DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

ANNUAL REPORT
State Medicaid Fraud Control Units

Fiscal Years 1997, 1998 and 1999
(October 1, 1996 - September 30, 1997)
(October 1, 1997 - September 30, 1998)
(October 1, 1998 - September 30, 1999)

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June 2000

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INTRODUCTION

This is the tenth Office of Inspector General (OIG) Annual Report on the performance of the State Medicaid Fraud Control Units. This report includes Federal Fiscal Years 1997, 1998 and 1999, and covers a period spanning from October 1, 1996 through September 30, 1999.

In Fiscal Year (FY) 1997, FY 1998 and FY 1999, 47 States participated in the Medicaid fraud control grant program through their established Medicaid Fraud Control Units (Units). The Units' mission is to investigate and prosecute Medicaid provider fraud and patient abuse. Forty-one Units were located within the Office of State Attorney General. The remaining six Units were located in various other State agencies. The Units' authority to investigate and prosecute cases involving Medicaid provider fraud varies from State to State. Each Unit operates within the framework of its respective State laws and prosecutorial guidelines.

At the inception of the program in FY 1978, a total of $9.1 million in Federal grant funds were awarded to the 17 Units established at that time. By the end of FY 1999, the program had granted over $89 million in Federal funds, with a cumulative total of just over $1 billion in Federal grant funds awarded to the Units from FY 1978 through FY 1999.

At the close of calendar year 1999, the District of Columbia (D.C.) submitted an application for a Federally funded Medicaid Fraud Unit to the Secretary of the Department of Health and Human Services (DHHS). The application was approved and the D.C. Unit is now operational.

STATE MEDICAID FRAUD CONTROL UNITS
ANNUAL REPORT FOR FISCAL YEARS 1997/1998/1999

Background

Medicaid, the Federal/State program under Title XIX of the Social Security Act, is the result of legislation enacted in 1965 which provided for State administered and Federally monitored financing of medical services for individuals in need. Each State provides Medicaid benefits to persons who cannot otherwise afford health care services and whose incomes are above the maximum allowable under the State's public assistance program. Each State is allowed to set use and dollar limitations on the amount, duration and scope of Medicaid coverage. As a result, each State has considerable flexibility in establishing the nature and extent of health care services available to Medicaid recipients, even services beyond those required by the Health Care Financing Administration (HCFA).

By 1977, the Medicaid program had expanded significantly, costing Federal and State Governments $19 billion a year. Estimates also showed that fraud and abuse caused the Medicaid program to lose at least $653 million a year. Among the types of health care providers committing Medicaid fraud were nursing homes, hospitals, dentists, physicians, podiatrists, pharmacists, durable medical equipment suppliers, laboratories and medical transportation companies. Concerned by the increase of suspected fraud and abuse against both Medicare and Medicaid, Congress passed legislation to stem the rising tide of criminal activity against the two largest Federal health care programs. On October 25, 1977, the President signed into law the Medicare/Medicaid Anti-Fraud and Abuse Amendments. As cited in Public Law (Pub. Law) 95-142, the key objectives of the amendments were ". . .to strengthen the capability of the Government to detect, prosecute, and punish fraudulent activities under the Medicare and Medicaid programs ...". In addition, section 17 of the amendments provided 90 percent of the Federal funding needed for a 3-year period to States that establish Medicaid fraud and abuse control units that met certain standards. Initially, the HCFA had responsibility for administering the Medicaid fraud control grant program for the former Department of Health, Education and Welfare (DHEW), and for providing Federal oversight and guidance to the Units.

In order to promote and fulfill the long term goals of Pub. Law 95-142, permanent Federal funding of the Units beyond the initial 3-year period was enacted into law as part of the Omnibus Reconciliation Act of 1980, Pub. Law 96-499. This law made Federal grant funds available at a rate of 90 percent for the first 3 years of a Unit's operation and 75 percent thereafter.

The cumulative loss resulting from fraud and abuse against Medicare and Medicaid posed a significant threat to the integrity and stability of both programs. The enactment of the Medicare/Medicaid Anti-Fraud and Abuse Amendments represented one of the most significant and comprehensive steps taken by the Federal Government to thwart fraud and abuse in Federal health care programs.

Oversight of the Units

In 1976, the Office of Inspector General within DHEW was established. "An independent and objective unit," the OIG's mission was: "(1) to conduct and supervise audits and investigations relating to programs and operations of the Department of Health, Education, and Welfare; (2) to provide leadership and coordination and recommend policies for activities designed (A) to promote economy and efficiency in the administration of, and (B) to prevent and detect fraud and abuse in, such programs and operations; and (3) to provide a means for keeping the Secretary and the Congress fully and currently informed about problems and deficiencies relating to the administration of such programs and operations and the necessity for and progress of corrective action."

Since the HCFA had responsibility for administering the Federal Medicaid fraud control grant program, their major tasks included monitoring and overseeing the overall activities of the Units as well as annually certifying them to receive Federal grant funding.

However, it was later deemed that the functions and activities of the Units were more closely related to the OIG's investigative function. In 1979, Federal oversight and administration of the Units were transferred from the HCFA to the OIG. The Secretary of the Department of Health and Human Services, formerly DHEW, delegated certification authority for each Unit to the Inspector General.

In accordance with section 1902 (a)(61) of the Social Security Act, and the authority delegated to the Inspector General, 12 standards for assessing the Units performance were developed and made effective on September 26, 1994. The OIG uses these 12 Performance Standards as guidelines to assess the effectiveness and efficiency of the Units and to determine whether the Units are carrying out their duties and responsibilities as required by current Federal regulations. (Appendix A)

Currently, within the OIG, Office of Investigations, the State Medicaid Oversight and Policy Staff (SMOPS) has primary responsibility to oversee the activities of the 48 Units now in operation.

Certification / Recertification

Each State interested in establishing a Unit must submit an initial application for certification to the Secretary of DHHS. When establishing a Unit, a State must also meet several major

requirements to attain both Federal certification and grant funding for the proposed Unit. Among these major requirements, the Unit must be a single, identifiable entity of the State government composed of (i) one or more attorneys experienced in investigating or prosecuting criminal cases or civil fraud who are capable of giving informed advice on applicable law and procedures and providing effective prosecution or liaison with other prosecutors; (ii) one or more experienced auditors capable of supervising the review of financial records and advising or assisting in the investigation of alleged fraud; and (iii) a senior investigator with substantial experience in commercial or financial investigations who is capable of supervising and directing the investigative activities of the Unit. The Secretary of DHHS will notify the State whether their application meets the Federal requirements for initial certification and if it is approved. Initial application approval and certification by the Secretary is valid for only a one year period.

For an established Unit to continue receiving Federal certification and grant funding from DHHS, the Unit must submit an annual reapplication to the OIG, SMOPS, at least 60 days prior to the end of its current 12-month certification period. In considering a Unit's eligibility for recertification, the SMOPS thoroughly reviews the reapplication documentation submitted. The SMOPS assesses whether the Unit seeking recertification has fully complied with the 12 Performance Standards, and whether the Unit utilized its Federal resources effectively in detecting, investigating and prosecuting Medicaid fraud and patient abuse cases. If applicable, the SMOPS would also evaluate the results of any on-site Unit reviews conducted during the preceding 12 months. Once reviewed and assessed, the SMOPS notifies the Unit in writing if their application for recertification is approved.

Exclusion Authority

In order to encourage the States to refer civil fraud cases involving Medicare and Medicaid to DHHS, the Congress adopted the Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. Law 100-93, that effectively increased the share a State could collect when civil fines are assessed in a case.

This legislation was the result of a 1984 Government Accounting Office report that concluded that several gaps existed in the exclusion authority of DHHS. Pub. Law 100-93 expanded the authority of the Secretary of DHHS to exclude unfit, unscrupulous or abusive health care practitioners from participating in a variety of Government health care programs. The legislation required the Secretary of DHHS to exclude those individuals or entities convicted of program-related crimes or patient abuse or neglect. It also expanded the Secretary's discretionary authority to exclude those individuals or entities convicted of a Federal or State crime relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or financial abuse, if the offenses were committed in connection with a Government health care program. In addition, Pub. Law 100-93 gave the Secretary of DHHS the author-

ity to exclude those persons or entities convicted of interfering with a health care fraud investigation, or whose license to provide health care was suspended or revoked, or who failed to provide access to available records to both Federal and State agencies when performing their lawful or statutory functions.

In FY 1997, the OIG excluded a total of 2,719 persons and/or entities from participation in Medicare, Medicaid and other Federally sponsored health care programs. Of this number, 421 were based on referrals made to the OIG by the Units. During FY 1998, a total of 3,021 persons and/or entities were excluded from participation by the OIG. In this period, the number of referrals received from the Units totaled 489. In FY 1999, the OIG obtained a total of 2,976 exclusions. The number of credited referrals made to the OIG by the Units in FY 1999 totaled 679.

Civil Remedies

The Civil Monetary Penalties Law (CMPL) of 1981 authorizes the Secretary of DHHS to impose administrative monetary penalties and assessments on persons who make false or improper claims for payments under the Medicare, Medicaid, Maternal and Child Health Services Block Grant and Block Grants to States for Social Services programs.

Under CMPL, the OIG has the authority to impose a civil monetary penalty of up to $10,000 per improper item or service claimed, to impose an assessment of up to three times that amount and to exclude persons from participation in the Medicare and Medicaid programs.

More recently, some Units have increased the use of their State's civil statutes in prosecuting civil cases involving Medicaid providers. Issues arise, however, when States and their respective Units reach settlement agreements with these providers without adequately or appropriately coordinating their efforts with DHHS or other affected Federal agencies. Such agreements, when reached without the involvement and/or concurrence of either the OIG or other concerned Federal authorities, move to circumvent the purposes for which the Federal CMPL was enacted with regards to civil prosecutions involving the Medicare and Medicaid programs.

To further address this matter, the OIG issued Policy Transmittal No. 99-01. This transmittal specifically outlines the OIG's policy regarding civil case prosecutions when the Units are involved. (Appendix C)

Surveillance and Utilization Review Sub-system (SURS)

The State Medicaid agencies, with a few exceptions, are required to maintain a Medicaid Management Information System (MMIS). A vital part of the MMIS is the Surveillance and Utilization Review Sub-system (SURS). The SURS has two primary purposes: (1) to process

information on medical and health care services to guide Medicaid program managers and (2) to identify the providers (and recipients) most likely to commit fraud against the Medicaid program. In addition, by Federal regulation, the single State Medicaid agencies are required to enter into a Memorandum of Understanding (MOU) with their respective State Unit. The purpose for developing and implementing a MOU is to: (1) facilitate a mutual agreement by which the Medicaid agency would refer all suspected cases or incidences of provider fraud to the Unit and (2) to affirm that all such requests made by the Unit to the Medicaid agency for needed provider records and/or computerized information maintained by the Medicaid agency will be adequately furnished to the Unit.

When providers with aberrant patterns or practices are identified by the State Medicaid agency, and more specifically the SURS, that information should then be made available to the Unit. Many Units rely on referrals received from the SURS in generating the majority of their case investigations. This process is aided immensely when an effective MOU is in place between a Unit and the single State Medicaid agency. Thus, the relationship between the Unit and the SURS is a critical one. In most States, the cooperation between the two offices usually leads to a more efficient process of identifying and prosecuting fraud in the Medicaid program. The OIG encourages the Units and the SURS to continue their ongoing dialogue, including holding regularly scheduled meetings to discuss the Units' progress in investigating cases referred to them by the SURS.

Grant Expenditures

In FY 1997, DHHS awarded the Units over $80 million in Federal grant funds. At the end of the period, the Units personnel totaled 1,290, and of this number 933 represented professional staff (i.e., attorneys, auditors and investigators). In FY 1998, the Units received grant awards exceeding $85 million. The Units' work force in FY 1998 totaled 1,306 personnel nationwide. The number of professional staff employed by the Units at the end of FY 1998 was unchanged from the previous fiscal year. (Appendix B)

In FY 1999, the Units received grant awards from DHHS totaling approximately $90 million. The total number of personnel employed by the Units at the end of FY 1999 was 1,339. In FY 1999, the number of professional staff employed remained consistent with the number reported for FY 1998. (Appendix B)

Statistical Accomplishments

Collectively, in FY 1997, the Units recovered over $147 million in court ordered restitution, fines and penalties. In this same period, a total of 871 convictions were achieved. In FY 1998, the Units recovered over $83 million and obtained a total of 937 convictions. For FY 1999, just over $88 million was recovered by the Units. The total number of convictions achieved for the period was 886. (Appendix B)

National Health Care Fraud And Abuse Control Program

Federal efforts to combat health care fraud and abuse were consolidated and strengthened by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HIPAA established a National Health Care Fraud and Abuse Control Program (Program) under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services, acting through the Department's Office of Inspector General. The Program was designed to coordinate Federal, State and local law enforcement activities with respect to health care fraud and abuse.

In FY 1999, Federal prosecutors filed 371 criminal indictments in health care cases, a 16 percent increase over 1998. A total of 396 defendants were convicted for health care fraud-related crimes.

In FY 1999, the Federal Government won or negotiated more than $524 million in judgments, settlements and administrative impositions in health care fraud cases and proceedings. As a result of these activities and prior year judgments, settlements and administrative impositions, the Federal Government collected $490 million in 1999. Nearly $369 million of the funds collected and disbursed in 1999 were returned to the Medicare Trust Fund. An additional $4.7 million was recovered as the Federal share of Medicaid restitution. In addition, in FY 1999, 2,976 individuals and entities were excluded from participating in Medicare, Medicaid and other Federally sponsored health care programs.

The Program continues to maximize the effectiveness and efficiency of law enforcement efforts by promoting information sharing and collaboration among Federal, State and local agencies. Such collaborations increased in FY 1999, through heightened data sharing, joint training and establishment of a National Health Care Fraud Task Force chaired by the Deputy Attorney General. In addition to the many joint health care investigations undertaken, collaborative efforts also produced effective new beneficiary outreach programs and fraud prevention efforts.

Healthcare Integrity Protection Data Bank (HIPDB)

The HIPAA called for the establishment of a national healthcare fraud and abuse data collection program for the reporting of certain final adverse actions against health care providers, suppliers and practitioners. On October 1, 1999, all Federal and State agencies and health plans began reporting certain final adverse actions taken against healthcare practitioners, providers and suppliers to the new Healthcare Integrity and Protection Data Bank (HIPDB).

The HIPDB provides a resource to assist Federal and State agencies and health plans in checking the qualifications of the health care practitioner, provider or supplier with whom they seek to contract, affiliate, hire, license or credential.

The following health care-related adverse actions must be reported to the HIPDB:

1) Civil judgments against healthcare practitioners, providers and suppliers in Federal or State courts, related to the delivery of healthcare items or services;

2) Federal and State criminal convictions against healthcare practitioners, providers or suppliers, related to the delivery of healthcare items or services;

3) Actions taken by Federal or State agencies responsible for licensing and certification of healthcare practitioners, providers and suppliers;

4) Exclusions of healthcare practitioners, providers and suppliers from participation in Federal or State healthcare programs; and

5) Any other adjudicated actions or decisions as established by regulation.

Any non-Federal health plan that fails to report the required adverse actions is subject to a civil monetary penalty of up to $25,000 for each action not reported.

Beginning in January 2000, health plans and Federal and State governmental agencies will be able to request the disclosure of information from the HIPDB for a query fee of $4.00 per name. The HIPDB information will not be available to the general public; however, a healthcare practitioner, provider or supplier may request the disclosure of their own information for a fee.

The Division of Quality Assurance, Bureau of Health Professions, Health Resources and Services Administration of the U.S. Department of Health and Human Services will manage the HIPDB.

Expanded Authority - Public Law 106-170

On December 16, 1999, the President signed into law section 407 of The Ticket to Work and Work Incentives Improvement Act of 1999, Pub. Law 106-170, which expands the jurisdiction of the Units in two ways. First, the new law allows the Units, with the approval of the OIG, to investigate fraud in the Federal Medicare program in limited situations where the case is "primarily related to Medicaid." This will allow the Units, in appropriate cases, to investigate and prosecute Medicare fraud when it may not be efficient or practical for the OIG or other Federal agencies to investigate. Secondly, the law allows the Units to investigate and prosecute patient abuse or neglect in non-Medicaid "board and care" facilities, thus fulfilling an important need of this vulnerable population.

Award Recognition

Each year, the OIG selects at least one Unit to receive the Inspector General's State Fraud Award. One major criteria includes a Unit's demonstrated ability to effectively combat fraud and abuse committed against the State's Medicaid program.

For FY 1997, the Tennessee Medicaid Fraud Control Unit was chosen to receive the Inspector General's State Fraud Award. During the period, the Tennessee Unit obtained a total of 21 convictions and recovered over $4 million. In FY 1997, just over $1 million in Federal grant funding was awarded to the Unit to support its activities. Among the Tennessee Unit's many successes in FY 1997 was its high payback ratio that yielded a net gain to the Medicaid program of just under $3 million.

The Georgia Medicaid Fraud Control Unit was the recipient of the State Fraud Award for FY 1998. Because of the cooperation and collaborative efforts exhibited by both the Unit and its State partners, e.g., the Georgia Bureau of Investigation (GBI), the State Auditor's Office and the Attorney General's Office, the Georgia Unit was recognized by the OIG for its diligence in combating fraud and abuse that occurred in the State's Medicaid program during fiscal year 1998.

Although the Georgia Unit had only received its initial Federal certification as an established Unit in early 1995, in FY 1998, the Georgia Unit along with its State partners were successful in obtaining a total of 36 convictions and recovering approximately $3.4 million in court ordered fines and restitution. The number of convictions achieved by the Unit in FY 1998 placed it statistically in the top ten among the then 47 established Units in the total number of convictions accomplished for the period.

Award Recipients

Above (center), Mr. William Benson, Director, Tennessee Medicaid Fraud Control Unit receives the 1997 Inspector General's State Fraud Award from Inspector General June Gibbs Brown. Standing to the right of Mr. Benson is Mr. John E. Hartwig, Deputy Inspector General for Investigations.

Above (top row), a delegation from the State of Georgia accepts the 1998 State Fraud Award. Leading the delegation (center) is Georgia's Attorney General Thurbert E. Baker. Mr. Baker was accompanied by the Unit's Director, Mr. Charles M. Richards (top left) and GBI Special Agent in Charge J. Steven Edwards (top right). The 1998 award was presented to the Georgia delegation by Mr. Michael F. Mangano, Principal Deputy Inspector General (bottom row left). Standing to the left of Mr. Mangano is Mr. Hartwig.

CASE NARRATIVES

Billing Company

An owner of an Ohio billing company pled guilty to Medicaid fraud and was sentenced to 18 months imprisonment (suspended) and 60 months probation. The owner sold provider numbers to individuals who then billed Medicaid for services that, in some cases, were not reimbursable. In addition, the defendant was ordered to pay $37,455.84 in restitution and $6,000 in investigative costs incurred by the State. **(FY 1998)**

A Federal jury returned a total of 48 guilty verdicts against a Delaware billing company's owner and his father for Medicare and Medicaid fraud. The billing company along with a Delaware ambulance service were convicted of conspiracy to defraud the two programs of more than $225,000. Claims were submitted by the billing company for emergency ambulance services provided to individual patients, when, in fact, the patients were transported in groups by vans for routine dialysis treatment. **(FY 1999)**

Dentists

In Florida, a dentist agreed to pay the State $21,000 for over billing dental services provided. From January 1993 through October 1995, the dentist treated children who were eligible for Medicaid. In numerous instances, such as extractions, the dentist up coded and billed Medicaid for a higher paying service than was actually provided or allowed. As part of the settlement, the dentist also agreed to pay $4,000 in investigative costs incurred by the State Medicaid Fraud Control Unit. **(FY 1997)**

Following a two-year investigation, a dentist in Alaska was convicted of overcharging the Medicaid program and five private insurers. The dentist falsified dates of service, characterized restoration procedures as emergencies and misstated the amounts and types of services provided. The dentist was sentenced to 6 months imprisonment, 4 years probation, 330 hours of community service and ordered to pay $5,335 in restitution to the State's Medicaid program. **(FY 1998)**

Two Michigan dentists and a professional dental corporation were charged with multiple counts for defrauding the Medicaid program of an estimated $100,000. The dentists provided dental services to Medicaid patients at a Detroit dental clinic and fraudulently billed the Medicaid program for services not provided. **(FY 1999)**

Drug Diversion

A New York man was sentenced for his role in a "Black Market Drug Ring" that stole millions of dollars worth of cancer drugs from local hospitals. The man obtained the drugs from his wife, who stole the drugs while working as a pharmacy buyer. In addition, a former

pharmacist and a former director of a health science center pled guilty in connection with the scheme. The principal defendant pled guilty to criminal diversion of prescription medication. His guilty plea included failure to pay New York State income tax on stolen money and filing a false return. The defendant was required to make restitution in the amount of $200,000. His wife was also convicted for her part in the scheme. **(FY 1998)**

Durable Medical Equipment (DME)

A DME supplier in Kansas, who falsely stated that he operated out of the State of Kansas when actually his headquarters was in Florida, was sentenced to 10 years imprisonment and ordered to pay $4.1 million in restitution. The defendant's business sold DME products to nursing homes, including wound care kits, incontinence care kits, ostomy kits and "pouches" (adult undergarments). Investigation revealed that fraudulent billings were sent to Medicare and Medicaid and several private insurers for the undergarments using an incorrect procedure code. This improper up coding allowed the defendant's company to bill for each "pouch" at a rate of $8.44 when the actual costs ranged from $0.30 to $0.40. Between 1993 and 1994, claims were made to the various programs in excess of $45 million. The DME supplier was convicted in Kansas. He must also forfeit $32 million to the State of Florida. **(FY 1998)**

In Florida, eight residents were arrested for their involvement in a lucrative money laundering scheme. The investigation uncovered a network of DME suppliers and individuals who collaborated to defraud the Medicaid program. Through fraudulent claims generated by various Medicaid providers and DME companies, the eight individuals were successful in laundering more than $90,000. The fraudulent claims totaled in excess of $500,000. **(FY 1998)**

Home Health Care

A Certified Nursing Assistant (CNA) in North Carolina pled guilty to provider fraud. A supervisor at the health care agency employing the CNA became suspicious when the CNA's work hours overlapped with work hours at a second agency. Documentation the CNA submitted to her employing agency showed that her intent was to receive payment from both agencies for the same hours worked. She was sentenced to 45 days (suspended) in the custody of the Sheriff's Department. She was placed on unsupervised probation for a period of 24 months and ordered to pay $3,000 in restitution to the Medicaid program. A fine of $1,000 and court costs in the amount of $125 were also assessed. **(FY 1998)**

The owner of a New Hampshire home health agency and the agency pled guilty to charges of theft and Medicaid fraud. The loss to the Medicaid program was estimated at $60,000. From October 1991 through September 1994, the home health agency owner engaged in a

multi-faceted scheme to increase medical reimbursements that included up coding, inflating hours worked by nurse employees and billing the services of clinical nursing supervisors as though they were being utilized for direct patient care. The owner was sentenced to 1 year incarceration with 9 months suspended and 3 years probation. The owner was also fined $5,000 and ordered to provide 500 hours of community service. The home health agency was fined $25,000. **(FY 1999)**

Hospitals

In Virginia, a hospital chain agreed to pay the Federal Government $800,000 to resolve its liability in a case where provisions of the Federal False Claims Act were violated. The hospitals involved were ordered to pay the Medicaid program the interest that had accrued since 1995. The hospitals reportedly submitted false claims to the Virginia Medicaid program relating to obstetrical services that resulted in overpayments. **(FY 1998)**

An Alabama hospital agreed to repay $476,947.45 to the State's Medicaid program for billing errors that occurred over a period of time at the hospital. The investigation found that certain billing practices administered by the hospital were not in accordance with Medicaid regulations. The investigation also discovered inaccuracies in the coding of the levels of care provided to emergency room patients. In addition, problems of duplicate billings for certain blood-work services performed were also found. The hospital also agreed to pay $150,000 to the State for investigative costs. **(FY 1999)**

Laboratories

The president of a now defunct New York medical laboratory was sentenced to 1 to 3 years imprisonment and ordered to pay $1.2 million in restitution for billing Medicaid for services which were either not performed or only partially performed. The scheme was run through a local New York hospital, where patient laboratory records were falsified. The laboratory was responsible for performing drug abuse tests on convicts and methadone patients as well as performing routine lab screening(s) for Medicaid recipients. **(FY 1997)**

A large national laboratory headquartered in Michigan was ordered to pay $6.8 million in a multi-State Medicare-Medicaid settlement. The laboratory improperly billed both programs for numerous laboratory tests that were not ordered. The scheme involved billing for tests purportedly ordered by nursing homes, physicians' offices and health care organizations. The U.S. Attorney's Office and the Michigan Attorney General's Office assisted in the investigation and identified the false claims. The $6.8 million settlement amount was determined by examining improper billing claims made to the New York, Maryland, New Jersey, Pennsylvania and Michigan Medicare-Medicaid programs. **(FY 1998)**

Three defendants in California agreed to cooperate with the Bureau of Medi-Cal Fraud in its continuing probe of illegal blood trafficking activities in the State. The three defendants provided vials of blood to a laboratory and were paid $45.00 per vial. They also submitted fraudulent physicians' authorizations for patient orders to the laboratory involved, and the lab then billed Medi-Cal and Medicare. The laboratory's purpose was to run blood tests that provided information concerning a patient's aging process. In a one year period, the three defendants received more than $450,000 for their misdeeds. The laboratory received a combined $1.1 million from the Medi-Cal and Medicare programs. In November 1998, the laboratory discovered that the physicians never authorized any of the patient orders for blood-work. As a result, the lab agreed to cooperate with law enforcement and set aside $220,000 to settle with the two programs. **(FY 1999)**

Medical Center

A medical center in Hawaii agreed to pay the State over $1 million for over billing the Medicaid program over a 6-year period. The center also must pay $512,813 in damages and pay for investigative costs incurred by the State. Specifically, the investigation revealed that the center overcharged the Medicaid program by billing for patients' food supplements over the program's per diem rate. The center also improperly billed for patient medications at the higher hospital rates rather than at the lesser Medicaid rates. As part of the settlement, the center must also develop a compliance program to ensure that future billings comply with Medicaid laws and regulations. **(FY 1997)**

Medical Clinic

The owner of four medical clinics in California entered into a settlement agreement with the State and was sentenced to 5 years imprisonment and ordered to pay $1.3 million in restitution to the Medi-Cal program. The manager of the clinics was sentenced to 3 years probation with the following conditions: to serve 1 year in county jail; to pay $30,000 in restitution; to submit to search and seizure; and to not work in a heath care related business. The owner and manager operated the clinics in the Long Beach area and billed Medi-Cal using purchased copies of beneficiary identification cards. Clinic staff generated fraudulent patient charts for beneficiaries who never visited the clinics. Claims were then made to Medi-Cal for services that were never provided. **(FY 1998)**

The owner-operators of two California medical clinics billed for services for more patients than could have reasonably been served in a given period. These owner-operators paid drivers to bring in patients to copy their Medi-Cal cards. The clinics then subsequently billed Medi-Cal under five different provider names. As a result of their activities, the owner-operators were sentenced to 5 years probation. The terms of their probation at the time of sentencing included serving 1 year in county jail and paying $20,000 each in restitution.

They were also ordered to pay $30,000 in restitution during the term of their probation. **(FY 1999)**

Medical Transportation

In Georgia, two owners of a transportation company were charged and convicted with theft and conspiring to defraud the Medicaid program for submitting $1 million in false billings. The Georgia Department of Medical Assistance discovered the fraudulent scheme and referred the case to the Unit. The owners submitted numerous false claims to Medicaid, including billings for stretcher services that were not provided and for excessive mileage. Both owners were sentenced to 8 years imprisonment and 7 years probation. They were ordered to pay $1.3 million in restitution to the State Medicaid program and fined $20,000. **(FY 1997)**

A Connecticut man was convicted of defrauding the State's Medicaid program by over billing the program for taxi trips that he provided to Medicaid recipients. According to the criminal complaint, the individual transported Medicaid patients on one-way trips of only 17 miles and then billed the Medicaid program between $420 to $588 for the services. He repeated this pattern for all transportation services provided to the patients. He was arrested when an audit revealed that his quarterly Medicaid billing charges had increased over time from approximately $30,000 to $200,000. **(FY 1998)**

During the period January 1, 1994 through June 30, 1996, a medical transportation company in Ohio billed Medicaid for extra attendants on patient transports when in actuality, for a majority of runs, there were no extra attendants present. The owner of the company was convicted of Medicaid fraud, ordered to serve an 18 month sentence (suspended) and serve 5 years probation. He was ordered to pay $40,000 in restitution, fined an additional $2,500 and repay the State $5,000 for investigative costs. He was also ordered to perform 100 hours of community service. **(FY 1999)**

Nurse

An Oregon woman, who successfully masqueraded as a registered nurse for eight years, was sentenced to 10 days imprisonment, 5 years probation, ordered to make partial restitution of $16,240, and was banned from any employment directly or indirectly involving Medicare or Medicaid funds. The woman also was assessed a civil penalty of $1,000 imposed by the State board. A $600 penalty was issued against the facility who employed her for their failure to determine that she was not adequately qualified. **(FY 1998)**

A licensed practical nurse employed by a long term health care facility in Kansas pled guilty to obtaining a prescription-only drug by fraudulent means. The nurse telephoned in fictitious physicians' orders to a pharmacy to refill residents' prescriptions for Ultram. Two of

the residents were Medicaid recipients and Medicaid reimbursed the pharmacy $835.89 for the dispensed medication. The nurse was sentenced to 6 months in the county jail. She was ordered to repay the amount defrauded. **(FY 1999)**

Nursing Home

The owner and an administrator of a nursing home in Washington State pled guilty to attempting to submit false statements to Medicaid through fraudulent cost reports. For three years, the owner signed cost reports that contained false information. The owner also failed to acknowledge and return the Medicaid funds received during the 3 year period. The home's administrator became involved when she directed that both Medicare and Medicaid be billed. For each of the cost reports submitted, the administrator was listed as both the cost report preparer and the cost report contact person. The administrator's failure to acknowledge that unentitled Medicaid funds were being received by the facility meant that the facility illegally benefitted from program funds that it otherwise was not entitled to receive. **(FY 1998)**

An Oregon nursing home entered into an Assurance of Voluntary Compliance (AVC) with the Oregon Medicaid Fraud Control Unit. The Oregon Senior and Disabled Services Division licensed the home to provide services to residents insured by the Medicaid program, including those residing in the home's Alzheimer's Care Unit. For Medicaid recipients residing in the Alzheimer's Care Unit, Medicaid authorized a higher rate of reimbursement to the home for their care. In July 1998, a Medicaid recipient residing in the Alzheimer's Care Unit was transferred to the nursing home's general facility. However, the home continued to bill and receive payment from Medicaid for Alzheimer's care provided to that resident. As part of the AVC, the nursing home agreed to comply with all provisions of Federal, State and county law, and not to retaliate against anyone who cooperated in the investigation. They also agreed to pay restitution to Medicaid for the overpayments and to reimburse the State for investigative costs. **(FY 1999)**

Patient Abuse

A nurse's aide working in a New York nursing home was convicted and sentenced to 8-1/3 to 25 years imprisonment for raping and sexually abusing a comatose patient of the facility. Investigators became aware of the aide's criminal conduct after discovering that the aide had previously attacked a 49-year-old female patient with multiple sclerosis. On the basis of this case, the Attorney General initiated a proposal that would allow nursing homes to cross check applicants with the State's criminal background database. **(FY 1997)**

In Arizona, a Certified Nursing Assistant (CNA) was sentenced to 8 years imprisonment for assaulting three elderly female residents in an Arizona health care center. Over a three-

month period, the CNA abused 13 female patients, six of whom were named as victims in the indictment. The abuse included stuffing a feces-soiled washcloth into a patient's mouth, pulling patients up by their hair, slapping patients, spraying a liquid deodorizer in a patient's face and fracturing the hip of a 90-year-old Alzheimer's patient. When the health care center first learned of the abuses, the CNA was immediately terminated from employment and his nursing assistant license was revoked. **(FY 1997)**

A Certified Nursing Assistant (CNA) in Delaware pled guilty to physical abuse of a patient. The CNA admitted that on July 3, 1998, while working in a nursing home facility in the State, she struck a 94-year old resident in the face, leaving the victim with a black eye. The CNA was sentenced to 1 year imprisonment that was suspended in favor of probation. Probation was granted to the CNA with the condition that she not hold future employment in the health care field within the State of Delaware. **(FY 1999)**

Patient Funds

A bookkeeper employed by a Mississippi skilled nursing facility was sentenced to 1 year imprisonment for embezzlement. The investigation revealed that the bookkeeper had embezzled $4,000 in Medicaid funds that should have gone into the trust fund accounts of the patients residing at the facility. **(FY 1997)**

Pharmacy

The owner of a New York pharmacy was sentenced to 1 to 3 years imprisonment and ordered to pay $650,000 in restitution for submitting fraudulent Medicaid claims in excess of $1.4 million. Over a six year period, the owner falsified the prescription records of Medicaid recipients and submitted fraudulent claims to the State's Medicaid program. The investigation was initiated after a Medicaid beneficiary complained that her coverage was unfairly restricted due to the submissions of several questionable billings. **(FY 1997)**

Two pharmacies in Hawaii agreed to pay the State up to $1.3 million for over billing the Medicaid program. An audit revealed that the pharmacies billed for expensive name brand drugs when, in fact, cheaper generic drugs were actually dispensed. The audit found that the pharmacies over billed the program for $226,172 between 1989 and 1998. In addition to paying the amount over billed, the company agreed to pay $100,000 to reimburse the State for its investigative costs and audit expenses incurred. A total of $952,344 in other penalties was also assessed. **(FY 1998)**

In Florida, three individuals involved in a scheme to defraud the Medicaid program of over $3 million between April 1998 and April 1999 were arrested. The investigation revealed that a pharmacy was routinely purchasing prescriptions from Medicaid recipients and paying them cash in exchange for stolen merchandise. A search warrant executed at two pharma-

cies by Miami-Dade Police detectives recovered several stolen items including VCRs, mens' shirts, colognes and a variety of electronic equipment. **(FY 1999)**

Physicians

A Massachusetts physician pled guilty and was sentenced for illegally prescribing medically unnecessary controlled substances to patients. The physician was sentenced to 2 years imprisonment (with the balance suspended) and ordered to home confinement with electronic monitoring. As a condition of his probation, the physician must permanently surrender his medical licenses, undergo alcohol treatment counseling and submit to periodic drug checks. In addition, the physician was ordered to pay $75,000 in restitution to the State's Medicaid program. The Unit was assisted by the State Police Drug Division Unit, the U.S. Drug Enforcement Administration and the State Board of Registration in Medicine and Pharmacy. **(FY 1997)**

In Utah, a physician pled guilty to communications fraud and filing false claims. The investigation discovered that during the time period January 1992 through August 1994, the physician filed 900 fraudulent claims. These claims included billings for deceased persons, billings for patients transferred to other facilities, billings for patients who were not seen, billings for services while the primary physician was out of town and up coding to bill for higher services that were not performed. The physician received a suspended sentence and was ordered to pay restitution to the victims that included costs and penalties that totaled $55,167.59. The physician received 36 months probation and must also complete community service. **(FY 1999)**

Podiatrist

A podiatrist in North Carolina received a 48 month suspended sentence with supervised probation, on the condition that he perform 120 hours of community service. He was also ordered to pay $79,931 in restitution and a $120 fine. The podiatrist submitted false claims to both Medicaid and Medicare by claiming to have performed, among other services, toenail debridements on patients with amputated feet and services on deceased persons. **(FY 1997)**

Psychiatrist

In California, a psychiatrist was sentenced to 2 years imprisonment and ordered to pay $22,000 in restitution to Medi-Cal. He was also fined $1,000 and barred from engaging in future claims processing work in the area of workers' compensation. In his practice, the psychiatrist saw patients approximately ten minutes for psychotherapy, but billed Medicaid for sessions of a half hour to an hour. The psychiatrist's wife also participated in the fraud. For her involvement, she was ordered to serve 5 years probation and perform 1,000 hours of community service. **(FY 1997)**

Social Services

The former social service director of a long-term care facility was sentenced to 5 years supervised probation, ordered to make full restitution and perform 200 hours of community service for stealing over $7,200 from the facility's residents. The investigation revealed that the director submitted false documentation to Medicaid in the form of altered or fraudulent receipts for residents' purchases. In several of the instances where receipts were provided, the purchases made were inappropriate for the particular resident's needs. **(FY 1997)**

APPENDICES

APPENDIX A

PERFORMANCE STANDARDS

With the cooperation of the Units, the OIG developed twelve specific standards to be used when evaluating a Unit's performance. These twelve standards and their requirements are set forth below.

1. A Unit will be in conformance with all applicable statutes, regulations and policy directives. In meeting this standard, the Unit must meet, but is not limited to, the following requirements-

A. The Unit professional staff must consist of permanent employees working full-time on Medicaid fraud and patient abuse matters.

B. The Unit must be separate and distinct from the single State Medicaid agency.

C. The Unit must have prosecutorial authority or an approved formal procedure for referring cases to a prosecutor.

D. The Unit must submit annual reports, with appropriate certifications, on a timely basis.

E. The Unit must submit quarterly reports on a timely basis.

F. The Unit must comply with the Americans with Disabilities Act, the Equal Employment Opportunity requirements, the Drug Free Workplace requirements, Federal lobbying restrictions, and other such rules that are made conditions of the grant.

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2. A Unit should maintain staff levels in accordance with staffing allocations approved in its budget. In meeting this standard, the following performance indicators will be considered-

A. Does the Unit employ the number of staff that were included in the Unit's budget as approved by the OIG?

B. Does the Unit employ the number of attorneys, auditors, and investigators that were approved in the Unit's budget?

C. Does the Unit employ a reasonable size of professional staff in relation to the State's total Medicaid program expenditures?

D. Are the Unit office locations established on a rational basis and are such locations appropriately staffed?

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3. A Unit should establish policies and procedures for its operations, and maintain appropriate systems for case management and case tracking. In meeting this standard, the following performance indicators will be considered-

A. Does the Unit have policy and procedure manuals?

B. Is an adequate, computerized case management and tracking system in place?

4. A Unit should take steps to ensure that it maintains an adequate workload through referrals from the single State agency and other sources. In meeting this standard, the following performance indicators will be considered-

A. Does the Unit work with the single State agency to ensure adequate fraud referrals?
B. Does the Unit work with other agencies to encourage fraud referrals?
C. Does the Unit generate any of its own fraud cases?
D. Does the Unit ensure that adequate referrals of patient abuse complaints are received from all sources?

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5. A Unit's case mix, when possible, should cover all significant provider types. In meeting this standard, the following performance indicators will be considered-

A. Does the Unit seek to have a mix of cases among all types of providers in the State?
B. Does the Unit seek to have a mix of Medicaid fraud and Medicaid patient abuse cases?
C. Does the Unit seek to have a mix of cases that reflect the proportion of Medicaid expenditures for particular provider groups?
D. Are there any special Unit initiatives targeting specific provider types that affect case mix?
E. Does the Unit consider civil and administrative remedies when appropriate?

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6. A Unit should have a continuous case flow, and cases should be completed in a reasonable time. In meeting this standard, the following performance indicators will be considered-

A. Is each stage of an investigation and prosecution completed in an appropriate time frame?
B. Are supervisors approving the opening and closing of investigations?
C. Are supervisory reviews conducted periodically and noted in the case file?

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7. A Unit should have a process for monitoring the outcome of cases. In meeting this standard, the Unit's monitoring of the following case factors and outcomes will be considered-

A. The number, age, and type of cases in inventory.
B. The number of referrals to other agencies for prosecution.
C. The number of arrests and indictments.
D. The number of convictions.
E. The amount of overpayments identified.
F. The amount of fines and restitution ordered.

G. The amount of civil recoveries.
H. The numbers of administrative sanctions imposed.

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8. A Unit will cooperate with the OIG and other Federal agencies, whenever appropriate and consistent with its mission, in the investigation and prosecution of health care fraud. In meeting this standard, the following performance indicators will be considered-

A. Does the Unit communicate effectively with the OIG and other Federal agencies in investigating or prosecuting health care fraud in their State?
B. Does the Unit provide OIG regional management, and other Federal agencies, where appropriate, with timely information concerning significant actions in all cases being pursued by the Unit?
C. Does the Unit have an effective procedure for referring cases, when appropriate, to Federal agencies for investigation and other action?
D. Does the Unit transmit to the OIG, for purposes of program exclusions under section 1128 of the Social Security Act, reports of convictions, and copies of Judgment and Sentence or other acceptable documentation within 30 days or other reasonable time period?

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9. A Unit should make statutory or programmatic recommendations, when necessary, to the State government. In meeting this standard, the following performance indicators will be considered-

A. Does the Unit recommend amendments to the enforcement provisions of the State's statutes when necessary and appropriate to do so?
B. Does the Unit provide program recommendations to single State agency when appropriate?
C. Does the Unit monitor actions taken by State legislature or State Medicaid agency in response to recommendations?

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10. A Unit should periodically review its Memorandum of Understanding (MOU) with the single State Medicaid agency and seek amendments, as necessary, to ensure it reflects current law and practice. In meeting this standard, the following performance indicators will be considered-

A. Is the MOU more than 5 years old?
B. Does the MOU meet Federal legal requirements?
C. Does the MOU address cross-training with the fraud detection staff of the State Medic-

aid agency?

D. Does the MOU address the Unit's responsibility to make program recommendations to the Medicaid agency and monitor actions taken by the Medicaid agency concerning those recommendations?

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11. A Unit director should exercise proper fiscal control over the unit resources. In meeting this standard, the following performance indicators will be considered-

A. Does the Unit director receive on a timely basis copies of all fiscal and administrative reports concerning Unit expenditures from the State parent agency?

B. Does the Unit maintain an equipment inventory?

C. Does the Unit apply generally accepted accounting principles in its control of Unit funding?

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12. A Unit should maintain an annual training plan for all professional disciplines. In meeting the standard, the following performance indicators will be considered-

A. Does the Unit have a training plan in place and funds available to fully implement the plan?

B. Does the Unit have a minimum number of hours training requirement for each professional discipline, and does the staff comply with the requirement?

C. Are continuing education standards met for professional staff?

D. Does training undertaken by staff aid in the mission of the Unit?

These standards may be periodically reviewed and discussed with the Units and other State representatives to ascertain their effectiveness and applicability. Additional or revised performance standards will be proposed when deemed appropriate.

APPENDIX B

Unit Statistics for the Fiscal Year 1997

State	Unit Cost	Staff	Convictions	Recoveries
Alabama	$ 1,021,000	17	4	$ 375,803
Alaska	$ 421,000	6	2	$ 37,153
Arizona	$ 1,217,000	23	12	$ 2,114,448
Arkansas	$ 1,182,000	21	47	$ 3,597,144
California	$ 8,712,000	132	41	$ 30,887,072
Colorado	$ 622,000	11	10	$ 385,788
Connecticut	$ 572,000	7	1	$ 479,930
Delaware	$ 564,000	9	19	$ 1,048,033
Florida	$ 5,086,000	88	117	$18,857,373
Georgia	$ 2,644,000	41	28	$ 6,004,548
Hawaii	$ 870,000	16	2	$ 942,481
Illinois	$ 1,492,000	26	16	$ 3,889,455
Indiana	$ 1,201,000	22	3	$13,184,503
Iowa	$ 381,000	8	14	$ 861,901
Kansas	$ 831,000	12	3	$ 4,470,570
Kentucky	$ 707,000	18	1	$ 5,883,410
Louisiana	$ 1,316,000	24	43	$ 4,432,875
Maine	$ 357,000	4	6	$ 270,118
Maryland	$ 1,204,000	20	14	$ 2,251,861

State	Unit Cost	Staff	Convictions	Recoveries
Massachusetts	$ 1,655,000	27	10	$ 1,495,568
Michigan	$ 2,401,000	39	30	$ 1,473,621
Minnesota	$ 718,000	10	5	$ 1,164,222
Mississippi	$ 784,000	18	46	$ 812,030
Missouri	$ 1,464,000	23	5	$ 1,575,865
Montana	$ 328,180	7	2	$ 3,185
Nevada	$ 712,000	13	6	$ 160,026
New Hampshire	$ 450,000	9	3	$. 61,681
New Jersey	$ 1,655,000	26	2	$ 4,972,181
New Mexico	$ 673,000	13	10	$ 184,014
New York	$22,287,000	292	97	$ 7,759,937
North Carolina	$ 1,483,000	20	11	$ 3,710,120
Ohio	$ 2,148,000	47	30	$ 1,562,134
Oklahoma	$ 633,000	18	45	$ 417,515
Oregon	$ 366,000	6	8	$ 472,605
Pennsylvania	$ 3,258,000	50	10	$ 291,294
Rhode Island	$ 662,000	14	14	$ 144,789
South Carolina	$ 701,000	12	10	$ 595,542
South Dakota	$ 234,000	5	5	$ 144,698
Tennessee	$ 1,066,000	23	21	$ 4,016,095

State	Unit Cost	Staff	Convictions	Recoveries
Texas	$ 2,307,000	42	61	$ 5,980,261
Utah	$ 1,025,000	13	5	$ 3,435
Vermont	$ 293,000	5	4	$ 67,680
Virginia	$ 692,000	14	17	$ 2,134,004
Washington	$ 913,000	17	7	$ 2,184,045
West Virginia	$ 442,966	10	13	$ 5,854,308
Wisconsin	$ 492,000	8	11	$ 340,978
Wyoming	$ 314,000	4	0	$ 86,000
TOTAL	**$80,557,146**	**1290**	**871**	**$147,642,299**

Units Statistics for the Fiscal Year 1998

State	Unit Cost	Staff	Convictions	Recoveries
Alabama	$ 1,019,000	17	3	$ 582,687
Alaska	$ 478,000	6	5	$ 26,056
Arizona	$ 1,004,426	13	10	$ 1,782,411
Arkansas	$ 1,267,000	21	36	$ 1,903,392
California	$ 9,350,000	132	66	$ 8,148,100
Colorado	$ 624,000	11	7	$ 221,101
Connecticut	$ 548,000	7	3	$ 245,000
Delaware	$ 514,000	9	12	$ 567,366
Florida	$ 5,326,000	100	71	$ 5,009,168
Georgia	$ 2,419,650	43	36	$ 3,434,692
Hawaii	$ 916,000	16	4	$ 2,698,648
Illinois	$ 2,063,000	29	22	$ 7,297,354
Indiana	$ 1,144,000	24	10	$ 1,453,747
Iowa	$ 533,036	10	12	$ 39,491
Kansas	$ 968,000	12	2	$ 75,127
Kentucky	$ 912,500	19	4	$ 1,157,387
Louisiana	$ 1,210,000	24	53	$ 3,662,228
Maine	$ 343,000	6	5	$ 157,177
Maryland	$ 1,209,000	20	12	$ 124,293

State	Unit Cost	Staff	Convictions	Recoveries
Massachusetts	$ 1,729,000	27	9	$ 1,330,517
Michigan	$ 2,420,000	39	39	$ 1,662,954
Minnesota	$ 784,000	12	6	$ 2,488,536
Mississippi	$ 881,000	18	52	$ 527,352
Missouri	$ 1,425,000	23	5	$ 321,667
Montana	$ 319,000	7	6	$ 668,602
Nevada	$ 759,000	13	4	$ 1,139,757
New Hampshire	$ 450,000	9	10	$ 59,110
New Jersey	$ 1,969,000	32	11	$ 2,801,599
New Mexico	$ 644,275	13	13	$ 546,188
New York	$24,683,000	292	123	$ 10,591,197
North Carolina	$ 1,447,000	20	7	$ 2,321,403
Ohio	$ 2,456,000	41	43	$ 2,643,503
Oklahoma	$ 720,000	18	40	$ 648,935
Oregon	$ 412,000	6	10	$ 267,291
Pennsylvania	$ 3,076,000	49	25	$ 1,375,160
Rhode Island	$ 681,000	14	12	$ 14,421
South Carolina	$ 750,000	13	23	$ 756,415
South Dakota	$ 244,000	5	3	$ 259,314
Tennessee	$ 1,137,000	23	35	$ 3,646,138

State	Unit Cost	Staff	Convictions	Recoveries
Texas	$ 2,422,000	34	46	$ 8,042,233
Utah	$ 1,078,000	13	10	$ 45,586
Vermont	$ 302,000	6	5	$ 1,694
Virginia	$ 712,000	14	10	$ 1,807,611
Washington	$ 1,032,000	18	4	$ 320,383
West Virginia	$ 600,000	16	2	$ 290,987
Wisconsin	$ 552,000	8	11	$ 448,623
Wyoming	$ 261,000	4	0	$ 13,032
TOTAL	**$85,793,887**	**1306**	**937**	**$83,625,633**

Unit Statistics for the Fiscal Year 1999

State	Unit Cost	Staff	Convictions	Recoveries
Alabama	$ 805,000	10	1	$ 862,000
Alaska	$ 475,000	6	1	$ 7,868
Arizona	$ 1,006,000	13	17	$ 2,077,907
Arkansas	$ 1,373,000	22	33	$ 360,897
California	$ 8,811,000	152	52	$ 2,293,582
Colorado	$ 672,000	11	15	$ 1,147,539
Connecticut	$ 476,000	7	2	$ 63,239
Delaware	$ 676,000	13	20	$ 40,846
Florida	$ 6,247,745	104	78	$ 4,460,559
Georgia	$ 3,050,000	43	19	$13,394,751
Hawaii	$ 904,000	16	2	$ 4,789,568
Illinois	$ 2,413,000	32	32	$ 1,263,700
Indiana	$ 1,251,000	23	6	$ 1,185,985
Iowa	$ 556,000	11	10	$ 157,856
Kansas	$ 784,000	12	6	$ 8,906
Kentucky	$ 1,020,000	19	15	$ 1,490,660
Louisiana	$ 1,166,000	24	42	$ 1,262,329
Maine	$ 342,000	6	2	$ 372,390
Maryland	$ 1,201,000	20	15	$ 1,875,155

State	Unit Cost	Staff	Convictions	Recoveries
Massachusetts	$ 1,778,000	27	7	$ 1,982,474
Michigan	$ 2,583,000	39	24	$ 2,267,768
Minnesota	$ 855,000	14	2	$ 2,594,542
Mississippi	$ 889,000	19	43	$ 1,159,382
Missouri	$ 1,540,000	23	10	$ 569,081
Montana	$ 329,000	7	3	$ 363,497
Nevada	$ 725,000	13	2	$ 286,632
New Hampshire	$ 473,000	6	9	$ 389,255
New Jersey	$ 1,983,000	32	14	$ 4,843,511
New Mexico	$ 686,000	13	10	$ 153,202
New York	$25,917,000	292	130	$13,308,600
North Carolina	$ 1,684,000	26	15	$ 3,452,221
Ohio	$ 2,433,000	41	44	$ 882,633
Oklahoma	$ 764,000	17	25	$ 262,600
Oregon	$ 469,000	6	9	$ 1,060,570
Pennsylvania	$ 3,213,000	50	22	$ 727,394
Rhode Island	$ 701,000	12	10	$ 66,983
South Carolina	$ 787,000	13	38	$ 148,802
South Dakota	$ 261,000	5	1	$ 217,232
Tennessee	$ 1,149,000	23	12	$ 3,526,438

State	Unit Cost	Staff	Convictions	Recoveries
Texas	$ 2,543,000	37	33	$ 6,363,737
Utah	$ 1,081,000	13	11	$ 30,976
Vermont	$ 331,000	6	5	$ 149,969
Virginia	$ 743,000	13	7	$ 2,308,275
Washington	$ 1,083,000	18	17	$ 4,444,005
West Virginia	$ 634,000	15	4	$ 13,966
Wisconsin	$ 579,000	11	9	$ 7,832
Wyoming	$ 262,000	4	2	$ 41,013
TOTAL	**$89,703,745**	**1339**	**886**	**$88,738,327**

APPENDIX C

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

TO: All Medicaid Fraud Control Units

SUBJECT: State Fraud Policy Transmittal No. 98-01
Program Income

This transmittal is to clarify the Office of Inspector General (OIG) policy regarding the definition, approval, retention and reporting of program income by Medicaid Fraud Control Units (MFCUs), and issue guidelines pursuant to 45 CFR section 92.25. Program income means gross income received by the MFCU directly generated by a grant supported activity and is defined as the court-ordered reimbursement of the Units cost of investigation and prosecution. Except for program income ordered by a court before and after the date of this transmittal expressed below, this policy supercedes all letters from the OIG State Fraud Branch and telephone instructions regarding the definition, approval and retention of program income. The Financial Status Report regulations have been and remain in full force and effect.

This transmittal applies to program income ordered by a court on or after the date of this transmittal. Program income ordered prior to the date of this transmittal may be used in accordance with OIG approvals previously issued to the specific MFCU. Additionally, as of the date of this issuance, all new program income awarded by the court may not be carried over to the next fiscal year in order to be used as a general use fund. It must be used and reported on the Financial Status Report (Form 269) in the Federal fiscal year in which it was awarded by the court.

All Units are required to report the MFCU funds custodian, account number(s) and the amount of retained program income beginning with Fiscal Year 1993 through Fiscal Year 1998. It was never intended that these funds be carried over from fiscal year to fiscal year.

Effective October 1, 1998, the following guidelines shall be the OIG policy regarding program income:

When a Medicaid Fraud Control Unit enters into a civil or criminal settlement, the agreement must provide that the Medicaid program be made whole by means of restitution for both the State and Federal share before the agreement allocates monies to penalties, investigative costs or damages.

When a MFCU recovers monies that meet the definition of "program income" pursuant to 45 CFR 92.25, typically termed "investigative costs," then that MFCU must report the program income to the OIG. The Financial Status Report (Form 269), due 30 days after the end of each fiscal quarter and 90 days after the end of each grant period, includes a detailed reporting of program income and how it is used.

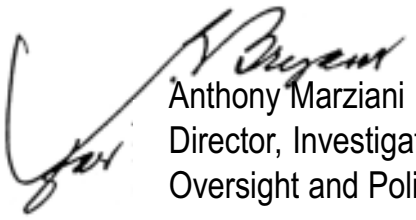
In determining how to use program income, Units may use the funds to meet the cost sharing requirements of the grant (typically 25 percent) pursuant to section 92.25(g)(3), provided the MFCU has a letter from OIG allowing retention of those funds. A copy of the approval letter should be attached to the appropriate Financial Status Report (Form 269) in accordance with item 12 of that report.

If approved by OIG in writing, any program income in excess of the State share for the fiscal year credited may be added to the funds committed to the grant agreement, in accordance with the addition method of section 92.25(g)(2). Any request for approval under the addition method must include a proposal for the use of those in MFCU operations. If the MFCU does not receive such approval, the funds must be deducted from total allowable costs in accordance with section 92.25(g)(1). A copy of the approval letter should be attached to the appropriate Financial Status Report (Form 269) in accordance with item 12 of that report.

As an alternative to the cost sharing or matching method, a MFCU must either: (a) deduct program income from total allowable costs in accordance with the deduction alternative of section 92.25(g)(l), or (b) upon approval from OIG, the MFCU may retain part or all of program income as a supplement to its annual budget in accordance with the addition method of section 92.25(g)(2).

Any request for approval under the addition method must include a proposal for the use of those funds in the MFCU operations.

Questions regarding this transmittal should be directed to Robert Bryant, Director, State Medicaid Oversight and Policy Staff (SMOPS) at (202) 619-3557.



Anthony Marziani
Director, Investigative
Oversight and Policy

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

TO: All Medicaid Fraud Control Units

SUBJECT: State Fraud Policy Transmittal No. 99-01
Investigation, Prosecution, and Referral of Civil Fraud Case

The purpose of this transmittal is to clarify the Office of Inspector General (OIG) policy with respect to the investigation, prosecution, and referral of civil cases by State Medicaid Fraud Control Units (MFCUs).

The authorizing statute for the MFCUs provides in section 1903(q)(3) of the Social Security Act that a MFCU "function is conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan under [Title XIX of the Social Security Act]." See also 42 C.F.R. 1007.11(a).

The first priority for MFCUs has been, and remains, the investigation and prosecution, or referral for prosecution, of criminal violations related to the operation of a State Medicaid program. However, in recent years, both State and Federal prosecutors have increasingly relied on civil remedies to achieve a full resolution of health fraud cases. The assessment of civil penalties and damages is an appropriate law enforcement tool when providers lack the specific intent required for criminal conviction but satisfy the applicable civil standard of liability.

We understand that the approach to potential civil cases varies greatly among the MFCUs. We are concerned that for those MFCUs that do not perform civil investigations, meritorious civil remedies may go unpursued when no potential criminal remedy exists. Civil cases could be prosecuted under applicable State civil fraud statutes or could be referred to the Federal Government for imposition of multiple damages and penalties under the Federal civil False Claims Act. Alternatively, if authorized by the Department of Justice, the OIG may seek assessments and penalties under the Civil Monetary Penalties Law. Also, in addition to or as an alternative to monetary recoveries, the OIG may seek to impose a permissive exclusion from Medicaid and other Federal health care programs.

Accordingly, OIG interprets section 1903(q)(3) of the Social Security Act and section 1007.11(a) of Title 42, Code of Federal Regulations, "Duties and Responsibilities of the Unit," to require that all provider fraud cases that are declined criminally be investigated and/or analyzed fully for their civil potential. OIG further interprets 42 C.F.R. 1007.11(e), requiring a MFCU to "make available to Federal investigators or prosecutors all information in its possession concerning fraud in the provision or administration of medical assistance" under the program, to say that if no State civil fraud statute exists, or if State laws do not allow the recovery of damages for both the State and Federal share of the Medicaid payments, meritorious civil cases should then be referred to the U.S. Department of Justice or the U.S. Attorney's Office, as well as the appropriate Field or Suboffice of the Office of Investigations, OIG.

In sum, meritorious civil cases that are declined criminally should be tried under State law or referred to the U.S. Department of Justice, the U.S. Attorney's Office, or the Field or Suboffice of the Office of Investigations, OIG.

If you have any questions regarding this transmittal, please contact Joseph Prekker, Director, State Medicaid Oversight and Policy Staff. He can be reached at (202) 619-3557.

Frank J. Nahlik
Assistant Inspector General
for Investigative Oversight
and Support

TO: All Medicaid Fraud Control Units

SUBJECT: State Fraud Policy Transmittal No. 99-02
Public Disclosure Requests and Safeguarding of Privacy Rights

This transmittal is to clarify the Office of Inspector General (OIG) policy with respect to the safeguarding of privacy rights by State Medicaid Fraud Control Units (MFCU's) when MFCU's receive requests from the public for investigative records.

Federal regulations provide, as one "duty and responsibility," that a MFCU "will safeguard the privacy rights of all individuals and will provide safeguards to prevent the misuse of information under the unit's control,"(42 CFR, section 1007.11(f)). One situation in which a MFCU must safeguard privacy rights is when a Unit receives a request for investigative records under a State public disclosure law. Such requests may be for investigative files in either fraud or patient abuse or neglect cases.

In determining what information to disclose in response to a request from the public, a MFCU is subject to its State's public disclosure law. In order to meet the Federal confidentiality requirement, a MFCU must protect, to the fullest extent authorized by such laws, the identities of witnesses, victims, and informants, as well as the identities of suspects when the allegations are unsubstantiated, unless such identities are already in the public domain or the individuals clearly consented to the release of their identities. Such identities are typically protected by redacting identifying information, or information that could lead to those identities, from files being released.

A MFCU should immediately contact the Director of the OIG State Medicaid Oversight and Policy Staff in the following situations:

- If a MFCU interprets its State public disclosure law in such a manner that it cannot protect from release the identities of witnesses, victims, and informants, as well as the identities of suspects when the allegations are unsubstantiated, unless such identities are already in the public domain or the individuals clearly consented to the release of their identities. We may discuss with the Unit appropriate legislative remedies to bring the MFCU into compliance with the Federal regulation.

- If a MFCU receives a public disclosure request and intends to release the identities of witnesses, victims, and informants, as well as the identities of suspects when the allegations are unsubstantiated, in the situations described above. The MFCU must provide OIG adequate time prior to the anticipated release for OIG to provide its analysis of the situation or other appropriate assistance. The Medicaid Fraud Control Units should not inform OIG about routine requests for investigative information that do not involve the identities of individuals or other sensitive situations.

Providing OIG adequate and timely notice in these situations will help ensure that Units are complying with, and OIG is adequately enforcing, the Federal requirement regarding individual privacy rights.

If you have any questions regarding this transmittal, please contact Joseph Prekker, Director, State Medicaid Oversight and Policy Staff at (202) 619-3557.

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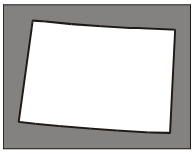

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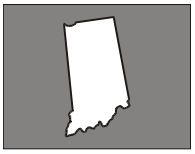

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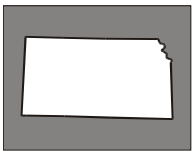

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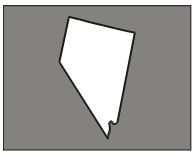

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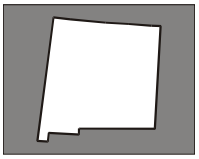

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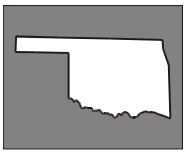

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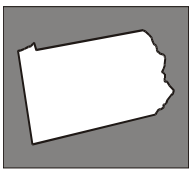

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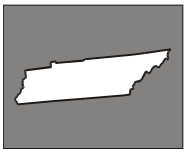

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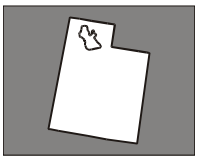

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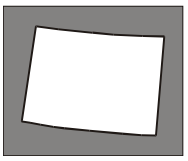

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