the allegations and recover program funds. The SIU, as well as all of OIG, formulates recommendations to address fraud vulnerability, internal control and accountability relating to program law, regulation, policy and procedure.

SIU Investigation Highlights

Adoption Assistance Program Fraud

An SIU agent investigated allegations that adoptive parents failed to report that their adopted child was no longer in their home. The agent found that the parents received more than $19,000 in Adoption Assistance Program benefits for which they were not eligible. The investigation also found that the parents improperly received an additional $87,000 in FAP and MA benefits for the absent child. The investigation was referred for prosecution.

Child Development and Care (CDC) Provider Fraud

The SIU investigated allegations that a CDC provider was falsifying billing records for children in her care. The investigation revealed that the provider overbilled the department. The provider was criminally charged and pled guilty. The provider was ordered to pay restitution of $55,000 to the State of Michigan.

HIGH RISK MEDICAID UNIT (HRMU)

The HRMU reviews beneficiaries' use of MA for potential abuse. HRMU agents investigate beneficiaries who potentially abuse or misuse MA services and benefits. HRMU works with OIG's Investigative Analytics section to identify high risk behaviors such as:

- Beneficiaries who received strong opioid prescriptions with no corresponding diagnosis.
- Beneficiaries who sought opioid prescriptions from multiple doctors and/or pharmacies over a short period of time.
- Beneficiaries who traveled long distances to seek strong opioid prescriptions.

After investigation, OIG's HRMU forwards these beneficiaries to the MDHHS' Benefits Monitoring Program (BMP) for review. BMP and/or the associated health plan makes the determination that the beneficiary's behavior indicates the need that they be confined to care with a specified provider and/or pharmacy for a two-year period. Upon confinement, all non-emergency medical care and/or prescriptions must be authorized by the designated health provider and dispensed by the designated pharmacy to be covered by MA.

In addition, HRMU agents identify criminal schemes and report activities to the proper authorities to include state and local drug task force teams, prosecutors and the Medicaid Fraud Control Unit.

HRMU Investigation Highlights

Multiple Doctors and Prescriptions
An OIG investigation determined that a beneficiary utilized more than five different pharmacies to fill controlled substance prescriptions during a quarter. The beneficiary obtained more than nine controlled substance prescriptions during three separate quarters. The beneficiary obtained controlled substance prescriptions from 12 different providers from nine different practices. BMP confined the beneficiary to a specified provider for two years resulting in MA cost avoidance of $19,708.

Excessive Emergency Department Visits and Multiple Providers
An OIG investigation revealed that a beneficiary utilized emergency departments more than two times during multiple fiscal quarters. The beneficiary obtained nine controlled substance prescriptions during a quarter from three different providers from three different practices. BMP confined the beneficiary to a specified provider for two years, resulting in MA cost avoidance of $19,708.

Excessive Emergency Department Visits, Multiple Doctors & Pharmacies
An OIG investigation determined that a beneficiary utilized the emergency department 14 times within a 10-day period with only two follow-up appointments with a provider. The beneficiary obtained 12 controlled substance prescriptions from seven different providers while using nine different pharmacies to fill the prescriptions. The beneficiary paid cash for a controlled substance prescription covered by Medicaid. BMP confined the beneficiary to a specified provider for two years, resulting in MA cost avoidance of $19,708.

COOPERATIVE DISABILITY INVESTIGATIONS (CDI) UNIT

Since 2014, OIG has partnered with the Social Security Administration Office of Inspector General (SSA-OIG) through a Cooperative Disability Investigations (CDI) program in Michigan. CDI combats fraud by investigating questionable claims, statements and activities of claimants, medical providers, interpreters or other service providers who are suspected of disability fraud. The results of these investigations are presented to federal and state prosecutors for consideration of prosecution and to the MDHHS Disability Determination Services (DDS) for its use in making timely and accurate disability determinations. The CDI unit supports the strategic goal of ensuring integrity of the Social Security programs with zero tolerance for fraud and abuse. The unit also serves to deter fraud in related federal and state benefit programs. Any person deemed eligible for Supplemental Security Income (SSI) is automatically made eligible for MA. OIG's participation in the CDI unit realizes savings to Michigan taxpayers for stopping both SSI and MA fraud.

In FY 2023, the two OIG agents, working in partnership with SSA-OIG, produced a total cost avoidance of $4 million.

CDI Unit Investigation Highlight

Disability Fraud

The Detroit CDI Unit investigated a 51-year-old individual, who was receiving Title II Disability Insurance Benefits (DIB) and Title XVI Supplemental Security Income (SSI) since 2001, due to bipolar disorder and anxiety. An anonymous complainant reported the subject was working as a manager of a convenience store that also operated as a pizzeria and deli. The allegation reported that the individual was responsible for serving customers while operating the cash register, placing food orders, cooking and cleaning. The allegation further reported the individual was paid under the table in cash to conceal the individual's work activity from the Social Security Administration (SSA).

The individual had informed SSA they had not worked since the last disability review. They also reported that they couldn't be around crowds or loud noises, couldn't concentrate, complete tasks or follow instructions. The individual stated they cannot leave the house without having a panic attack and shops online because going into stores is too difficult for them. They further stated the only time they leave their home is when they have an appointment.

CDI Task Force Officers began surveillance operations at the individual's alleged place of employment and observed the individual inside the convenience store completing an array of transactions such as attending to the cash register, checking out customers and stocking shelves. The individual operated the cash register and provided change to customers without assistance from anyone. When interviewed, the owner of the establishment reported the individual works five days a week, opens and operates the store by themself, makes pizza, stocks, operates the cash register and places orders.

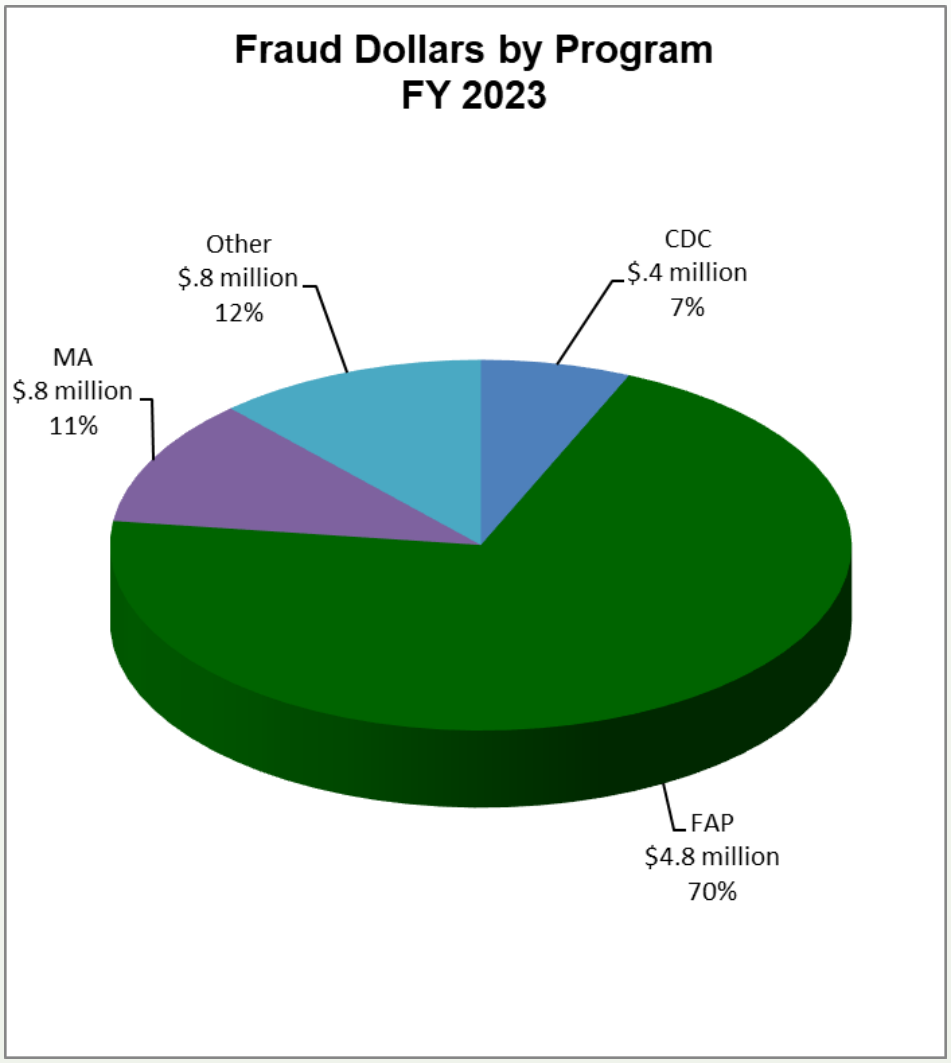
As a result of the investigation, the DDS determined there was significant medical improvement and the individual's benefits were ceased. The investigation resulted in SSA savings of $57,534 and non-SSA savings of $84,885.

PROGRAM INTEGRITY IMPACTS

OIG's Enforcement Division determined more than $6.8 million in fraud during FY 2023 within multiple Michigan public assistance program areas. Because of the Enforcement Division efforts, during FY 2023, 132 felony warrants were authorized by county, state and federal prosecutors. Investigations by Enforcement Division agents have uncovered $33.8 million in fraud during the last three years.

Program Highlights

- FAP accounted for 70 percent of Michigan's public assistance fraud during FY 2023.
- OIG completed 3,137 investigations of FAP fraud resulting in 120 criminal warrants issued for a fiscal year total of $4.8 million in fraud found.
- OIG completed 316 investigations of MA fraud resulting in $758,526 in fraud found.
- OIG completed 36 CDC cases resulting in $446,574 in fraud found for the Michigan Department of Education (MDE).



CDC = Child Development and Care Program

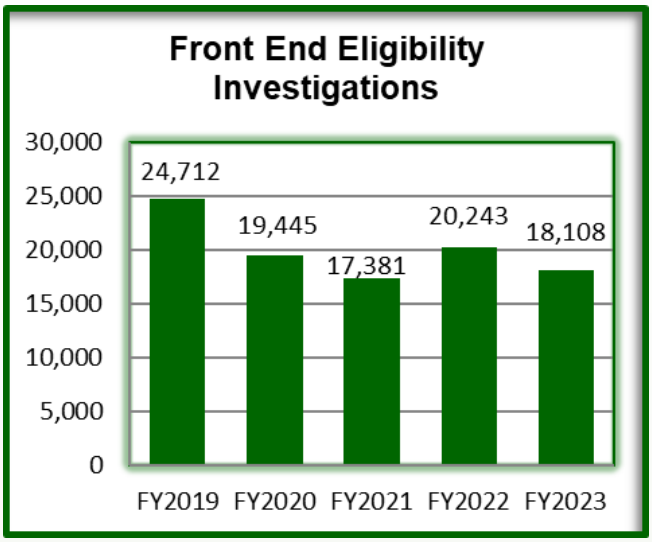
FAP = Food Assistance Program

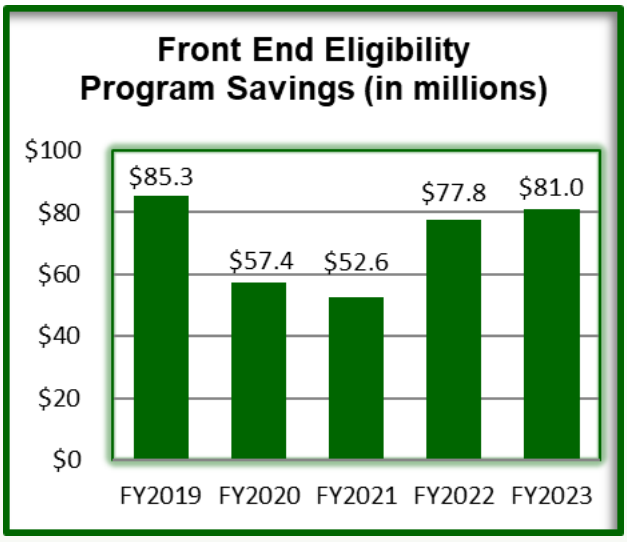
MA = Medicaid Program

Other = Adult/Children's Services, Family Independence Program, State Disability, State Emergency Relief

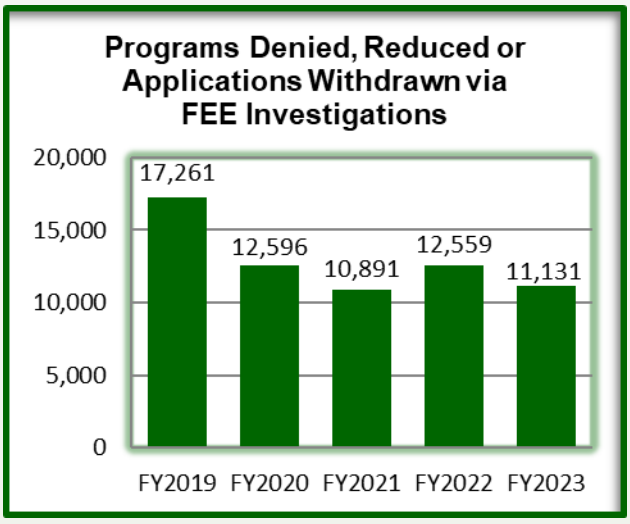
FEE: EARLY FRAUD DETECTION AND PREVENTION

The OIG conducts investigations when clients are suspected of misrepresenting their eligibility for public assistance. FEE investigations are initiated when assistance applications or other submitted documentation appear to contain suspicious or error-prone information. In focusing on fraud prevention through FEE, OIG ensures public assistance program integrity and increased savings for the taxpayers.





Working toward fraud prevention, Enforcement Division agents conducted 18,108 investigations in FY 2023 and identified $81 million in cost avoidance. Investigations by these agents have resulted in $354 million in program savings for taxpayers over the last five-year period.



Examples of health services provider fraud, waste and abuse:

* Billing for medical services not actually performed.
* Billing for unnecessary services.
* Billing for more expensive services than actually performed.
* Billing for services separately that should legitimately be one billing.
* Billing more than once for the same medical service.
* Dispensing generic drugs but billing for brand-name drugs.
* Billing for supplies/medication not dispensed.

INTEGRITY DIVISION

In FY 2023, Michigan's health services programs had a combined budget of approximately $23.3 billion and paid approximately 248,000 providers for goods and services provided to beneficiaries covered under those programs. OIG's Integrity Division (OIG-ID) fulfills the program integrity functions required by the Centers for Medicare and Medicaid Services (CMS) under 42 CFR §455.13-17, 42 CFR §455.21-23 and 42 CFR §455.500-518.

The Integrity Division is responsible for conducting and supervising activities to prevent, detect and investigate provider fraud, waste and abuse in Michigan's health services programs, including Michigan's Medicaid Program, Mental Health Program, MI Child Program and Children's Special Health Care Services Program (for the purposes of this report, these health services programs will be described using the general term "Medicaid.")

Through its investigations, the Integrity Division works to ensure that the money spent on health services is used for the best care of the beneficiaries. There are several unique programs and units that focus on important aspects of investigation and fraud detection and prevention.

INVESTIGATIONS

The Integrity Division conducts investigations into alleged Medicaid fraud, waste and abuse and receives referrals from the public, beneficiaries, providers and other government and/or state law enforcement and regulatory agencies.

RECOVERY AUDIT CONTRACTOR

The Integrity Division has contracted with a vendor to perform audits and recover overpayments from Medicaid providers.

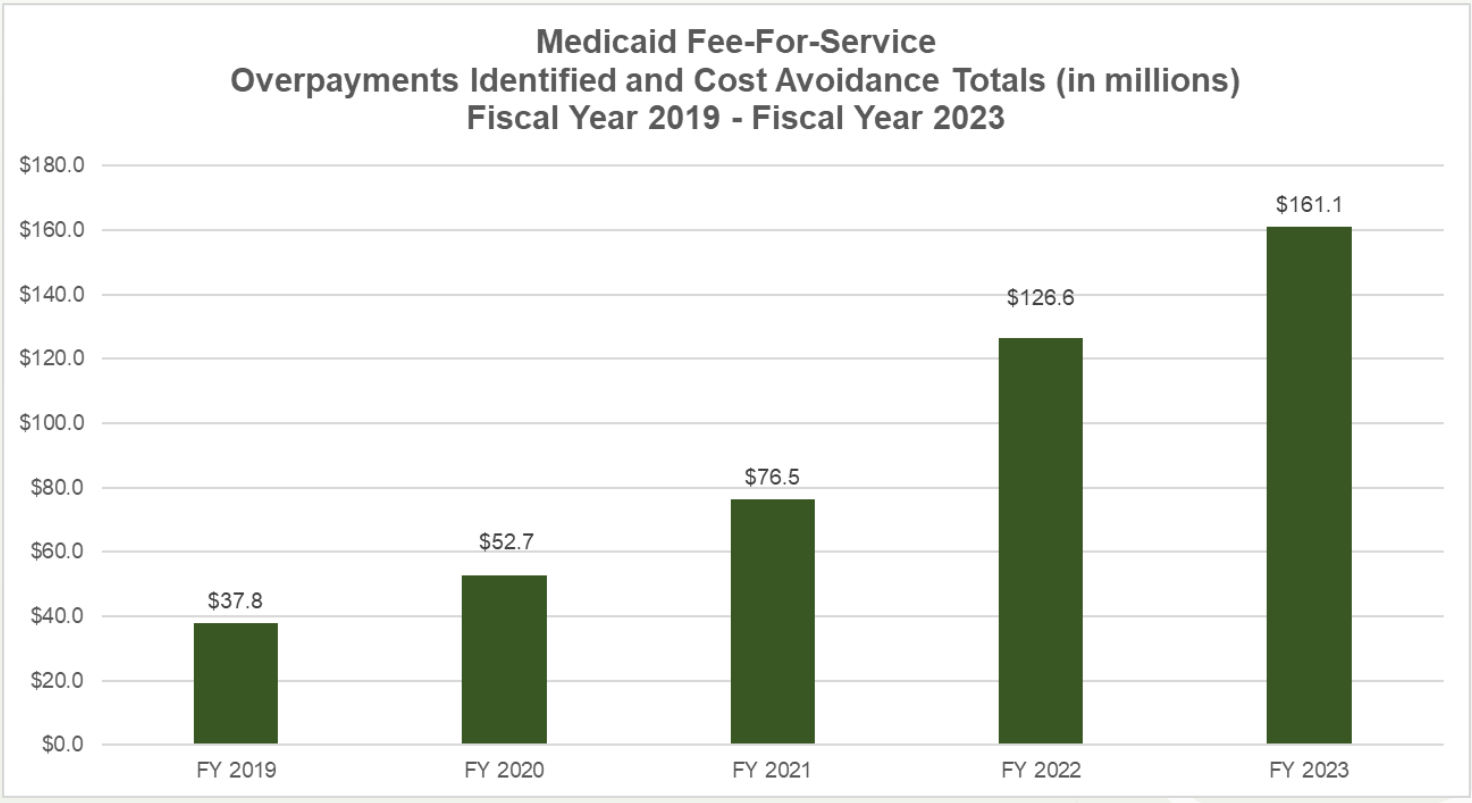
MANAGED CARE OVERSIGHT

The Integrity Division is responsible for monitoring the program integrity activities of Michigan Medicaid's Managed Care Organizations (MCO). Quarterly, MCOs are required to report their program integrity activities performed. These activities include data mining, audits, investigations, overpayment recoveries, etc.

HEALTH SERVICES PROGRAMS IMPACTS

In FY 2023, OIG-ID had an overall impact to direct Medicaid spending (i.e., fee-for-service (FFS)) totaling $161.1 million through the following activities:

- Identified a total of $17.5 million in overpayments made to Medicaid providers. To date, more than $6.9 million has been recovered while the remaining $10.6 million is being repaid over time.
- Received 535 allegations of potentially fraudulent activity from various sources (e.g., 128 tips from beneficiaries, 187 tips from the public (53 anonymous), 161 referrals from inside MDHHS and 25 tips from providers).
- Identified 494 audit targets through data analytics.
- Completed 1,189 fraud investigations.
- Prevented an estimated $66 million in future payments through reduced billing activities as a result of Medicaid provider audits and investigations.
- Sanctioned 98 Medicaid providers, preventing an estimated $18.3 million in future payments.
    - OIG-ID is responsible for making the determination to sanction a provider based on the grounds specified by MCL 400.111e and 42 CFR §455.23.
- Referred 49 Medicaid providers to the Medicaid Fraud Control Unit (MFCU) for criminal investigation.
    - In accordance with federal regulation (42 CFR §455.21), the MFCU is the first referral destination for all cases of suspected Medicaid provider fraud.



FIELD INVESTIGATION SECTION OVERVIEW

Due to the magnitude and complexity of Michigan's health services program, OIG-ID utilizes six regionalized investigative units. Each unit primarily investigates fraud allegations dealing with the following provider types in its assigned region:

Dental	Mental Health
Durable Medical Equipment (DME)	MI Choice Waiver
Emergency Transportation	Non-Emergency Transportation
Federally Qualified Health Centers	Nursing Home
Hearing and Vision	Pharmacy
Home Health Agency	Physical Therapy
Home Help	Physician
Hospice	Private Duty Nursing
Hospital	Rural Health Clinics
Laboratory	Substance Abuse Clinics
Local Health Departments	Tribal Health Centers
Maternal Infant Health Program	Urgent Care Centers

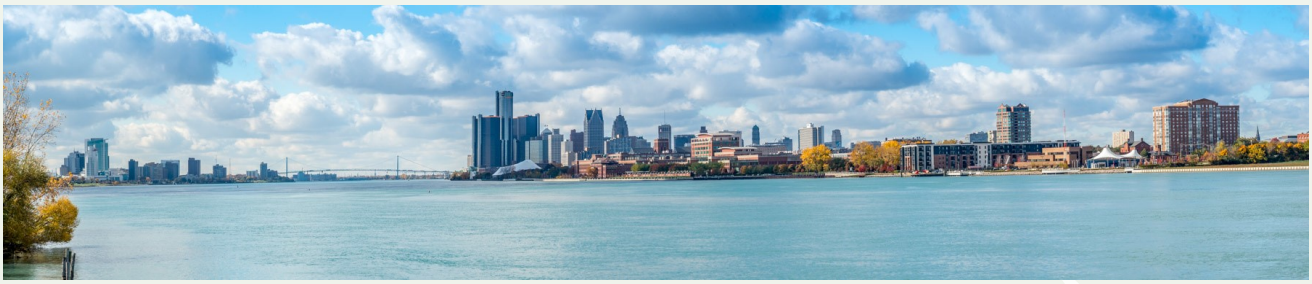
These regionalized teams enable OIG-ID to better coordinate efforts, thereby enhancing the accuracy, completeness and overall effectiveness where OIG can achieve its mission.

OIG-ID's field investigation sections are primarily responsible for:

- Identifying vulnerabilities where a more robust Medicaid policy and/or system edit would have prevented fraud, waste or abuse and making formal recommendations to prevent future claims from being paid.

- Investigating allegations of Medicaid provider fraud, waste and abuse, leading to the following outcomes:

    - Referring Medicaid provider fraud to the Michigan Department of Attorney General's Health Care Fraud Division.
    - Suspending payments to Medicaid providers when it is determined there is a credible allegation of fraud for which an investigation is pending.
    - Identifying and recovering non-fraud overpayments from Medicaid providers and MCOs.
    - Educating providers on proper Medicaid billing practices.
    - Referring information and evidence to regulatory agencies and licensure boards.



Fraud Investigation Highlights

Home Help
In FY 2023, receivables were established for 518 home help providers totaling approximately $9.4 million for payments made while their beneficiaries were either hospitalized or after their death, while the provider was incarcerated or for other noncompliance with Medicaid policy.

Hospital Discharge Day Management
In FY 2023, 19 medical clinic providers agreed to repay the Medicaid program a total of $728,622 that they received as a result of billing for CPT code 99239 (more than a 30-minute hospital discharge day management service) when CPT 99238 (hospital discharge day management, 30 minutes or less) should have been billed.

Durable Medical Equipment (DME)
In FY 2023, 16 DME providers agreed to repay the Medicaid program a total of $454,551 that they received as a result of billing for oxygen and oxygen supplies for patients who did not meet the Medicaid requirements for oxygen saturation.

Maternal Infant Health Program (MIHP)
In FY 2023, 14 MIHP providers agreed to repay the Medicaid program a total of $234,914 that they received as a result of billing for services that violated Medicaid MIHP policy.

Pharmacy
Pharmaceutical inventory audits are performed to validate that items supplied to Medicaid beneficiaries are supported by purchase invoices, as required by Medicaid policy.

In FY 2023, 65 pharmacy providers agreed to repay the Medicaid program a total of approximately $4.4 million as a result of pharmaceutical inventory audits, not billing the actual acquisition cost (AAC) for medications included in the 340B Drug Discount Program, billing for a higher quantity than the medical records support, billing for refills after the death of a beneficiary and other Medicaid policy violations.

Private Duty Nursing
In FY 2023, two Private Duty Nursing providers agreed to repay the Medicaid program a total of $73,067 that they received as a result of billing for services that violated Medicaid documentation policy requirements.

CONTRACT OVERSIGHT SECTION OVERVIEW

The Contract Oversight Section is comprised of two units, the Vendor Oversight Unit and the Managed Care Organization (MCO) Oversight Unit.

VENDOR OVERSIGHT UNIT

The Vendor Oversight Unit is responsible for ensuring the success of OIG-ID's Vendor Audit Program. OIG-ID financial recovery activities include third-party audit contractors to improve program integrity.

- The Affordable Care Act requires Medicaid agencies to contract with a Recovery Audit Contractor (RAC) to identify and recover overpayments.
    - In FY 2018, CMS approved a waiver to allow OIG to utilize their Unified Program Integrity Contractor (UPIC) as the Michigan Medicaid RAC.
    - The UPIC performs data mining algorithms on the Medicaid database to identify potential areas of recovery. These scenarios are preapproved by OIG's Vendor Oversight Unit analysts.
    - OIG's Vendor Oversight Unit analysts also review and preapprove each proposed UPIC audit target as well as their sample selection prior to record review.
- In FY 2023, the UPIC identified $1.2 million in overpayments made to Medicaid providers and prevented an estimated $59.4 million in future payments through reduced billing activities as a result of Medicaid provider audits.

MCO OVERSIGHT UNIT

The MCO Oversight Unit is responsible for monitoring the program integrity activities of Michigan Medicaid's MCOs.

- In coordination with the MDHHS Managed Care Plan Division, OIG-ID requires each of Michigan Medicaid's physical health and dental MCOs to complete section six of the Managed Care Compliance Review tool.
    - Section six requires each MCO to report to OIG-ID their program integrity activities performed each quarter. Program integrity activities include information relating to tips/ grievances received (including explanation of benefits), data mining activities, audits performed and provider disenrollments.

MCO Oversight Unit Highlights

Provider Audits/Reviews
In FY 2023, Michigan Medicaid's 41 MCOs performed a total of 1,180 provider audits and/or reviews, resulting in a total reduction of MCO encounter payments of $18.4 million.

Provider Sanctions
In FY 2023, OIG-ID agents prevented an estimated $19.9 million in Medicaid MCO encounter payments as a result of provider suspensions.

MCO OVERSIGHT UNIT

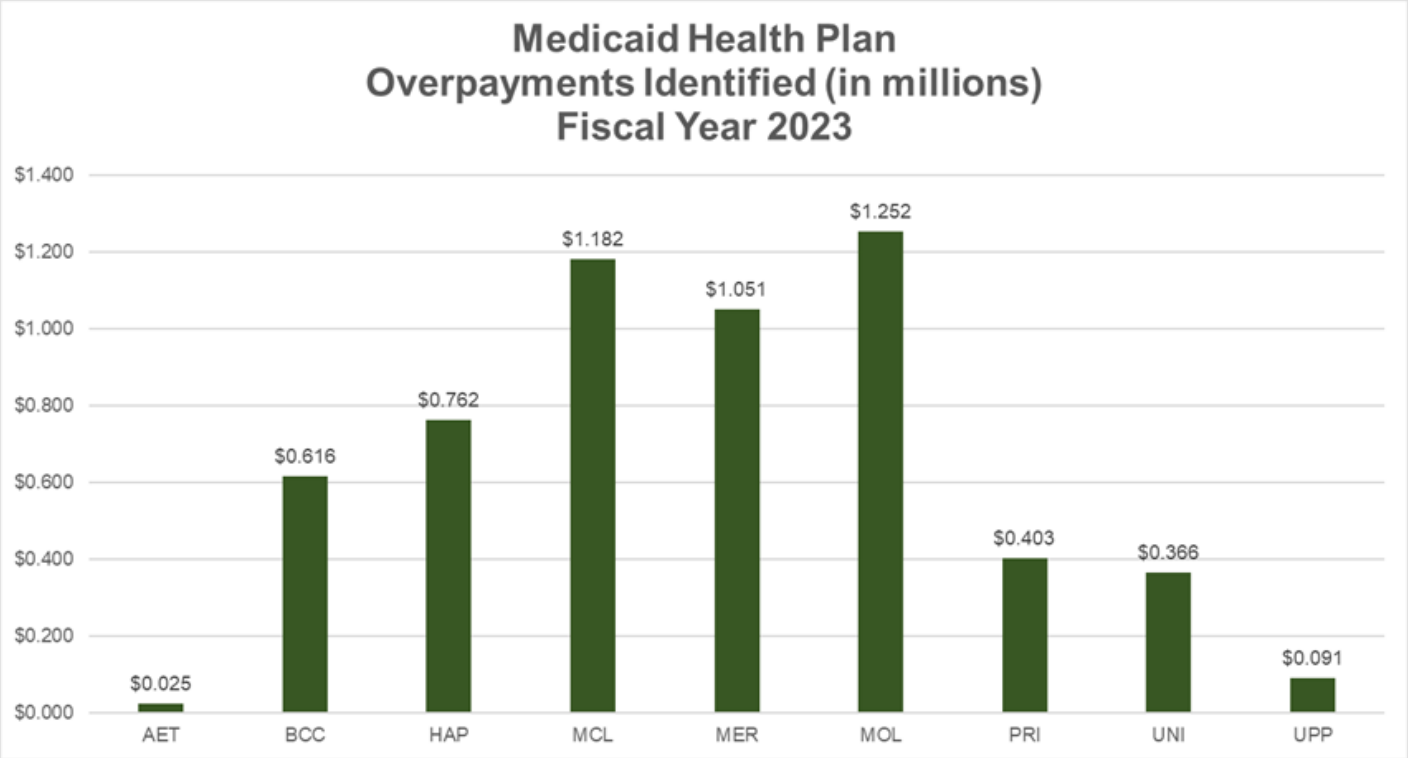
- MI Choice Waiver Agencies and Prepaid Inpatient Health Plans are also required to submit these program integrity activity reports quarterly.

- As MCOs submit their quarterly reports, OIG-ID's MCO Oversight Unit analysts review each report for compliance. An MCO's report can receive a met or unmet rating. MCOs who receive an unmet rating must submit a Corrective Action Plan (CAP).

    * CAP submissions are reviewed by the MCO Oversight Unit analysts to ensure the CAP meets contract requirements.

- MCOs are required to refer all credible allegations of fraud to the MCO Oversight Unit.

    * An OIG-ID analyst is assigned to each MCO fraud referral to evaluate the referral and determine if the allegation was credible and if the fraudulent activity occurred systemwide among other health plans and Medicaid fee-for-service.
    * If the allegation is deemed to be credible, a formal referral is made to the Michigan Department of Attorney General's MFCU.



The Medicaid Health Plans are: Aetna Better Health of Michigan (AET), Blue Cross Complete of Michigan (BCC), HAP Empowered (HAP), McLaren Health Plan (MCL), Meridian Health Plan of Michigan (MER), Molina Healthcare of Michigan (MOL), Priority Health Choice (PRI), UnitedHealthcare Community Plan (UNI), and Upper Peninsula Health Plan (UPP).

OPERATIONS DIVISION

OIG's Operations Division (OIG-OD) is comprised of three areas: Administrative Services, Investigative Analytics and Policy & Training.

Administrative Services is responsible for overall administrative support of the administration. It manages budget development and monitoring, system security, fraud hotlines, investigative process support as well as overseeing of the day-to-day business operations. For example, in FY 2023, Administrative Services provided extensive quality control reviews on more than 1,100 investigative packets referred to the Michigan Office of Administrative Hearings and Rules for debt collection and program disqualification requests.

Investigative Analytics is responsible for the analytic solutions that support ongoing investigations and fraud referrals. This section is responsible for a multitude of complex analysis, predictive analytics and data mining solutions to highlight potential fraud. Investigative Analytics provides system administrator support as well as unique and specialized skills for program integrity efforts.

Investigative Analytics section also houses the Technical Systems Unit (TSU), which oversees the development and maintenance of technical systems that support OIG's investigators and analysts. The TSU also creates reporting solutions for internal, state and federal needs. TSU is responsible for ensuring timely and accurate data is available for analysis and fraud referral generation.

The Policy & Training Unit (P&T) is responsible for ensuring accurate and timely policy review, development and implementation. The unit reviews, researches and analyzes current and proposed department policy, state laws, federal legislation and associated MDHHS and OIG policy changes. It is responsible for developing and delivering training to OIG staff as the need develops. This includes planning, coordinating and facilitating both internal and external training events.

Administrative Services Highlight

New Staff Recruitment, Selection and Onboarding

During FY 2023, OIG was able to hire 17 new employees. Administrative Services coordinated the hiring and selection process for the various OIG work units to make this happen. Administrative Services staff also ensured that new employees had all of their needed equipment (e.g., computers, phones, etc.) on their first day of employment, regardless of working in an office or remote.

POLICY & TRAINING UNIT (P&T)

OIG's P&T is responsible for the new hire orientation program for all new OIG employees. This provides a consistent introduction and overview of the department, the administration and OIG's mission. The unit oversees the program to ensure employees are educated on OIG's values, history and an understanding of the importance of all three divisions that make up OIG. P&T continues to identify and implement on-the-job training materials to create a highly skilled workforce. The unit reviews and analyzes proposed department policies to ensure program integrity and offer recommendations as needed. The unit analyzes the impact of those proposed polices and the effect it could potentially have on OIG business processes as well as the potential global impact on the department.

P&T Highlights

OIG's Training Institute

This fiscal year, P&T continued to develop, facilitate and enhance OIG's Training Institute (OTI). Through a structured training program, OTI provides a solid foundation of knowledge for new employees. It is designed to develop critical skills and judgement along with professional habits that will prepare staff for a successful career with OIG. Training opportunities include: Computer Based Trainings (CBTs), Instructor Lead Trainings (ILTs), desk aids and proficiency tests followed by on-the-job training with a designated lead investigator.

OTI courses and materials are launched and tracked using OIG's Learning Management System (LMS). Supplemental training resources are also available on OIG's SharePoint site. At the conclusion of FY 2023, OIG's LMS is the repository for 23 ILTs, 19 CBTs, 16 desk aids, 40 testing tools and 92 on-the-job training tasks and activities.

During FY 2023, nine training groups, compromised of 17 new hires, began the OTI program. All three OIG divisions had at least one new hire who participated. Division specific OTI sessions with key staff were facilitated to gather feedback and incorporate necessary changes.

To ensure OTI courses and materials remain relevant and up to date, all active training materials are reviewed and modified by subject matter experts throughout the calendar year.

Training Events

P&T facilitated seven training events for OIG staff in FY 2023. The unit hosted training for investigators to further their professional development in addition to offering soft skill training opportunities.

Final Department Reviews

During FY 2023, the unit reviewed and analyzed 56 proposed department polices associated with MDHHS. These reviews support both the office (for early awareness of changing policies) and the department (from our improvement recommendations).

Promoting Diversity, Equity and Inclusion (DEI) at OIG

P&T assisted OIG's DEI Council member with hosting several DEI workshops for OIG staff. These workshops facilitated awareness of unconscious bias, cultural competence and other barriers to diversity, equity, inclusion (DEI) and belonging. The discussions in these workshops helped to promote an inclusive workplace culture, assisting in employee engagement and employee retention by fostering relationship building, communication and empathy. These workshops were a chance to bring people together who may not typically work together to hear different perspectives or experiences.

INVESTIGATIVE ANALYTICS

OIG OD's Investigative Analytics section (IAU) is responsible for providing analytic support for ongoing investigations and fraud referrals. IAU uses tools and techniques, as well as knowledge of program rules, to mine state-owned data for fraud, waste and abuse events and trends. Data analytics allows for detection and identification of patterns of fraudulent behavior that may not otherwise be clear. OIG investigators use analytics information to focus their efforts to areas with the greatest risk and return, leading to recoveries and discouraging future abuse.

Examples of additional Investigative Analytics functions and responsibilities include:

- FAP Trafficking Data Mining.
- Medicaid Fraud, Waste & Abuse Data Mining.
- Social Media Analysis.
- Internet Protocol Locator Project.
- Identity Theft/Application Fraud Analysis.
- Asset Detection.
- Out-of-State Bridge Card Transaction Analysis.
- Provider and Recipient Vital Records Match.
- Public Assistance Reporting Information System (PARIS) Match Analysis.
- USDA-FNS Client Integrity Referral Analysis.
- County Jail Match Analysis.

Investigative Analytics Highlights

EBT Card Cloning

During FY 2023, thousands of Michigan EBT card holders were affected by a nationwide EBT card-cloning fraud. IAU developed algorithms and tools for early detection of compromised EBT accounts and skimmer locations. These data mining activities have resulted in the detection and confiscation of five skimmers at Michigan retailers. These analytics and tools enable OIG to quickly identify fraudulent retailers across the country and report them to the proper officials. The implementation of these activities and new preventative protocols have safeguarded more than 7,300 MDHHS EBT accounts and more than $1.1 million of EBT funds.

Public Assistance Reporting Information System (PARIS) Investigations

IAU utilizes the national PARIS Interstate Match to identify individuals receiving public assistance in Michigan and another state at the same time. The resulting OIG investigation increases program integrity in Michigan's public assistance programs by removing ineligible beneficiaries. In FY 2023, PARIS matches resulted in $28.2 million in annualized cost avoidance.

Medicaid Encounter Data Integrity

IAU completed a major encounter validation project in FY 2023 that focused on duplicate encounter claims, identifying groups of encounter claims that were improperly paid. These claims were then forwarded to the health plans for investigation of inaccurate data submissions to MDHHS and overpayments to providers. Health plans were made responsible for conducting an analysis of these duplicate claims and devising long-term solutions. This initiative led to the discovery of significant errors in data submissions, resulting in the adjustment or voiding of nearly $400,000 in duplicate encounter claims.

Analytics for Overpayment/Fraud Detection

In FY 2023, approximately 73 percent of OIG's Medicaid provider recoupment cases and 48 percent of public assistance fraud investigations were generated as a part of IAU's data analytics/data mining efforts.

High Risk Medicaid Unit (HRMU) Analytics

IAU leverages technical expertise and Medicaid program knowledge to identify recipients and providers that may be abusing the program's resources. More than 99 percent of referrals to the HRMU are generated from analytics.

Out-of-State Spending

Exclusive out-of-state spending for an extended period is an indicator that the individual may no longer be a Michigan resident. IAU utilizes MDHHS' EBT transaction data to identify individuals with FAP spending exclusively outside of Michigan for at least three months. In FY 2023, the project resulted in $2.4 million in annualized cost avoidance.

TECHNICAL SYSTEMS UNIT (TSU)

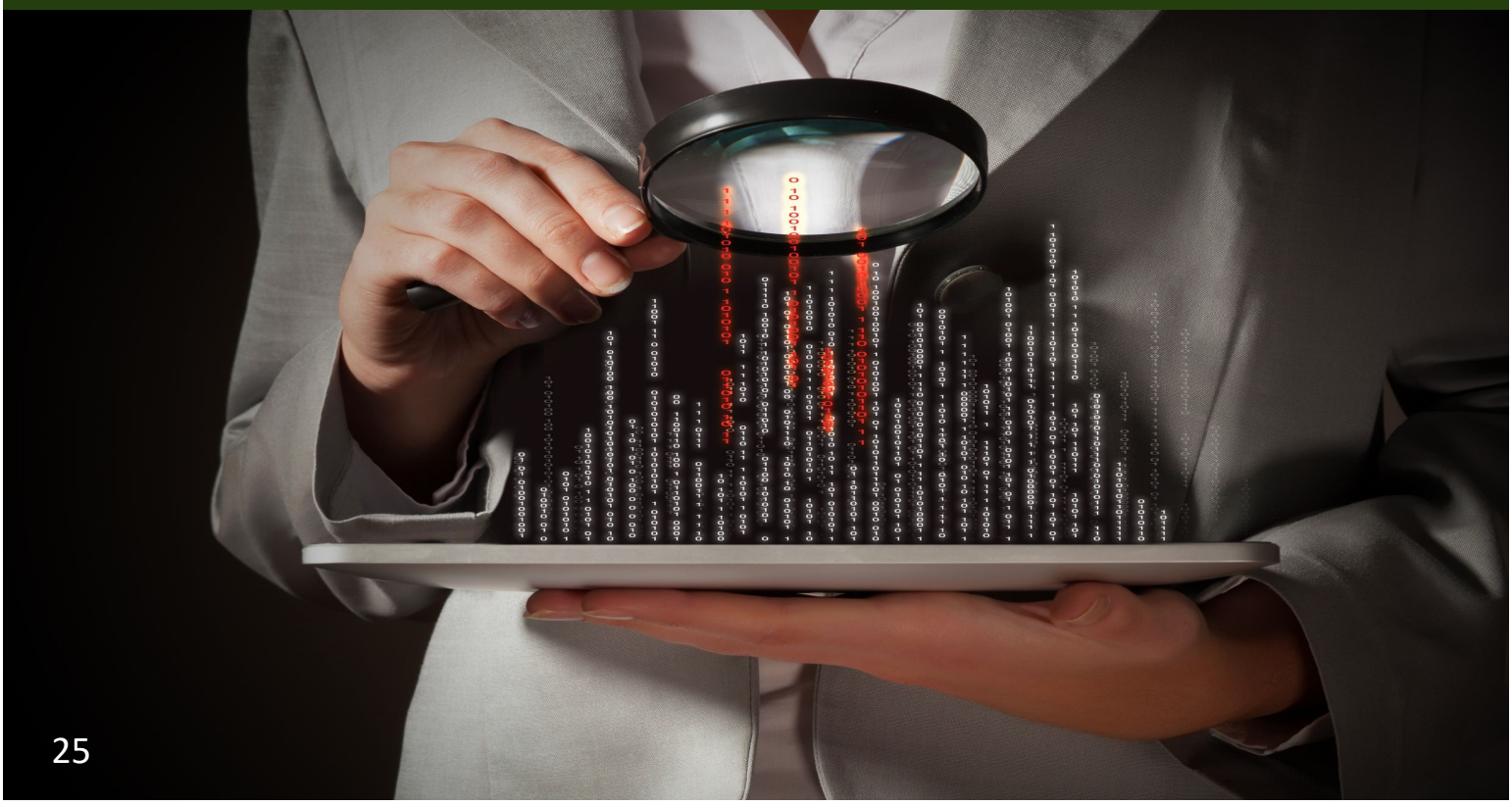
OIG's Investigative Analytics section houses the TSU, which is responsible for maintaining and enhancing OIG's two major case management systems: 1) Michigan Inspector General System (MIGS) and 2) Medicaid Audit Recovery & Investigation System (MARIS). TSU also develops and maintains investigative data reporting tools for use by OIG agents. The unit provides OIG leadership with comprehensive reporting solutions to monitor the administration's productivity. TSU ensures timely and accurate data for use by OIG for program integrity purposes.

TSU Highlights

In FY 2023, OIG's Technical Support Unit (TSU) implemented key updates to the Integrity Division's MARIS case management system, enhancing reporting capabilities for more effective management, improving investigative workflows, and expanding tracking capabilities for Medicaid program integrity audits.

TSU has also been instrumental in prolonging the lifespan of the Enforcement Division's legacy case management system, MIGS, by collaborating with the vendor to ensure adequate server space and resources. Concurrently, TSU is making strides in developing a next-generation case management system. FY 2023 marked the initiation of comprehensive user acceptance testing for a complete system rebuild, involving extensive collaboration with OIG's Enforcement Division users.

Continuing its commitment to internal process improvement, TSU has focused on documenting and standardizing key procedures, such as investigative EBT card use and system downtime notifications. These efforts aim to establish consistent practices, with an ongoing annual review of major recurring activities to enhance overall efficiency and effectiveness.



OIG ACTIVITIES

OIG is involved in many areas of the department that affect program integrity. Included are examples of operational activities:

Claims Establishment: OIG makes recommendations directly to MDHHS concerning all aspects of the recipient claims establishment process. Responsibilities include program content development, policy, procedures, program monitoring and measurement of outcomes and program advocacy.

Electronic Benefit Transfer (EBT): Food assistance and cash assistance benefits are electronically transferred to an account accessible by the client debit card called the Michigan Bridge Card. Transactions are analyzed for fraud trends to include out-of-state purchases for more than 30 days, non-recipients using Bridge Cards and other patterns of FAP trafficking.

Employee Fraud: The OIG Special Investigations Unit conducts investigations of MDHHS employees who are alleged to have committed crimes involving public assistance programs. Investigations have included embezzlement, failure to report employment when receiving state public assistance and creating and maintaining fictitious public assistance cases. Employees who have allegedly committed a criminal offense are referred to the Michigan Department of Attorney General for review of criminal charges.

Estate Recovery Fraud Investigations: The OIG collaborates with the MDHHS' Third Party Liability division to investigate potential fraud by individuals who received long-term care Medicaid payments. The estates of individuals who received Medicaid payments fraudulently are subject to repayment.

Front End Eligibility (FEE): MDHHS caseworkers may request an investigation by an OIG agent when applications or recertifications for public assistance contain suspicious or error-prone information. OIG agents investigate, substantiate or refute discrepancies and suspicious activities; the results may involve an assistance case not being opened, reduced benefits issued and/or case closure.

Hotline – Health Services: The public and other state/federal entities report allegations of potentially fraudulent activity in the Medicaid program to OIG through a variety of methods including email, telephone and toll-free hotline.

Hotline – Human Services: Recipient fraud referrals that come through the MDHHS website are forwarded to the corresponding local office. The referral is routed to the appropriate caseworker and manager for review, and the Enforcement Division is notified directly if the fraud referral meets certain criteria.

LEIN (Law Enforcement Information Network): OIG, through its Terminal Agency Coordinator (TAC), is responsible for the integrity and security of sensitive and confidential information contained in the LEIN system. OIG provides extensive training for LEIN operators, maintains the LEIN policy and procedure manuals for LEIN use by OIG and investigates LEIN violations.

MCO Program Integrity Activities: Each MCO reports their program integrity activities performed each quarter to OIG. As MCOs submit their quarterly reports, OIG-ID staff review each of the 41 reports for compliance. An MCO's report can receive a met or unmet rating. MCOs who receive an unmet rating must submit a Corrective Action Plan.

Policy Recommendations: OIG provides a leadership role in recommendations for policy changes to enhance prevention and detection of fraud by the continuous review of proposed and current department policy.

Provider Fraud – Health Services: OIG uses an investigative process to detect and deter potential instances of fraud, waste and abuse in health services programs. Provider fraud may include giving or receiving bribes or kickbacks, unacceptable medical and/or billing practices, misusing or abusing Medicaid services, falsifying records or giving false information. Cases involving credible allegations of fraud or other illegal activities are forwarded to the Michigan Department of Attorney General's Health Care Fraud Division for pursuit of appropriate civil or criminal prosecution.

Provider Fraud (non-Medicaid): These are intentional false billings or intentional inaccurate statements by a provider in areas such as Child Development and Care, Foster Care and Adoption Assistance Program payments, as well as contractors or other related businesses.

Provider Sanctions: Participation as a provider in the Medicaid program is subject to denial, suspension, termination or probation on the grounds specified by section 400.111e of the Social Welfare Act (Act 280 of 1939). OIG is responsible for making the determination to sanction a provider based on these grounds (e.g., provider is convicted of violating the Medicaid false claims act or a substantially similar statute of another state or the federal government; provider is convicted of, or pleads guilty to, a criminal offense or attempted criminal offense relating to the provider's practice of health care; provider's failure to comply with professionally accepted standards of medical practice, etc.).

Recipient Fraud: Recipient fraud occurs when there is intentional deception or misrepresentation, with the knowledge that the deception could result in the receipt of unauthorized benefits.

Social Media: OIG actively monitors social media sites such as Facebook, Craigslist and Twitter for FAP trafficking solicitations. OIG's Benefit Trafficking Unit conducts investigations on these hits.

Glossary of Acronyms

AAC	Actual Acquisition Cost
BMP	Benefits Monitoring Program
BTU	Benefit Trafficking Unit
CAP	Corrective Action Plan
CBTs	Computer Based Trainings
CDC	Child Development and Care
CDI	Cooperative Disability Investigation
CMS	Centers for Medicare and Medicaid Services
DDS	Disability Determination Services
DEI	Diversity, Equity, and Inclusion
DIB	Disability Insurance Benefits
DME	Durable Medical Equipment
EBT	Electronic Benefit Transfer
FAP	Food Assistance Program
FEE	Front End Eligibility investigations
FFS	Fee-For-Service
FIP	Family Independence Program
FNS	Food and Nutrition Service
FY	Fiscal Year
HRMU	High Risk Medicaid Unit
IAU	Investigative Analytics section
ILTs	Instructor Lead Trainings
IPV	Intentional Program Violation
ITU	Identity Theft Unit
LEIN	Law Enforcement Information Network
LMS	Learning Management System
MA	Medicaid program
MARIS	Medicaid Audit Recovery & Investigation System
MCL	Michigan Compiled Law
MCO	Managed Care Organizations
MDHHS	Michigan Department of Health and Human Services
MFCU	Medicaid Fraud Control Unit
MIGS	Michigan Inspector General System
MIHP	Maternal Infant Health Program
OIG	Office of Inspector General
OIG-ID	Office of Inspector General's Integrity Division
OIG-OD	Office of Inspector General's Operations Division
OTI	Office of Inspector General's Training Institute
PARIS	Public Assistance Reporting Information System
P&T	Policy & Training Unit
RAC	Recovery Audit Contractor
SDA	State Disability Assistance
SER	State Emergency Relief
SIU	Special Investigations Unit
SSA	Social Security Administration
SSA-OIG	Social Security Administration Office of Inspector General
SSI	Supplemental Security Income
TAC	Terminal Agency Coordinator
TSU	Technical Systems Unit
UPIC	Unified Program Integrity Contractor
USDA	United States Department of Agriculture

REPORT FRAUD

Examples of Welfare Fraud:

- Providing false or untrue information to receive MDHHS assistance benefits.
- Not reporting income.
- Hiding assets (bank accounts, property, etc.).
- Not reporting mandatory group members that also reside in the home.
- Trading or selling food benefits or Bridge Cards.
- Purchasing beverage(s) that require a bottle deposit, dumping/discarding beverage(s) and then returning the container(s) to obtain the cash deposit refund.
- Accepting food benefits/Bridge Card for unauthorized items (retailers only).

Report Welfare Fraud at: Michigan.gov/Fraud

Examples of Medicaid Provider Fraud:

- Billing for patients who did not really receive services.
- Billing for nonexistent patients or patients of other providers.
- Billing for a service and/or equipment that was not provided.
- Billing for items and services that the patient no longer needs.
- Overcharging for equipment or services.
- Billing for lengthy counseling sessions when only short sessions were provided.
- Concealing ownership or associations in a related company.
- Paying or accepting a “kickback” in exchange for a referral for medical services or equipment.
- Billing more than once for the same service.
- Billing for medical services that were actually provided by unlicensed or excluded personnel.
- Ordering tests or prescriptions that the patient does not need.

Report Medicaid Provider Fraud at: Michigan.gov/Fraud or 855-643-7283

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