

# FY 2024 Annual Report



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

Stacie Sampson, Inspector General

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## 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) 2024 Annual Report.

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

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

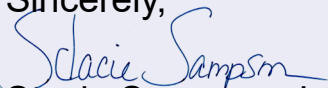
I am fortunate to lead such a dedicated team and am proud of our ongoing work to improve integrity in the programs administered by MDHHS.

Due to MDHHS OIG staff's dedicated work in FY 2024, we accounted for approximately \$306.8 million in program integrity efforts including, but not limited to, the following accomplishments:

- Completed 1,082 health services provider fraud, waste and abuse investigations, which identified a total of \$18.8 million in overpayments and prevented an estimated \$183.7 million in future payments through reduced billing activities as a result of health services provider audits, investigations and sanctions.
- Performed 16,982 public assistance eligibility investigations resulting in cost avoidance of more than \$80.9 million, including \$2.6 million in cost avoidance from disqualifications of public assistance recipients for intentional program violations.
- Completed 3,354 public assistance fraud investigations, identifying \$19.9 million of public assistance program fraud.
- As a result of our fraud investigations, county, state and federal prosecutors authorized 197 felony warrants.

I want to thank MDHHS OIG's staff, fellow state employees and all Michiganders who reported suspected fraud, waste and abuse in FY 2024 and encourage them to continue to do so in the future. Together, we can further strengthen the integrity of the public assistance programs administered by MDHHS.

Sincerely,



Stacie Sampson, Inspector General



# MDHHS OIG AUTHORITY

Created in 1972, OIG is a criminal justice agency in the MDHHS under Michigan Compiled Law (MCL) 400.43b and Executive Orders No. 2010-1 and No. 2015-4. The primary duty of MDHHS OIG is to investigate cases of suspected fraud, waste and abuse involving MDHHS assistance programs. In addition, MDHHS 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.

## MISSION STATEMENT

The mission of MDHHS OIG is to assist the department in maintaining integrity and accountability in the administration of its health and human services programs.

The office shall serve as an independent and autonomous entity within the department to lead the integrity efforts of health and human services programs by seeking out, detecting and investigating provider and recipient fraud, waste and abuse.





# MDHHS OIG VALUES

MDHHS OIG is accountable to the people of the State of Michigan for maintaining the highest standards of integrity and good moral character.

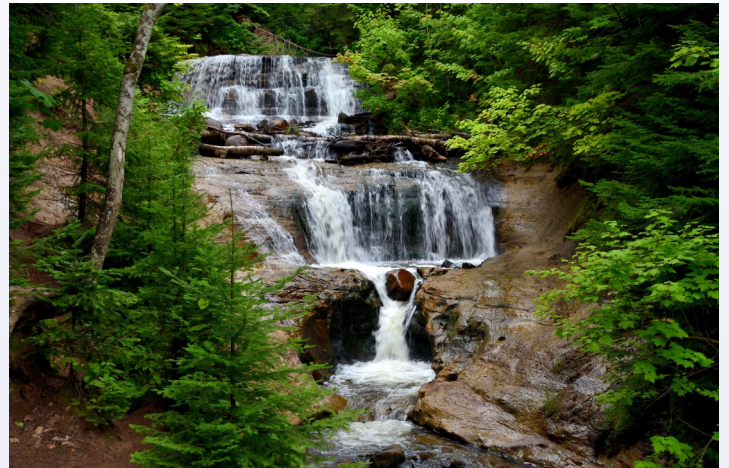
As members of MDHHS OIG, we must work together as a team to plan and strive for excellence, realizing that the daily decisions that are made will reflect on the future of the people we investigate as well as our organization as a whole.

## Recognition

- Recognize the accomplishments of those who make significant contributions toward our mission, values, goals and objectives.

## Dignity

- Dedicate ourselves to treat all people with respect, fairness and compassion.



## Innovation

- Strive to identify new activities to produce a greater impact on fraud, waste and abuse in programs administered by MDHHS.

## Teamwork

- 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

- We will display the highest possible standards of professional and ethical conduct.
- Understand that the integrity of MDHHS OIG must never be compromised. The public demands, and we must accept, that the integrity of an MDHHS OIG employee must be above reproach. Strive to reach the highest standards of honesty and integrity.
- Conduct ourselves in a manner that does not discredit the criminal justice profession or MDHHS OIG. Maintain the integrity of our 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 us with special favor or consideration.

## Excellence

- We are expected to meet the responsibilities of our assigned job duties, be responsible for our actions and be accountable to our supervisors, co-workers and to the residents we serve.
- Perform the duties of the MDHHS OIG mission to our utmost ability.
- Know the laws, rules and policies that will aid us in performing our 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 ourselves and our organization, take ownership of our work and be leaders in our areas of responsibility.





## MDHHS ADMINISTERED PROGRAMS

The primary duty of the inspector general is to investigate cases of alleged fraud, waste and abuse in the programs administered by MDHHS. These programs are vital because they provide essential resources and support for individuals and communities, addressing social determinants of health, promoting well-being and ensuring access to health care, social services and other crucial needs.

### Examples of MDHHS public assistance programs include:

#### **Adoption Assistance Program (AAP)**

Financial assistance and medical support to adoptive families, particularly people adopting children from the foster care system who have special needs.

#### **Food Assistance Program (FAP)**

Temporary food assistance for eligible low-income families and individuals.

#### **Family Independence Program (FIP)**

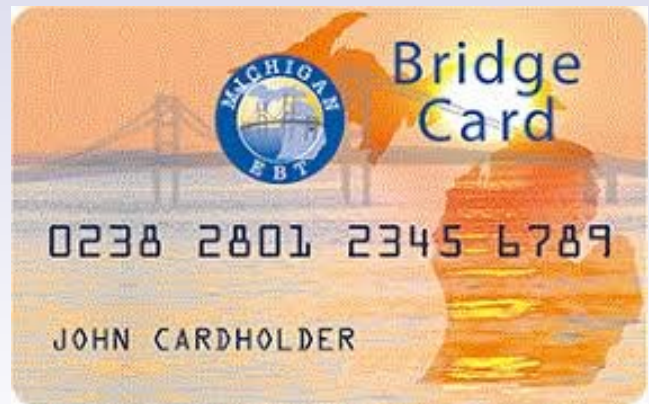
Also known as cash assistance, provides temporary financial assistance to eligible pregnant women and low-income families with minor children, aiming to help them achieve self-sufficiency.

#### **Medical Services Program (Medicaid)**

A health care program that provides comprehensive health care services to low-income adults and children.

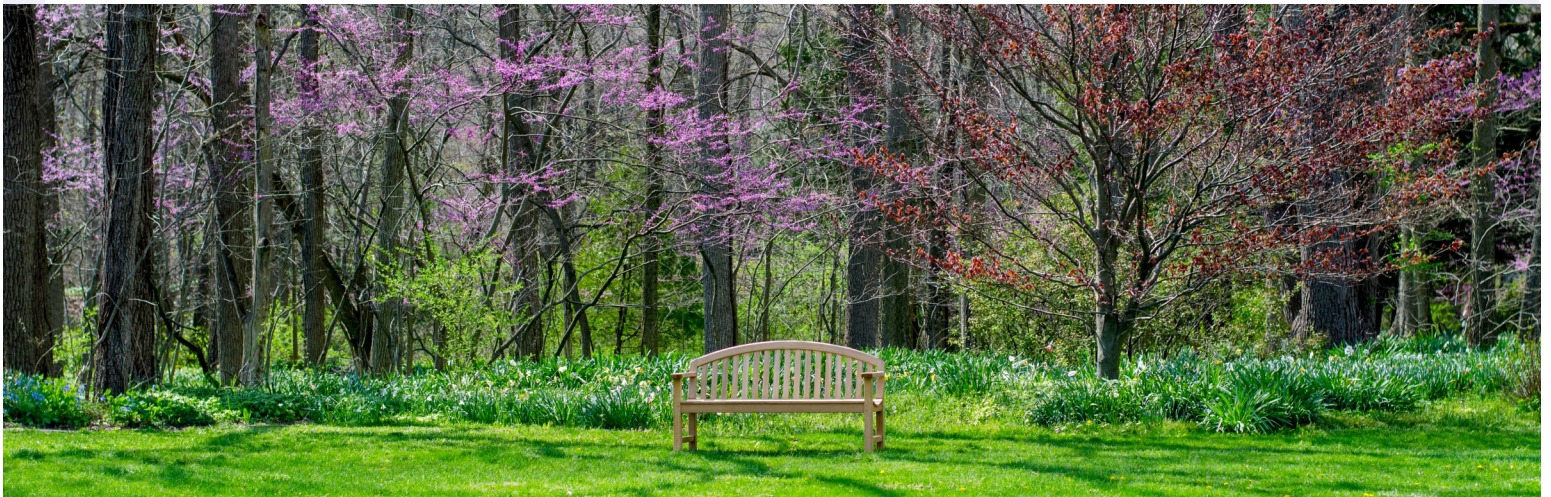
#### **Child Development and Care (CDC)**

Supports low-income working families by providing access to affordable, high-quality early care and afterschool programs.



#### **State Emergency Relief (SER)**

Provides immediate help to individuals and families facing conditions of extreme hardship or for emergencies that threaten health and safety.





## OFFICE OF INSPECTOR GENERAL OVERVIEW

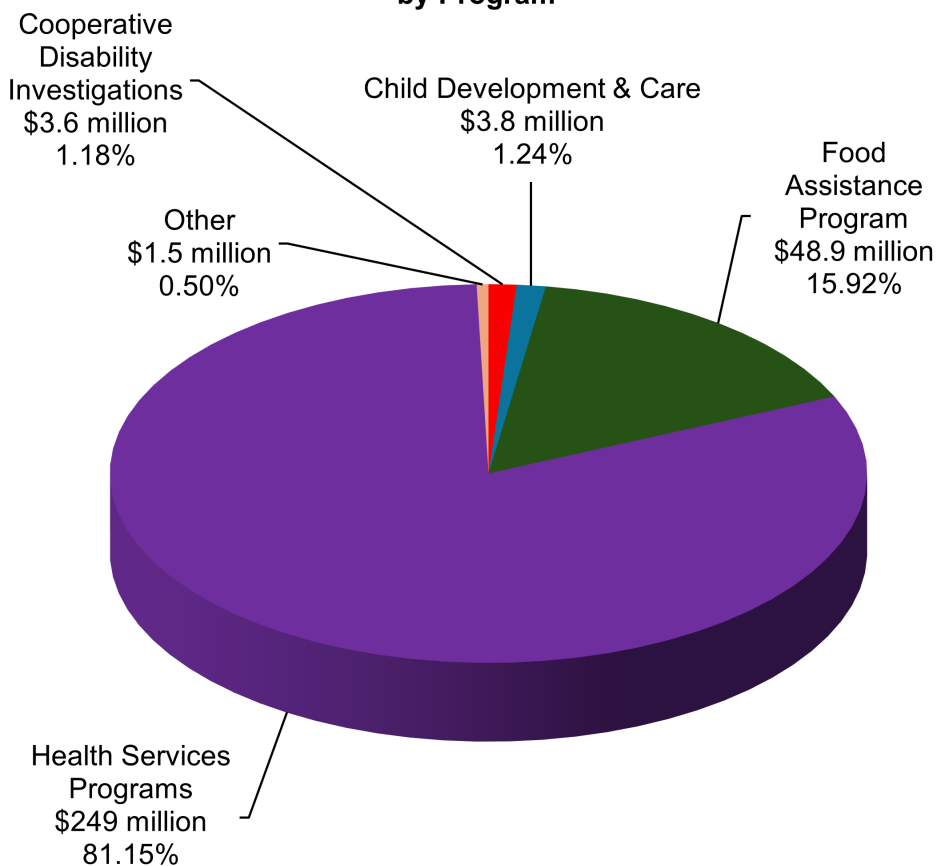
As the criminal justice agency within the department, agents of MDHHS OIG provide investigation and advisory services to ensure appropriate and efficient use of available public resources in the State of Michigan.

These agents and their managers are strategically located throughout Michigan to assist MDHHS in maintaining integrity and accountability in the administration of its public assistance programs.



## MDHHS OIG IMPACT ON PUBLIC ASSISTANCE PROGRAMS

**FY 2024**  
**Public Assistance Fraud, Waste & Abuse**  
**Detection & Prevention Efforts**  
**by Program**



Note: Other includes FIP (Family Independence Program), SER (State Emergency Relief), AAP (Adoption Assistance Program), etc.



## INVESTIGATIVE ANALYTICS

Data analytics allows for the detection and identification of patterns of fraudulent behavior that may not otherwise be evident. Our data scientists utilize tools and techniques, as well as knowledge of program rules, to mine state-owned data to identify fraud, waste and abuse events and trends. Our investigators use this analytics information to focus their efforts on areas with the greatest risk and return, leading to recoveries and discouraging future abuse. In FY 2024, data analytics generated 57% of MDHHS OIG's Medicaid provider investigations and 44% of public assistance fraud investigations.

### *Examples of data analytics include:*

- **Home Help Hospitalization Match** identifies claims for home help services which overlap with claims for beneficiary hospitalization.
- **Medicaid Beneficiary Program Abuse** includes drug seeking behavior, inexplicable non-emergency medical transportation and excessive emergency department visits.  
  
Technical expertise and Medicaid program knowledge are leveraged to identify beneficiaries that may be abusing the program's resources.
- **Provider Peer Grouping** seeks to cluster similar providers and identify suspicious behavior through outlier activity.
- **IP Address Location Analysis** identifies program integrity issues including, but not limited to, residency, identity theft and employee fraud.
- **Self-Reported Income Match** identifies discrepancies where reported income on an application for assistance is significantly lower than income reported on state tax records.
- **Online Shopping Analysis** uses geolocation and transaction data to identify suspect Electronic Benefit Transfer (EBT) transactions at online retailers.

### *FY 2024 Investigative Analytics Highlights*

#### ***Out-of-State EBT Card Spending***

Exclusive out-of-state EBT card spending for an extended period of time is an indicator that the individual may no longer be a Michigan resident. We utilize MDHHS' EBT transaction data to identify individuals with spending exclusively outside of Michigan for at least three months.

In FY 2024, this project resulted in \$9 million in annualized cost avoidance.

#### ***Medicaid Encounter Data Integrity***

A major encounter validation project was completed in FY 2024 that focused on examining the accuracy of Prepaid Inpatient Health Plan (PIHP) encounter claims data, and identifying groups of encounter claims that were improperly paid.

We partnered with the PIHPs individually and directed them to investigate the encounter claims' validity. Two PIHPs have confirmed inaccurate data submissions have been made to MDHHS inflating payments upwards of \$1.8 million, of which \$543,000 has been properly voided. This scenario will continue into FY 2025.



## ***FY 2024 Investigative Analytics Highlights***

### ***Cloned POS Terminals***

A new business process was developed to identify cloned point of sale (POS) terminals and coordinate with the EBT vendor to block the fraudulent terminals. Cloned POS terminals are used to process fraudulent EBT transactions with stolen card information.

As a result of this new business workflow, 60 fraudulent POS terminals were identified and blocked in FY 2024.

### ***EBT Card Cloning***

During FY 2024, thousands of Michigan EBT card holders were affected by a nationwide EBT card-cloning stolen benefits scheme. We developed algorithms and tools for early detection of compromised EBT accounts and skimmer locations.

These analytics and tools enable MDHHS OIG to quickly identify fraudulent retailers across the country and report them to the proper officials. In FY 2024, our efforts resulted in the detection and confiscation of 44 skimmers at Michigan retailers.

The implementation of these activities and new preventative protocols have safeguarded more than 76,485 MDHHS EBT accounts and more than \$16.6 million of EBT funds.

### ***IP Locator Project***

Internet Protocol (IP) Locator data was leveraged to identify recipients who were placing online public assistance applications while located outside of Michigan. This analysis delved further to pinpoint recipients who were also using their EBT benefits outside of Michigan, including non-Michigan deliveries and/or store pickups.

In the last quarter of FY 2024, this resulted in \$152,000 in annualized cost avoidance. This scenario will be continued in FY 2025.

### ***PARIS Investigations***

The national Public Assistance Reporting Information System (PARIS) Interstate Match is utilized to identify individuals receiving public assistance in Michigan and another state at the same time.

The resulting MDHHS OIG investigation increases program integrity in Michigan's public assistance programs by removing ineligible beneficiaries. In FY 2024, PARIS matches resulted in \$19.7 million in annualized cost avoidance.





## HEALTH SERVICES PROVIDERS

Pursuant to Executive Order No. 2010-1, MDHHS OIG is responsible for conducting and supervising activities to prevent, detect and investigate fraud, waste and abuse in Michigan's health services programs, including the Medicaid Program, Mental Health Program, MI Child Program and Children's Special Health Care Services Program.

In FY 2024, Michigan's health services programs had a combined budget of approximately \$23.7 billion and paid approximately 237,000 providers through almost 90 million transactions for goods and services provided to approximately four million beneficiaries covered under those programs.

### PROVIDER INVESTIGATIONS

In FY 2024, we identified \$18.8 million in fee-for-service (FFS) overpayments made to health services providers and prevented an estimated \$99.5 million in future payments through reduced billing activities as a result of health services provider investigations.

### RECOVERY AUDIT CONTRACTOR

The Affordable Care Act (ACA) requires Medicaid agencies to contract with a Recovery Audit Contractor (RAC) to identify and recover overpayments. In FY 2024, our RAC identified \$388,870 in overpayments made to health services providers and prevented an estimated \$69.7 million in future payments through reduced billing activities as a result of health services provider audits.

### MANAGED CARE OVERSIGHT

Quarterly, each Michigan Medicaid Managed Care Organization (MCO) is required to report their program integrity activities to MDHHS OIG. In FY 2024, Michigan Medicaid's 41 MCOs performed a total of 1,219 provider audits and/or reviews and identified \$16.7 million in overpayments.

### PROVIDER SANCTIONS

When appropriate, we may issue a sanction against the enrollment of a Medicaid provider based on the grounds specified by MCL 400.111d-f. In FY 2024, 184 health services providers were sanctioned, preventing an estimated \$14.6 million in future payments.



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 be one billing.
- Paying or accepting a "kickback" in exchange for a referral for medical services or equipment.
- Billing for medical services that were actually provided by unlicensed or excluded personnel.



## HEALTH SERVICES PROVIDER INVESTIGATIONS OVERVIEW

Due to the magnitude and complexity of Michigan's health services programs, MDHHS OIG utilizes regionalized investigative teams that are focused on health services provider fraud, waste and abuse investigations. Each team primarily investigates fraud, waste and abuse allegations dealing with the following provider types in their assigned region:

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

These regionalized teams enable MDHHS OIG to better coordinate efforts, thereby enhancing the accuracy, completeness and overall effectiveness of their investigations. These regional health care fraud investigators are primarily responsible for:

- Identifying vulnerabilities where a more robust policy and/or system edit would have prevented fraud, waste or abuse and making formal recommendations to prevent future fraudulent claims from being paid.
- Investigating allegations of health services provider fraud, waste and abuse, leading to the following outcomes:



- ♦ Referring Medicaid provider fraud to the Medicaid Fraud Control Unit (MFCU).
- ♦ Suspending payments to 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 health services providers and MCOs.
- ♦ Educating providers on proper health services billing practices.
- ♦ Referring information and evidence to regulatory agencies and licensure boards.

## ***FY 2024 Health Services Provider Investigation Highlights***

### ***Complaints***

In FY 2024, we received 569 allegations of potentially fraudulent activity from various sources (e.g., 148 tips from beneficiaries, 139 tips from the public (52 anonymous), 166 referrals from inside MDHHS and 65 tips from providers) and identified 767 investigative targets through data analytics.

### ***PCS***

Receivables were established for 420 PCS providers totaling approximately \$8.5 million.

Approximately \$7.8 million of this amount is for PCS agency reviews, which include a review of payroll records, non-enrolled individual caregivers, payments made while beneficiaries were either hospitalized and/or after their death or for other noncompliance with Medicaid policy.

### ***Pharmacy***

Pharmacy invoice reconciliations (IR) are performed to validate that prescription medications supplied to Medicaid beneficiaries are supported by purchase invoices, as required by Medicaid policy and MCL 400.111b(6).

Pharmacy investigations resulted in 56 pharmacy providers agreeing to repay MDHHS a total of \$6 million for Medicaid policy violations, including billing for a higher quantity than their records support, not billing the actual acquisition cost for medications included in the 340B Drug Discount Program, billing for refills after the death of a beneficiary, etc.

### ***Integrated Care Organizations (ICOs)***

ICOs are health plans for Medicaid beneficiaries who also have Medicare coverage. Medicaid pays the ICO a monthly capitation (i.e., insurance premium), and the ICO pays the providers directly for services provided.

As a result of our efforts, 13 long term care facilities and hospice providers agreed to repay \$1.5 million due to improperly being paid by MDHHS directly for service periods when their beneficiaries were enrolled in the integrated care program and the ICO received capitation payments for those same service periods. These 13 long-term care facilities and hospice providers were to be reimbursed by the ICO for those services.

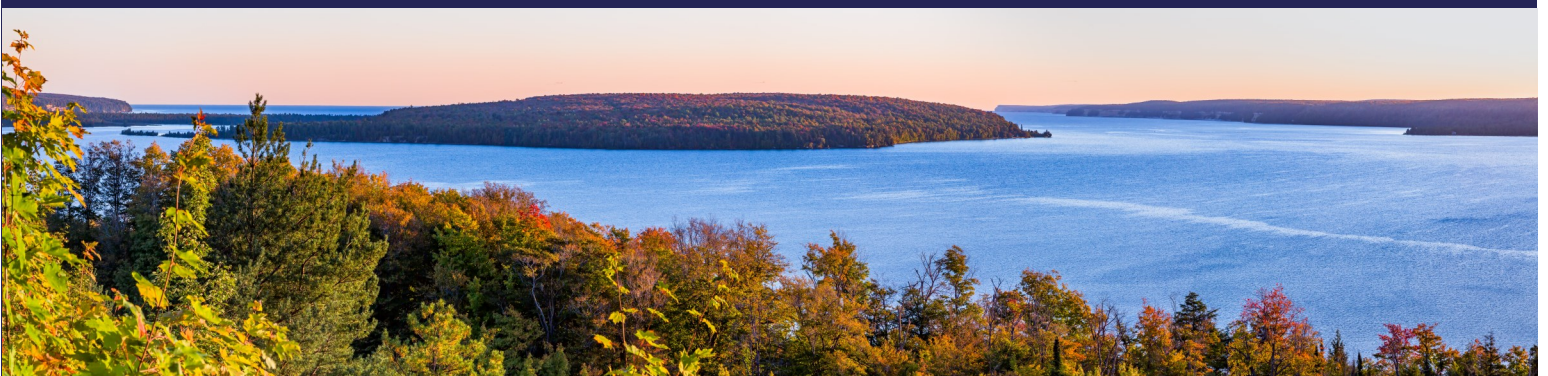
Additionally, two ICOs repaid Michigan Medicaid \$18,592 in capitation payments that were paid on behalf of Medicaid beneficiaries who were not enrolled in the ICO program at the time of the capitation payment.

### ***Medicaid Fraud Control Unit (MFCU)***

In accordance with 42 CFR § 455.21, the MFCU is the first referral destination for all cases of suspected health services provider fraud.

In FY 2024, we referred 21 health services providers to the Medicaid Fraud Control Unit (MFCU) for criminal investigation.

A total of 16 previously referred providers were convicted and/or signed civil settlement agreements. These providers were required to pay \$1.1 million in restitution.





## ***Examples of Health Services Beneficiary Utilization Fraud include:***

- Altering a doctor's prescription to obtain prescription drugs or medical equipment that are not medically necessary and/or to which they are not entitled.
- Helping a doctor file false claims by having tests they do not need.
- Accepting payment from a doctor for referring other beneficiaries for medical services.
- NEMT fraud includes any situation where a patient deliberately misrepresents their medical transportation needs to gain access to NEMT services/reimbursements they are not entitled to.
- The fraudulent sale of prescription drugs or medical equipment to others, which has a high potential for conspiracy between providers and beneficiaries.
- Accepting payment from a doctor for referring other beneficiaries for medical services.
- PCS fraud includes any situation where a patient falsely claims to require more care than needed, claiming to be homebound when they are not, forging signatures on medical forms and/or exaggerating the severity of their condition to justify more hours of care. PCS fraud also has a high potential for conspiracy between providers and beneficiaries.

## ***FY 2024 Health Services Beneficiary Utilization Fraud Investigation Highlights***

### ***Benefit Monitoring Program (BMP)***

Medicaid beneficiaries who abuse or misuse their Medicaid benefit are referred to the BMP for review. The BMP and/or the associated health plan makes the determination as to whether the beneficiary's behavior indicates the need to confine their care with a specified physician and/or pharmacy for a two-year period. Upon confinement, all non-emergency medical care and/or prescriptions must be authorized by the designated physician and dispensed by the designated pharmacy to be covered by Medicaid.

These investigations resulted in 284 Medicaid beneficiaries being confined to a specified pharmacy and/or physician, resulting in \$14.5 million in proposed cost avoidance.

### ***NEMT***

NEMT fraud investigations identified 28 Medicaid beneficiaries who deliberately misrepresented their medical transportation needs to obtain \$1 million in NEMT reimbursements that they were not entitled to.

### ***PCS***

A Medicaid beneficiary was alleged to have falsely reported needing assistance with daily living activities through the home help program. Evidence gathered during the investigation revealed that the beneficiary was able to perform the daily tasks associated with someone who could live independently and that the beneficiary provided fraudulent medical documents to obtain home help program approval.

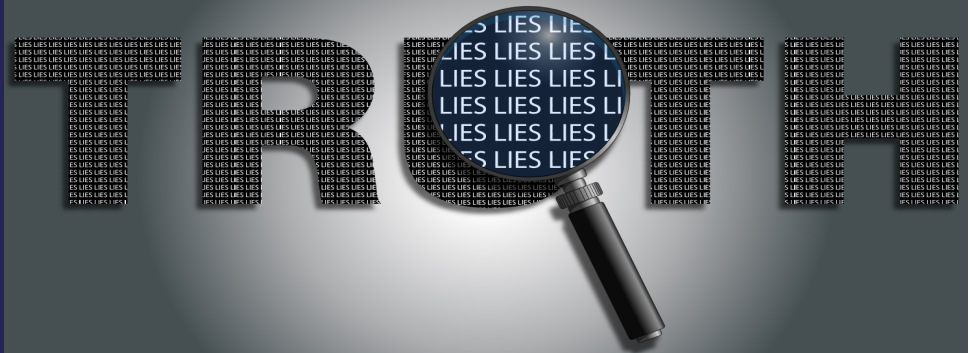
The beneficiary's personal care services were denied resulting in an annual cost avoidance of \$5,822.



# RECIPIENT ELIGIBILITY FRAUD

Each public assistance benefit program has its own set of eligibility rules relating to an individuals residency, citizenship, income, household composition and/or assets.

Recipient eligibility fraud investigators determine whether a recipient was truthful in their public assistance benefit program application and that their eligibility determination was accurate.



## FRONT END ELIGIBILITY PROGRAM

The Front End Eligibility (FEE) program is a fraud prevention initiative established by MDHHS OIG to reduce errors and overpayments in public assistance benefit programs when applications or recertifications for public assistance contain suspicious or error-prone information.

The goal of the FEE program is to support a partnership between MDHHS OIG and the local office staff early in the eligibility determination, which results in significant cost savings for MDHHS.

The local office staff refer suspicious applications and our investigators confirm the accuracy of the residency, citizenship, income, household composition and/or asset information disclosed by the applicant. The investigation is completed within 15 workdays, the agent responds to the eligibility staff with their findings and the eligibility staff determines eligibility based on these findings.

In FY 2024, MDHHS OIG performed almost 8,100 FEE investigations resulting in 4,278 denied, reduced or withdrawn public assistance benefit applications and \$31.6 million in cost avoidance.

In FY 2024, MDHHS OIG performed 16,982 public assistance benefit investigations resulting in \$80.9 million in cost avoidance and 3,354 fraud investigations resulting in \$19.9 million in fraud found.



### ***Examples of Recipient Eligibility Fraud include:***

- ***Unreported self-employment and/or income fraud*** – recipients misrepresent their income when they applied for benefits to qualify for benefits to which they are not entitled.
- ***Unreported asset fraud*** – recipients underreport their assets when applying for benefits to qualify for benefits to which they are not entitled.
- ***Residency fraud*** – recipients intentionally provide false information or withhold facts to falsely qualify for benefits in a state or locality where the individual does not actually reside.
- ***Group composition fraud*** – recipients fail to report their spouse as a member of the household and include them in the group's shared income or assets, to qualify for benefits to which they are not entitled.
- ***Dual assistance fraud*** – recipients apply for and receive benefits in another state while also receiving benefits in Michigan.
- ***Medicaid long term care eligibility fraud*** – recipients purposely not disclosing income and/or asset information to gain long term care Medicaid eligibility to which they are not entitled.

### ***FY 2024 Recipient Eligibility Fraud Investigation Highlights***

#### ***Unreported Income Fraud***

A recipient did not accurately report that they were married and living with their spouse, nor did they report their spouse's employment income to MDHHS. The recipient was ineligible for benefits due to the household income exceeding the food assistance program limits. As a result of our investigation, the recipient was criminally charged by the Bay County Prosecutor's Office, pled no contest to welfare fraud and was ordered to pay \$14,720 in restitution and to serve six months of probation.

#### ***Unreported Self-Employment Fraud***

A recipient did not report owning a business nor the self-employment income from that business to MDHHS. The co-mingling of personal expenses out of the non-reported business income affected benefit eligibility. An administrative hearing decision concluded the recipient committed an intentional program violation and was subject to a 12-month FAP disqualification and recovery of \$45,004. The recipient appealed to circuit court and the decision was upheld.

#### ***Unreported Income Fraud***

A recipient did not accurately report they were married and living with their spouse, nor did they report their spouse's employment income to MDHHS. Ongoing benefits were closed resulting in an annual cost savings of \$10,020. In addition, an intentional program violation hearing was held, resulting in authorized recovery of \$7,434 in FAP benefits and the recipient received a 12-month FAP disqualification.

#### ***Unreported Asset Fraud***

A recipient did not report a mutual fund valued at over \$143,000 to MDHHS between August 2019 and November 2022. As a result of our investigation, the recipient was criminally charged by the Tuscola County Prosecutor's Office, pled guilty to welfare fraud, and was ordered to pay \$38,481 in restitution and sentenced to six months of probation.



## ***FY 2024 Recipient Eligibility Fraud Investigation Highlights, cont.***

### ***Group Composition Fraud***

We conducted a joint investigation with the Social Security Administration which identified a recipient who did not report living with their spouse, their spouse's employment income or Social Security payments when applying for benefits.

The recipient was charged by the U.S. Attorney's Office and pled guilty to felony food stamp fraud. The recipient was ordered to pay \$108,635 in restitution and was committed to the Federal Bureau of Prisons for a term of one month. Upon release from imprisonment the recipient was placed on supervised release for a term of two years.

### ***Group Composition Fraud***

A recipient did not report being married and living with their spouse, nor did they report the spouse's income and jointly held real estate assets. During the investigation, we discovered that the recipient filed fraudulent applications and rental agreements with MDHHS to conceal their relationship, household income and the true ownership of the property.

An administrative hearing decision concluded the recipient committed an intentional program violation and ordered the recipient to pay \$36,388 in restitution and serve a 12-month program disqualification.

### ***False Identity Fraud***

A recipient applied for public assistance benefits using a false identity by creating a non-existent twin sibling with the same first and middle name.

As a result of our investigation, the recipient was criminally charged by the Kalamazoo County Prosecutor's Office, pled guilty to two felonies for welfare fraud and failure to inform, and was ordered to pay \$11,457 in restitution, court fines and costs, and was placed on probation for 18 months.

### ***Medicaid Long Term Care Fraud***

An investigation revealed that a beneficiary received Medicaid Long Term Care benefits after their power of attorney failed to properly disclose assets to determine eligibility. By failing to report these assets, \$72,500, in Medicaid benefits were fraudulently obtained. The power of attorney pleaded guilty to welfare fraud and was ordered to pay restitution.

### ***Dual Assistance Fraud***

A recipient did not properly report receiving FAP benefits in both Michigan and Arizona. The recipient maintained a residence and employment outside of Michigan, exclusively utilizing their benefits in Arizona for over six months.

The investigation was referred to the Michigan Department of Attorney General for participation in the welfare fraud diversion program. The recipient was ordered to pay \$7,053 in restitution and received a 10-year program disqualification.

### ***Residency Fraud***

A recipient was spending their FAP benefits exclusively outside the State of Michigan. The investigation revealed that the recipient had gained employment and had moved their family to Georgia. As a result, the recipient's FAP and Medicaid benefits were closed, resulting in an annual cost avoidance of \$68,148.

### ***Residency Fraud***

A recipient was receiving duplicate food assistance and Medicaid program benefits from the state of Georgia. The investigation revealed evidence that the recipient's group member was no longer living in the state but was under a power of attorney in Georgia. As a result, the recipient's FAP and Medicaid benefits were closed resulting in an annual cost avoidance of \$43,428.

## SPECIAL INVESTIGATIONS

The most complex criminal and civil complaints of fraud, waste and abuse in the programs administered by the department are considered special investigations.

Agents assigned to special investigations identify and determine the existence of sophisticated criminal conspiratorial schemes by MDHHS employees, contractors, businesses, vendors and recipients to receive program funds.

### MDHHS EMPLOYEE FRAUD

Fraud perpetrated by MDHHS employees may include using their position to receive kickbacks in exchange for approving benefit applications and/or directing services/grants to a specific provider/vendor, obtaining benefits for themselves and/or their friends/family, embezzlement, etc.

### ADOPTION ASSISTANCE FRAUD

Adoption assistance program fraud refers to the act of intentionally deceiving MDHHS to receive financial benefits from an adoption assistance program, typically by claiming eligibility for payments while not properly caring for the adopted child, or by continuing to receive funds after the adoption has been dissolved, essentially "keeping the money but not the child."

### CHILD DEVELOPMENT AND CARE FRAUD

Child Development and Care (CDC) provider fraud refers to any deceitful act by a childcare provider, such as intentionally misrepresenting the services provided to children, falsifying attendance records or claiming payment for care that was not given, in order to fraudulently receive government payments.

### CONTRACTOR FRAUD

Allegations of fraud perpetrated by MDHHS contractors and/or non-Medicaid providers includes, but is not limited to, false billing and/or offering kickbacks to MDHHS employees in exchange for contracts and/or payments for services.

In FY 2024, MDHHS OIG completed 147 special investigations and identified \$3.5 million of provider, contractor, recipient and MDHHS employee fraud.

## FY 2024 SPECIAL INVESTIGATIONS HIGHLIGHTS

### ***CDC Provider Fraud***

An investigation into allegations that a CDC provider was falsifying billing records for children in her care revealed that the provider overbilled the department for CDC benefits and received FAP benefits for which she was not entitled. The provider was criminally charged, pled no contest and was ordered to pay restitution of \$40,000 to the State of Michigan.

### ***Employee Fraud***

An investigation into allegations that a state employee failed to report the adoption of her foster child revealed she received \$6,740 in CDC benefits to which she was not entitled. The employee was criminally charged, pled guilty, ordered to pay full restitution and removed from State of Michigan employment.





# FY 2024 IDENTITY FRAUD INVESTIGATION HIGHLIGHTS

## ***FAP Identity Fraud***

During an identity fraud investigation, we discovered an individual used stolen identities to submit more than 200 fraudulent applications and steal \$33,000 in FAP benefits. The individual was criminally charged, pled guilty and ordered to pay full restitution.

After being charged in the first scheme, the individual continued to submit fraudulent applications to steal an additional \$148,000 in FAP benefits. Additional criminal charges are pending.



## ***FAP Identity Fraud***

During an identity fraud investigation, we discovered an individual used the identity of two deceased persons and other stolen identities to steal nearly \$75,000 in food assistance benefits.

The individual was criminally charged, pled guilty and was ordered to pay full restitution to the State of Michigan.

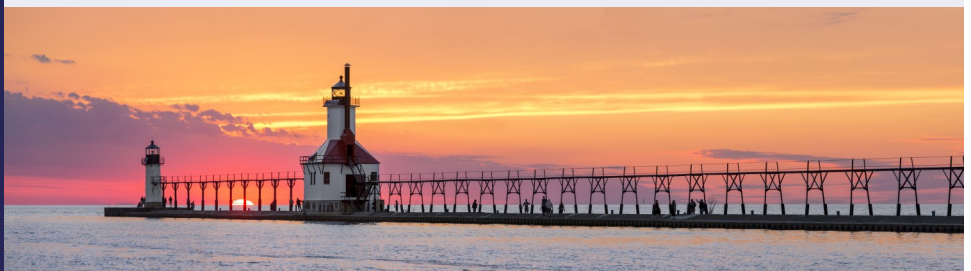


## IDENTITY FRAUD

Identity fraud is a pervasive crime that increased during the COVID-19 pandemic. In July 2021, MDHHS OIG established a specialized team focused on combatting the growing trend of public assistance fraud where individuals and criminal enterprises utilize stolen identities to apply for and obtain MDHHS public assistance program benefits.

These identity fraud investigators identify the existence of sophisticated criminal conspiratorial schemes through in-depth investigations, social media and advanced data analysis. Appropriate criminal charges are initiated to prosecute offenders and recover stolen program funds.

In FY 2024, MDHHS OIG investigated 65 criminal individuals and entities utilizing 943 stolen and fraudulent identities to illegally obtain and traffic FAP benefits which identified \$3.9 million in fraud and established more than \$3.6 million in related cost avoidance.



## PUBLIC ASSISTANCE PROGRAM BENEFIT TRAFFICKING FRAUD

Benefit trafficking is a crime that involves the buying, selling or trading of public assistance program benefits for cash or other ineligible items, including tobacco, alcohol, firearms, drugs and gambling.

Benefit trafficking investigators 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 BENEFIT TRAFFICKING

In cases of FAP trafficking, MDHHS OIG investigates the recipients while the U.S. Department of Agriculture (USDA) OIG investigates the retailers.



### MEDICAID BENEFIT TRAFFICKING

A Medicaid beneficiary may sell or loan their Medicaid card to another person who is not eligible for Medicaid, enabling them to fraudulently obtain health care services.

Medicaid funds are meant to provide health care to eligible individuals and fraud diverts these resources away from those who need them.



### CONSEQUENCES OF BENEFIT TRAFFICKING:

#### *Disqualification*

Individuals found to be involved in FAP trafficking may be disqualified from receiving benefits for a period of time, or permanently.

#### *Fines and/or imprisonment*

According to MCL 750.300a, individuals involved in FAP trafficking may face up to \$250,000 in fines and/or up to 10 years in prison.

#### *Recovery of benefits*

Individuals may be required to repay any improperly issued or acquired benefits.

In FY 2024, MDHHS OIG performed 460 FAP trafficking investigations, identifying \$5 million in fraud with 36 criminal warrants issued.



## ***Examples of Benefit Trafficking Fraud include:***

- ***Selling/purchasing benefits for cash*** – this includes selling and/or purchasing food assistance benefits for cash at less than face value.
- ***Soliciting trafficking through social media*** – this involves advertising or promoting the sale or purchase of food assistance benefits on social media platforms.
- ***Retailer fraud*** – some retailers violate the FAP by accepting food assistance for cash or for unauthorized items such as tobacco, alcohol, lottery tickets, etc. at less than face value.
- ***EBT card cloning*** – 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 of that cardholder.
- ***Cloning EBT terminals*** – cloned EBT POS terminals are used to process fraudulent EBT transactions with stolen card information.
- ***Stolen EBT terminal IDs*** – criminals are gaining access to USDA Food and Nutrition Service (FNS) terminal ID numbers from the dark web and other sources to replicate POS devices.

By cloning these terminals, unauthorized locations can process transactions that appear legitimate.

Criminals also program stolen terminals to redeem FAP program benefits here in Michigan and accept bridge cards in exchange for prohibited items.



Criminals may also deceive recipients by email, phone or in person to obtain their bridge card number and personal identification number (PIN).

## ***FY 2024 Benefit Trafficking Fraud Investigation Highlights***

### ***Catering FAP Fraud***

An investigation into unusual EBT card transactions revealed that the owner of a catering business purchased more than \$80,000 in food assistance benefits at a reduced rate to supply food for his business. The caterer was criminally charged and convicted of felony food stamp fraud, which resulted in court ordered restitution and a lifetime disqualification from SNAP. Further, additional program sanctions were established for the recipients who trafficked their EBT benefits with the business.

### ***EBT Vendor Employee Fraud***

An investigation into suspicious activity connected to Pandemic-EBT benefits designed to provide nutritious meals to children affected by the COVID-19 pandemic identified an employee of an EBT card vendor who used their access to steal more than \$57,000 in food assistance program benefits. The employee was charged and convicted of felony food stamp fraud and ordered to pay full restitution to the State of Michigan.

## COOPERATIVE DISABILITY INVESTIGATIONS

Since 2014, MDHHS OIG has partnered with the U.S. Social Security Administration Office of Inspector General (SSA-OIG) through a Cooperative Disability Investigations (CDI) program in Michigan. The CDI program 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 program supports the strategic goal of ensuring integrity of the Social Security programs with zero tolerance for fraud and abuse and also serves to deter fraud in related federal and state benefit programs. For example, any person deemed eligible for Supplemental Security Income (SSI) is automatically made eligible for Medicaid. Therefore, our participation in the CDI program realizes savings to Michigan taxpayers for stopping both SSI and Medicaid eligibility fraud.

In FY 2024, the two assigned MDHHS OIG agents, working in partnership with SSA-OIG, completed 31 cooperative disability investigations and produced total cost avoidance of \$3.6 million.

### ***FY 2024 Cooperative Disability Investigation Highlight***

The Detroit Cooperative Disability Investigations Unit (CDIU) received an anonymous complaint that a 48-year-old individual was working in the construction industry and being paid in cash. A review of SSA records revealed that the individual was receiving awarded disability benefits in 2013 due to “back problems.”

The investigation revealed the individual had a valid chauffeurs license, along with an endorsement to ride motorcycles. Additionally, the individual was found to be the registered owner of an enclosed trailer, two trucks and a motorcycle. During surveillance operations conducted by Detroit CDIU Task Force Officers (TFOs), the individual was observed on more than one occasion leaving their residence in the morning hours where they traveled to a home improvement store. The individual was observed wearing carpenter style blue jeans and work boots and walking with a normal gait, absent any medical assistive walking devices. After each trip to the home improvement store, the individual was observed driving to residential homes, where they approached the front door of the residences, was greeted by the homeowner, and then proceeded back to their truck to retrieve power tools and other items. The TFO’s observed the individual carrying and extending a ladder, where they proceeded to stand on the top rung of the ladder while working on the attic area of a detached garage.

Based on the findings from the investigation, a Medical Continuing Disability Review (CDR) was initiated. In the Medical CDR, the individual alleged disability due to carpal tunnel, herniated disks, decreased focus and left knee issues. The individual indicated they had not worked since being approved for disability benefits in 2013. The person attended a Consultative Exam (CE) where they ambulated with a cane and wore left knee and right elbow braces. The individual reported difficulty walking, standing and using their hands and fingers.

As a result of the investigation, the MDHHS DDS found there was reason to believe the individual committed similar fault in connection with their disability claim. The DDS determined there was significant medical improvement and the person’s benefits were ceased. The investigation resulted in SSA savings of \$184,738 and non-SSA savings of \$88,008.



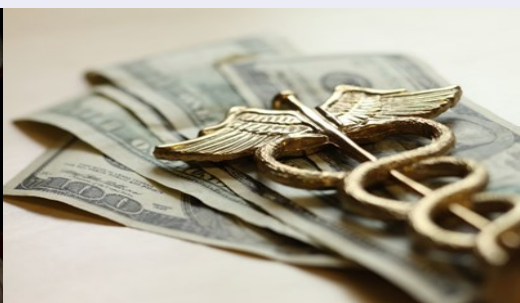
# HOW TO REPORT FRAUD

You can help protect your tax dollars by reporting suspected fraud. You can do this without giving your name, but if you give your name and contact information, it helps our investigators obtain additional information from you in the future.

Before you make a report, try to get as much information as possible, including:

- The name of the person and/or entity you suspect of committing fraud, this may be:
  - ♦ A person receiving benefits who:
    - \* Provided false or untrue information to receive MDHHS program assistance benefits.
    - \* Is hiding income and/or assets (e.g., bank accounts, property, etc.).
    - \* Did not report mandatory group members who also reside in their home.
    - \* Traded or sold their Medicaid benefit and/or Bridge Card.
    - \* Purchased beverages that require a bottle deposit, dumped/discarded the beverage and then returned the containers to obtain the cash deposit refund.
  - ♦ A person who purchases someone's Medicaid benefit and/or Bridge Card.
  - ♦ A retailer who is accepting food benefits/Bridge Card for unauthorized items.
  - ♦ A health care professional, pharmacy, hospital, nursing home or other facility providing Medicaid services who:
    - \* Billed for a service and/or equipment that was not provided, for nonexistent patients or patients of other providers, for patients who did not really receive services, and/or for items and services that the patient no longer needs.
    - \* Billed for lengthy counseling sessions when only short sessions were provided.
    - \* Ordered tests or prescriptions that the patient does not need.
    - \* Paid or accepted a “kickback” in exchange for a referral for medical services or equipment.
    - \* Billed for medical services that were actually provided by unlicensed or excluded personnel.
- The ID number, address, phone number, etc. of this person and/or entity .
- Date(s) the suspected fraud occurred.
- The amount of money involved.
- Description of the acts that you suspect involve fraud.

**Report Fraud at [Michigan.gov/Fraud](https://Michigan.gov/Fraud) or 855-MI-FRAUD (855-643-7283).**

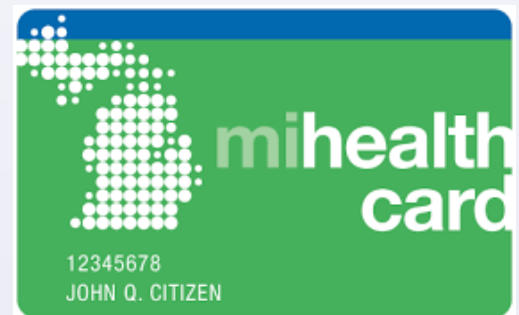


## FIGHTING FRAUD CAN PAY UP TO \$1,000

Pursuant to MCL 400.105d(1)(f), you may be eligible for a reward of up to \$1,000 if all of these seven conditions are met:

1. You must report the suspected medical assistance fraud directly to MDHHS OIG. If you reported the fraud to a Medicaid Health Plan, you must also report the fraud to MDHHS OIG.
2. The allegation must be specific, not general.
3. The suspected fraud must not have occurred later than six years from the date of the initial report.
4. You are a recipient or an entity providing services to a recipient of the medical services program.
5. The suspected fraud must be confirmed as potential fraud by MDHHS OIG and formally referred to the Attorney General's Medicaid Fraud Control Unit (AG MFCU) and accepted as a case for investigation.
6. You are not excluded from participating in the medical services program.
7. The person or organization you're reporting isn't already under investigation by MDHHS OIG or the AG MFCU for the suspected fraud.
8. Your report leads to criminal or civil action (or any associated settlement) by the AG MFCU **AND** the direct recovery of at least \$1,000 of State of Michigan Medicaid funds.

The incentive payment will be ten percent or \$1,000, whichever is less, of the state funds recovered. If multiple individuals qualify for a reward, the reward is shared among them.



If you want to know more about the Fraud Incentive Program, call 1-855-MI FRAUD (643-7283) or report online at [Michigan.gov/Fraud](https://Michigan.gov/Fraud). You must leave full contact information to be eligible for a reward.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

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