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Assemblymember Blayne Osborn
7230 Amigo Street
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Dear Assemblyman Osborn:

Thank you for the opportunity to share information about the Nevada Attorney General's Office Medicaid Fraud Control Unit (MFCU). Please find below responses to your letter dated July 31, 2026.

I hope you will join me in congratulating the success of the Nevada Attorney General's Office MFCU, which as you will see below, is one of the finest in the nation. In Federal Fiscal Year 2025, the MFCU conducted more than the national average of investigations of Medicaid provider fraud and elder abuse and successfully prosecuted more than twice the national average of fraud convictions. The MFCU did this work with less than half of the national average of staff. Quite simply, the Nevada Attorney General's Office MFCU punches above its weight in our mission to protect the integrity of one of Nevada's most important programs for our most vulnerable residents.

1. Medicaid Fraud Control Unit Case Acceptance

- *What criteria does the Medicaid Fraud Control Unit use when determining whether to accept a referral for criminal investigation?*

The MFCU considers a number of factors when determining whether to accept a referral for criminal or civil investigation. The decision making on referral acceptance or declination is a case-by-case situation. Some of these factors are determinative; for example, the MFCU cannot investigate matters outside of its jurisdiction or beyond the statute of limitations. These factors include, but are not limited, to the following:

i. Jurisdiction: The MFCU, according to the federal grant and performance standards that dictate operations of the MFCU (see 42 CFR 1007), can only investigate matters related to Medicaid provider fraud and the abuse/neglect of older or vulnerable adults when there is a Medicaid funding nexus. The MFCU **cannot** investigate Medicaid recipient fraud, which is a common misconception, yet the MFCU receives those referrals frequently and forwards them to Division of Welfare and Supportive Services or any additional appropriate State agency for further handling.

ii. Medicaid Exposure: The MFCU considers the exposure or potential loss amount to Medicaid when determining which referrals to investigate, giving more weight to those matters that have a higher exposure amount. This does not indicate that lower potential loss cases are not investigated, only that exposure is one of the factors to be considered.

iii. Case Mix: The MFCU's federal grant requires that the unit investigates a variety of different case types and Medicaid provider types. For example, the MFCU should not solely investigate one specific provider type, such as behavioral/mental health, but should try and investigate a variety of different types of providers since Medicaid fraud is not limited to just one provider type within Medicaid.

iv. Statute of Limitations/Age of Allegations: Violations involving Medicaid fraud or the abuse/neglect of older and vulnerable adults all have a statute of limitations, meaning that charges must be filed within a certain amount of time based on when the crime was discovered and/or committed. The age of the allegations or more historical allegations also can have evidentiary issues as witnesses have a difficult time having to recall specific services on specific dates they either received or provided many years ago.

v. Specific Intent: Criminal violations involving Medicaid fraud require specific intent (see NRS 422.540) from the perpetrator of the crime, meaning that the MFCU must prove that the defendant knew what they were doing was wrong, and that their end goal was to defraud the state's Medicaid plan. This higher standard of intent requires more substantial, and a greater degree of evidence compared to general intent crimes.

vi. Medicaid Policy: Medicaid policy governs what Medicaid providers should and should not do, and as a result plays a large role in the MFCU's investigations. When Medicaid's policy is

weak, unclear, or contradictory, it is very difficult to prove that a defendant intentionally did things improperly (specific intent), and not just by mistake. When the MFCU identifies a weakness or problem in Medicaid's policy, the Unit makes a policy recommendation to Medicaid to fix said weakness.

vii. MFCU Resources: The MFCU's resources are limited as the MFCU is only a staff of 20, which includes all levels of professionals and support staff. As a result, every referral receives a preliminary investigation, but not every referral can be opened as a full investigation. Currently Health and Human Services/Office of the Inspector General views ten cases per investigator as the benchmark of what makes a successful MFCU. All Nevada Attorney General's Office (NV AGO) MFCU investigators have at least ten matters assigned at all times, and some have significantly more than ten matters assigned to them for investigation. The NV AGO MFCU has less than half of the national average number of staff: 20 staff members versus the national average of 43 staff members.

viii. Referral Source: The MFCU receives referrals from a wide variety of sources, including the Nevada Health Authority, which includes Medicaid; Managed Care Organization (MCOs); other government agencies; Medicaid recipients; and the general public. The MFCU gives great weight to referrals submitted by Medicaid recipients, as these cases already have a built-in witness or victim willing to cooperate. The MFCU also gives great weight to referrals received by the MCOs. Since Nevada has changed to a Managed Care Model State, MCOs now oversee the vast majority of Medicaid services provided in Nevada. Due to this change, MCOs should provide the majority of the referrals that the MFCU receives because MCOs are now handling a majority of the Medicaid funds and recipient coverage in Nevada. As a result, the MFCU prioritizes MCO referrals in an effort to build stronger relationships with the MCOs and encourage the MCOs to make more referrals. The MFCU also gives a high priority status to referrals received from Medicaid. The MFCU has spent years developing a solid relationship with Medicaid, and as a result the MFCU recognizes the good work performed by Medicaid's Surveillance and Utilization Review (SUR) unit. The MFCU strives to accept as many referrals as it can from Medicaid and prosecute the most egregious providers that operate within the Medicaid system.

ix. Referral Quality: All referrals received by the MFCU undergo a preliminary investigation. During the preliminary investigation, the MFCU verifies that the providers in question are Medicaid providers, conducts a claims review to determine if there is loss exposure based on the initial allegation received, and reviews the allegations against Medicaid policy to determine if wrongdoing was actually committed or wrongdoing can be shown in Medicaid policy or code definition. Sometimes referrals are received that do not involve Medicaid providers (MFCU routinely gets referrals involving Medicare fraud, not Medicaid fraud, a common misconception), do not have enough information to conduct an investigation, do not contain allegations that constitute violations of law or Medicaid policy, come from anonymous sources that makes following up to obtain specific information on the allegations difficult or impossible, or contain blatantly false information that the MFCU historically has viewed as some providers wanting to eliminate competition by submitting a referral to the MFCU. These referrals are not generally opened for a full criminal investigation by the MFCU but will still go through a preliminary investigation.

x. Frequency/Severity: The MFCU tracks the referrals that it receives, and every time a new referral comes in the MFCU's intake team checks to see if the unit has received any previous referrals on the subjects involved. If the MFCU has received multiple referrals on a provider, the MFCU gives greater weight to that referral. Additionally, Medicaid or the HHS/OIG will occasionally identify a specific provider type or procedure code where there is a substantial amount of fraudulent activity. The MFCU then gives greater weight to those referrals that fall under that provider type or procedure code.

It should also be noted that if the MFCU cannot open a referral for full criminal investigation, 99 percent of the time the MFCU refers matters to other agencies that may have other authorities to address the allegations. For example, the MFCU may refer matters to Medicaid's Surveillance and Utilization Review (SUR) unit so that Medicaid can administratively investigate, recoup monies, or suspend/terminate the provider if appropriate.

The quality of Nevada's MFCU investigations and prosecutions is reflected in its success in fraud convictions. For Federal Fiscal Year 2025, NV AGO's MFCU obtained more than twice the national average of fraud convictions: 35 to 16 for the national average. Medicaid Fraud Control Units Annual Report: Fiscal Year 2025).

- *By fiscal year, how many referrals of Medicaid fraud have come from Medicaid Managed Care Organizations?*

The following reflects MCO referrals only:

i. FY 2019: 18
ii. FY 2020: 15
iii. FY 2021: 27
iv. FY 2022: 34
v. FY 2023: 19
vi. FY 2024: 30
vii. FY 2025: 39

- *Why were approximately 60 percent of referrals not accepted during this period? Of the referrals that were not accepted, how many were declined because of insufficient evidence, jurisdictional limitations, resource constraints, or other reasons?*

As discussed above, all referrals are accepted for preliminary investigation. The quality of referrals is a critical consideration in whether the MFCU can open a full criminal investigation.

Since December 2020 when MFCU began tracking specific declination data, more than 44 percent of referrals were accepted for full criminal investigation. It should be noted that acceptance of more than 40 percent of referrals from Medicaid (which does not include acceptance of MCO referrals) is actually twice the acceptance rate as identified by Health and Human Services/Office of the Inspector General as the national average (see: Medicaid Fraud Control Units Annual Report: Fiscal Year 2025).

Of the referrals that did not result in a full criminal investigation, more than half were not opened due to evidentiary issues, lack of Medicaid exposure, or the referral did not allege criminal fraud. The remainder were not opened due to resource constraints–as discussed above, MFCU investigators are already operating with a full or excessive caseload.

The MFCU has worked for over ten years with Medicaid and the MCOs to improve the quality of referrals to ensure referrals include sufficient evidence and allegations of criminal fraud. This work is done through monthly meetings, quarterly meetings, in person trainings, and MFCU consult calls, during which MFCU management makes themselves available to Medicaid and the MCOs to discuss possible referrals, evidence seen in possible referrals, or the strength of possible referrals.

One particular issue the MFCU has sought to address to improve the quality of referrals is the documentation of provider education. As discussed

above, the MFCU must have evidence of specific intent to prosecute a provider for fraud. One way to demonstrate knowledge and intent is to prove that Medicaid or the MCO instructed a provider on what conduct is proper and within policy, and the provider ignored policy and continued the improper conduct. If Medicaid or an MCO send a Credible Allegation of Fraud to the MFCU with an education letter, this bolsters the evidence against the provider. But the prior education is only as useful as the amount of detail provided by Medicaid or the MCO in the education letter and whether Medicaid and the MCOs obtained the provider's acknowledgement and understanding of the conduct. For example, there are some matters in which the MFCU itself will do a provider education if an investigation does not result in criminal charges or a civil recovery, but the MFCU wants to put the provider on notice of possible Medicaid policy issues. In those MFCU provider educations, the MFCU will provide copies of the applicable sections of the Medicaid Services Manual (MSM) and then obtain a signed and sometimes notarized statement from the provider that they have received this information. The MFCU has conducted outreach trainings with Medicaid and MCOs, to ensure they understand how to appropriately document provider education and a provider's acknowledgement so criminal cases can successfully move forward.

The MFCU started tracking the reasons they declined and/or did not accept referrals beginning in or around December 2020. As a result, the data for fiscal years 2019 and 2020, and some of the data for fiscal year 2021 is not included in the chart below:

Referrals Received from Medicaid Only		
Description	**#**	**% of Total**
Opened	106	44.35
Declined due to insufficient resources	62	25.49
Declined due to witness/evidentiary issues	11	4.6
Declined because allegations involved non-criminal administrative issues more appropriately handled by another agency	48	20.08
Declined due to lack of Medicaid exposure	4	1.67
Declined due to insufficient Medicaid policy	8	3.34
Total	239	N/A

- *Has your office established any benchmarks or performance goals regarding referral acceptance rates?*

The MFCU will accept as many referrals as the unit can legally and effectively work to combat provider fraud impacting Nevada Medicaid, (hereinafter Medicaid). The MFCU does not have, nor would it be appropriate or ethical for it to have, specific benchmarks, performance goals, or quotas related to criminal investigation acceptance rates. It should also be noted that the requirement of benchmarks or performance goals is not required by the MFCU's federal grant, rather, a Unit's effectiveness is tracked and measured through other Performance Standards found in 42 CFR 1007.

2. Reported Medicaid Fraud Recoveries

- *The Nevada Health Authority stated that it could not verify your office's public statement that more than $40.9 million has been recovered through Medicaid fraud restitution and indicated that these questions are best answered by the Attorney General's Office. Please provide the following information regarding the reported $40.9 million in recoveries:*

The AGO has repeatedly clarified that the $40.9 million dollar figure represents restitution judgments ordered by courts as a result of Nevada Attorney General's Office MFCU criminal and civil actions.

a. *How much represents funds that have actually been collected from defendants?*

b. *How much represents judgments, restitution orders, or settlements that have been awarded but remain outstanding?*

For questions 2a and 2b, below are the amounts ordered and remaining balance outstanding for all MFCU matters (criminal and civil) that were resolved from the start of SFY2019. The information is broken down into matters that the MFCU is still collecting the balance due as well as those matters that have already been turned over to the State Controller's Office (SCO) for collection efforts.

Judgments, Restitutions, and Settlements Monies Outstanding (SFY 2019—2026)			
	ALL	SCO	MFCU
Total Ordered:	$39,025,770.12	$11,726,468.80	$27,299,301.32
Total Outstanding:	$31,639,474.07	$11,530,762.33	$20,108,711.74

c. How much has been transmitted to Medicaid?

For State Fiscal Years (SFY) 2019 to current, the Office of the Attorney General has transferred $8,235,164.83 to Medicaid.

SFY	Amount
2019	1,579,401.76
2020	602,446.85
2021	1,214,223.55
2022	3,432,467.41
2023	909,338.02
2024	152,375.41
2025	331,413.93
2026	13,497.90
Grand Total	**8,235,164.83**

Data in the above chart is based on a document cross-reference between both AGO & Medicaid from the state's accounting system (DAWN).

d. How much has been remitted to the federal government?

The AGO does not have this information for restitution payments—Medicaid is the agency that would have the amount of monies remitted to the federal government. The MFCU/AGO only provides the information and direction to Medicaid to remit those funds to the federal government. The AGO cannot speak to what Medicaid has or has not remitted to the federal government.

e. How much has been retained by the State of Nevada?

Totals retained by the AGO from SFY 2019 to present total $4,078,531.46.

SFY	Amount
2019	762,139.39
2020	203,185.98
2021	278,010.27
2022	1,442,957.30
2023	275,050.92
2024	122,093.14
2025	421,339.38
2026	573,755.08
Grand Total	**4,078,531.46**

Data in the above chart is based on recorded revenue to MFCU/AGO account from DAWN.

The AGO cannot provide any information about the amount of monies retained by other Nevada agencies. Because of this, the AGO does not have data to provide statewide accounting of all retained funds.

f. How much remains uncollected as of the date of your response?

See the chart previously provided answering 2a and 2b.

3. Financial Reporting and Coordination

- *The Nevada Health Authority explained that it only receives the journal vouchers submitted by your office and does not have sufficient information to verify the total recoveries your office has publicly reported.*

This statement is incorrect. With every restitution transfer of funds, The Nevada Health Authority receives a Payment Distribution Memo with detailed information as discussed below, in addition to the transfer journal voucher document.

- *What process does your office use to track Medicaid fraud recoveries from the time restitution or a judgment is awarded until the funds are ultimately distributed?*

Currently the process of tracking payments is as follows:

i. Payment is received by the MFCU, and a receipt is provided to the payor.
ii. The MFCU reviews judgment of convictions, settlement, court orders, when obtaining payment from a Defendant and determining payor source. If applicable for non-restitution payments, the MFCU will calculate the Federal Medical Assistance Percentage / State Medical Assistance Percentage (FMAP/SMAP) split to determine how much of the payment should be received by Medicaid, the federal government, MCOs, and/or the MFCU for enforcement costs in accordance with NRS 228.410(5) and NRS 422.580(1)(c) as portion of the MFCU's budget is partially self-funded by enforcement costs. For all Medicaid restitution payments, the MFCU does not perform any FMAP/SMAP calculations, as those split calculations are to be performed by Medicaid.
iii. A Payment Distribution Memo (PDM) is created documenting these calculations and where the payments should be transferred. Supporting documentation is attached to the PDM. All PDMs are first reviewed and approved by the MFCU's Deputy Chief Investigator or their designee, who ensures that the FMAP/SMAP percentages are correctly calculated. The FMAP/SMAP percentage changes every October at the start of the new Federal Fiscal Year. The MFCU receives that split information from the MFCU's parent organization, the National Association of Medicaid Fraud Control Units (NAMFCU). Again, it is important to note for all Medicaid restitution payments, the MFCU does not do any FMAP/SMAP calculations for funds transferred to Medicaid, as those split calculations are left to Medicaid to determine.
iv. The PDM, supporting documentation, and payment itself are sent to the Attorney General's Fiscal unit for processing.
v. The MFCU's Financial Workbook with Payment file is updated with the payment information to include date, amount, case number, payment type, payor, payment method, etc. This spreadsheet allows the MFCU to track payments, payment history, and outstanding amount for each matter.

vi. ProLaw, the Attorney General's Office case management system, is updated with the necessary payment information.

vii. If a defendant fails to pay, the MFCU's collection process is initiated. The MFCU first reaches out to the defendants to attempt payment arrangements. This contact is conducted by sending two demand letters demanding payment of outstanding balances due. If these attempts are unsuccessful, the Defendant's account is sent to the Nevada State Controller's Office for formal debt collection efforts.

- *Why does Medicaid not have access to information necessary to verify the total recoveries publicly reported by your office?*

This is a recent request by Medicaid to access information it has historically not requested to conduct its mission. For amounts authorized for Nevada Health Authority transfers, total amounts recovered for the applicable transaction have previously been included on all of the distribution memos included with the transfer documents. Medicaid is now requesting additional information that potentially impacts payments that do not include Nevada Health Authority funds. The AGO is actively working with Nevada Health Authority to determine parameters for compliance with their requirements and will adjust internal policy as needed to accommodate these changes.

The AGO values transparency with other agencies and protecting the confidentiality of sensitive financial information, such as bank account information. Due to a previous issue in which a Medicaid employee may have inappropriately altered the amount of a legally authorized transfer, it is important to the NV AGO to maintain integrity of its confidential financial information. The NV AGO understands that Nevada Health Authority is working to return the unauthorized payments to the NV AGO.

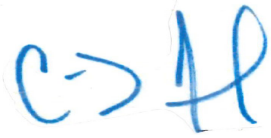
- *Are there any changes to reporting or interagency coordination that your office believes would improve transparency regarding Medicaid fraud recoveries?*

The MFCU and Medicaid are currently in discussions regarding the recovery process, documentation used in the payment process, and establishing a Memorandum of Understanding (MOU) between the agencies to address the payment and recovery process. The MOU will also cover certain case information that needs to be protected due to possible court seals in place. The AGO/MFCU is currently waiting on Medicaid to provide more specific information on the legal basis for their request, what their alleged

needs are in the recovery process, and what information allegedly they require to be included as a backup to the payment received and processed.

Please don't hesitate to reach out to my Office with any further questions or to discuss how we can jointly work to improve Nevada's Medicaid program to prevent fraud, protect taxpayer dollars, and ensure access to this vital program for the Nevadans who need it most.

Respectfully,



Aaron D. Ford
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