

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL**



**State Medicaid Fraud Control Units
Annual Report
Fiscal Year 2007**

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Summary

This is the 17th Office of Inspector General (OIG) Annual Report on the State Medicaid Fraud Control Units (MFCU). This report covers Federal fiscal year (FY) 2007, commencing October 1, 2006, and ending September 30, 2007.

During this reporting period, 49 States and the District of Columbia participated in the Medicaid fraud control grant program through their established MFCUs, including the reestablished State of Idaho MFCU. The mission of the MFCUs is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect. MFCUs' authority to investigate and prosecute cases involving Medicaid provider fraud and patient abuse and neglect varies from State to State. Forty-three of the MFCUs are located within Offices of State Attorneys General. The remaining seven MFCUs are located in various other State agencies.

In FY 2007, MFCUs recovered more than \$1.1 billion in court-ordered restitution, fines, civil settlements, and penalties. They also obtained 1,205 convictions. MFCUs reported a total of 607 instances in which civil actions were undertaken that resulted in successful outcomes. Of the 3,308 OIG exclusions from participation in the Medicare and Medicaid programs and other Federal health care programs in FY 2007, 805 exclusions were based on referrals made to OIG by the MFCUs.

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State Medicaid Fraud Control Units

Annual Report for Fiscal Year 2007

Medicaid Program

The Medicaid program was established in 1965 by Title XIX of the Social Security Act (the Act) to provide health care services to low-income and disabled Americans. Federal and State governments share in the cost of providing services to eligible Medicaid beneficiaries. The Federal share of Medicaid expenditures is calculated using the Federal medical assistance percentage rate established for each State, as well as Federal matching of 50 percent or more for various categories of administrative costs. Federal grant awards made to the Medicaid Fraud Control Units (MFCU) are generally funded on a 75-percent matching basis, with the States contributing the remaining 25 percent.

Within broad national guidelines set by the Federal Government, the Act enables States to furnish medical assistance to those who meet eligibility requirements. Within Federal guidelines, each State administers its own Medicaid program; sets its own eligibility standards; determines the type, amount, duration, and scope of services; and sets payment rates. States have the option of providing Medicaid services either on fee-for-service basis, in which an enrolled provider is reimbursed on a claim-by-claim basis for each covered service it provides, or through a variety of managed care arrangements as part of a State plan waiver program.

Oversight of the Medicaid Fraud Control Units

The Office of Inspector General (OIG) was established in 1976. The mission of OIG is to protect the integrity of Department of Health and Human Services (HHS) programs and the health and welfare of beneficiaries of HHS programs. OIG has a responsibility to report, both to the Secretary of HHS and to Congress, program and management problems and to make recommendations for correcting them. OIG's duties are carried out through a nationwide network of audits, investigations, evaluations, and other mission-related functions. OIG's Medicaid Fraud Unit Oversight Division, contained within the Office of Evaluation and Inspections, is responsible for overseeing the activities of the 50 MFCUs.

The Omnibus Budget Reconciliation Act of 1993, section 13625, as codified in section 1902(a) (61) of the Act, requires OIG to develop performance standards for assessing MFCUs. This section also requires all States to operate MFCUs or receive waivers from the Federal Government. The performance standards were created in consultation with the MFCU community and were made effective on September 26, 1994. OIG uses the performance standards as guidelines to assess the

MFCUs and to determine whether they are carrying out their duties and responsibilities in an effective and efficient manner.

Certification/Recertification

Each State establishing a MFCU must submit an initial application for certification to the Secretary of HHS. When establishing a MFCU, a State must meet several major requirements to obtain both Federal certification and grant funding for the proposed MFCU. Notably, there are two regulatory requirements which are especially critical when acquiring Federal certification, 42 CFR § 1007.5, which states that a MFCU “. . . must be a single, identifiable entity of the State government . . .” and 42 CFR § 1007.13(a), which states that a MFCU:

. . . must include: (1) One or more attorneys experienced in the investigation or prosecution of civil fraud or criminal cases, who are capable of giving informed advice on applicable law and procedures and providing effective prosecution or liaison with other prosecutors; (2) One or more experienced auditors capable of supervising the review of financial records and advising or assisting in the investigation of alleged fraud; and (3) 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 HHS notifies the submitting State whether its application meets the Federal requirements for initial certification and whether the application is approved. The initial application approval and certification by the Secretary are valid for a 1-year period.

For an established MFCU to continue receiving Federal certification and grant funding from HHS, it must submit the required reapplication documents and an annual report to OIG at least 60 days prior to the end of its current certification period. In considering a MFCU’s eligibility for recertification, OIG thoroughly reviews the submitted material and determines whether the MFCU fully complied with the 12 performance standards and whether Federal resources expended by the MFCU were effectively used in detecting, investigating, and prosecuting Medicaid fraud and patient abuse and neglect cases. In addition, as part of the recertification process, OIG also evaluates the results of any onsite reviews that were conducted during the previous certification period. Once all submitted information is reviewed and assessed, the MFCU is notified in writing that its application for recertification is approved or denied.

Surveillance and Utilization Review Subsystem

The State Medicaid agencies, with a few exceptions, are required to maintain a Medicaid Management Information System (MMIS). The MMIS is a claims payment and information retrieval system. A vital part of the MMIS is the Surveillance and Utilization Review Subsystem (SUR/S). SUR/S has two primary purposes: (1) to process information on medical and health care services that guide Medicaid program managers and (2) to identify the providers (and recipients) most likely to commit fraud against the Medicaid program.

Most MFCUs rely on referrals from the Medicaid agencies and/or the SUR/S to initiate many of their case investigations. When providers with aberrant patterns or practices are identified by SUR/S, the

information should be made available to the MFCU. Also, a MFCU is required to enter into a Memorandum of Understanding (MOU) with its respective State Medicaid agency. The MOU is intended to: (1) facilitate the referral of all suspected cases of provider fraud from the State Medicaid agencies to the MFCUs and (2) facilitate the routine exchange of information between the MFCUs and the State Medicaid agencies. Cooperation between these entities is essential to fostering a more efficient process of identifying and prosecuting fraud in the States' Medicaid programs.

Grant Expenditures

In FY 2007, HHS awarded MFCUs more than \$169 million in Federal grant funds. The number of individuals employed by MFCUs in FY 2007 was 1,814. Since the inception of the Medicaid fraud control grant program in FY 1978, Federal grants awarded to MFCUs have totaled more than \$2.1 billion.

Accomplishments

Collectively, in FY 2007, the 50 MFCUs obtained 1,205 convictions. Also in FY 2007, the MFCUs claimed total recoveries of more than \$1.1 billion in court-ordered restitution, fines, civil settlements, and penalties. Of the 3,308 OIG exclusions of individuals and entities from participation in Medicare, Medicaid, and other Federal health care programs in FY 2007, 805 were based on referrals made to OIG by MFCUs. The number of MFCU civil actions that resulted in successful outcomes was 607.

Statistical information alone does not reflect the full measure of the MFCUs' accomplishments or successes. MFCU cases involving abuse and neglect of beneficiaries in Medicaid-funded facilities, as well as board and care facilities, usually do not generate substantial monetary returns to a State's Medicaid program. Nevertheless, the investigation and prosecution of these cases by MFCUs is widely viewed as critical to providing high-quality health care services to particularly vulnerable beneficiaries.

In addition, MFCUs routinely engage in other noteworthy endeavors that are difficult to quantify. Such endeavors include: (1) presenting proposals to State legislatures that will positively affect the Medicaid program, (2) making recommendations to State Medicaid agencies to effect positive change to Medicaid policies and regulations, and (3) participating in joint case investigations/prosecutions involving Federal and State law enforcement agencies, as well as other State and local agencies.

Case Narratives

The following are examples of Medicaid fraud and patient abuse and neglect case investigations and prosecutions conducted by MFCUs in FY 2007.

Dentist

In Louisiana, a dentist who shared a dental practice with his father did not have a Medicaid provider number. The dentist treated the majority of the office's Medicaid patients, billing them under his father's Medicaid provider number. The son created what he termed "Medicaid Monday," the day set aside when the majority of the practice's Medicaid patients were treated. This was also the father's usual day off. The son also added emergency visits to the Medicaid billings, making it appear as if the Medicaid patients came in for emergency visits and then came back the next day for treatment. Many times the actual visit was a semiannual checkup. In addition to phantom emergency visits, the dentist billed for services not rendered. This scheme was uncovered when the son was arrested for allegedly choking a teenage patient and throwing the patient out of the dental chair. During interviews regarding the choking incident, employees tipped off police about the Medicaid fraud.

The defendant entered a plea of No Contest to Medicaid Fraud. He received a sentence of 1 year imprisonment deferred; was placed on active supervised probation; and was ordered to pay \$25,000 in restitution, fines, and penalties. Because of overpayments associated with his provider number, the father also returned \$100, 000 to the Medicaid program.

Drug Diversion

In South Dakota, an employee of an assisted living center pled guilty to possession of a controlled substance, a class 4 felony. The employee contacted a pharmacy and ordered controlled medications for two patients, but diverted at least some of the controlled substances for his own use. As part of the plea bargain agreement, the defendant agreed to pay restitution to the victims and costs to the State, totaling more than \$1,000. He also received a suspended imposition of sentence and was placed on probation.

In Oregon, a registered nurse was convicted on four counts of first degree theft, based on her diversion of prescription medications from three different Oregon long term care facilities where she worked. The MFCU investigation found that the nurse had also diverted medications when employed at an Oregon hospital in 2003, but had received a deferred adjudication by participating in a drug treatment program.

While subject to the conditions of the deferred adjudication, she obtained a nursing position at another center, where she was caught diverting prescription drugs and fired, but no report was made to law enforcement. Thereafter, the defendant obtained employment at another rehabilitation center, where she was again caught diverting drugs and fired. During the course of the MFCU investigation, she obtained employment as a nurse at yet another health care provider. After a MFCU investigator interviewed the manager, an internal audit was conducted, revealing that during her 4 months of employment, she diverted over 1,000 pills, mostly pain medications.

At sentencing, the defendant was ordered to surrender her nursing license, spend 30 days in custody, serve 3 years' probation, pay over \$7,000 in restitution for the stolen medications, undergo drug treatment, and perform 60 hours of community service.

Durable Medical Equipment

In the District of Columbia, a durable medical equipment (DME) supplier agreed to reimburse the Medicaid program \$1.5 million to settle allegations of False Claims Act violations. The Federal Bureau of Investigations (FBI) and the MFCU uncovered false billings that the DME submitted for medical items that the company alleged were supplied to Medicaid recipients residing in group homes in the District of Columbia. Those medical supplies were never ordered by treating physicians, were not medically necessary, and were never delivered to the group homes. In addition, the DME supplier will be excluded from participation in federally funded health care programs for 5 years.

In Colorado, the manager of a DME company pled guilty to two class 3 felony theft charges in connection with fraudulent claims submitted to the State's Medicaid program. The defendant oversaw hundreds of claims for power wheelchair repairs that either were not made, or took only a small fraction of the time claimed. The defendant and other company employees generated internal corporate documents that purported to show repairs (sometimes recording as much as 8 hours for tasks such as filling tires or replacing an armrest), often forging the signature of disabled recipients on the corporate forms. Over \$1 million was stolen by the company through these false claims and through a second scheme in which wheelchair part prices were inflated or billed without being provided. The manager received 5 years in State prison to be followed by 5 years' parole and was ordered to pay restitution of over \$728,000.

Embezzlement

In Arizona, the business office manager of an adult care facility perpetrated a fraud scheme by forging 33 resident trust fund checks totaling over \$34,000. The investigation revealed that the funds were diverted for the personal use and benefit of the manager, who used them to pay her home mortgage. The defendant was indicted on a total of 36 counts: 1 count of fraudulent schemes and artifices, 1 count of theft, 1 count of money laundering, and 33 counts of forgery. The defendant pled guilty to one count of theft, a class 2 felony, and was sentenced to 9 months' imprisonment and 7 years' probation.

False Claims

In Kansas, a not-for-profit corporation owned by a husband and wife provided counseling services, including drug and alcohol services, to Medicaid beneficiaries under the community-based drug and alcohol abuse services program. The defendants conspired and schemed to defraud the Medicaid program by billing and causing others to bill Medicaid services not provided or not necessary. This included billing for 17 children under the age of 12, whom the defendants acknowledged were not dependent on or addicted to drugs or alcohol and were not receiving any drug or alcohol abuse treatment. Two of these children were less than 2 months old when the defendants began billing for

their drug and alcohol abuse treatment. Over 34 percent of all the Medicaid funds paid to the defendants were for services reportedly provided to all these children. A review of all 1,331 claims submitted by the defendants over a period of 14 months revealed that none of the claims should have been paid because of failure to document services billed to Medicaid, failure to provide the services billed, no medical necessity for the services billed, no prior authorization to provide the services billed, or treatment that was not age appropriate. The defendants were found guilty of health care fraud and obstruction and were each sentenced to 92 months' imprisonment and ordered to repay restitution in the amount of \$1.2 million to the Kansas Medicaid program.

In California, a 39-count felony complaint was filed against a physician for paying a decoy to bring Medi-Cal beneficiaries to his clinic, for billing Medi-Cal for hepatitis B shots not provided, and for the medically unnecessary testing of blood and urine. The physician had already been suspended from the Medi-Cal program, but he hired another physician and used that physician's Medi-Cal provider number to bill the program. The physician pled guilty and his plea agreement included the voluntary surrender of his medical license for a period of 3 years as well as 6 months in county jail. The decoy also entered a plea agreement wherein he agreed to identify other Medi-Cal providers and assisted in their investigation and prosecution. This led to the investigation of seven more physicians. Six of the physicians admitted that they were involved in paying the decoy a per-patient fee to bring Medi-Cal beneficiaries to their clinics. As a result of the investigation, six felony complaints were filed against the physicians.

In Maryland, a provider of psychiatric rehabilitation and therapy for children and adults billed the Medicaid program in excess of \$4 million for services that were never rendered. At its peak, the provider enrolled over 1,200 children. However, the program did not have enough rehabilitation counselors to provide the required services. Under the direction of the Chief Financial Officer (CFO), the provider billed for services without any regard to whether the services were actually provided. The CFO directed that the company bill every two, three, or four times a week, even if no counselor had been assigned. As a result, billing records from the Mental Hygiene Administration, a Medicaid agency, showed that the provider billed for nearly 50,000 hours of rehabilitation services that it did not provide and the company collected almost \$3 million for services it never performed. In all, the CFO knowingly directed his employees to submit over 20,000 false statements to the Medicaid program. As a result of the plea agreement, the defendant will receive a jail sentence of between 24 and 30 months and will be required to make restitution payments.

In Texas, a Houston psychiatrist pled guilty to health care fraud and to receiving kickbacks and fraudulently submitting clinical medical necessity forms (CMNs). The doctor was charged with signing fraudulent CMNs claiming that patients were eligible for motorized wheelchairs. The psychiatrist was initially paid \$200 for each prescription that he wrote for various DME companies and recruiters. The psychiatrist also billed, through his clinic, medical visits for various psychiatric ailments when he wrote the CMNs for the patients. It was determined that he and others fraudulently billed Medicaid and Medicare approximately \$52 million and were paid \$30 million.

The psychiatrist was sentenced in Federal court to 60 months' imprisonment for conspiracy and 18 months for health care fraud and ordered to pay over \$20 million in restitution. This was a joint investigation by the MFCU, FBI, and HHS-OIG.

Financial Abuse

In New Jersey, following an investigation by the MFCU's Elder Abuse and Neglect Team, a certified social worker pled guilty to stealing in excess of \$70,000 from a now-deceased resident of long term care facility. The investigation uncovered evidence that the social worker misused a power of attorney by making numerous unauthorized withdrawals for his own use from the resident's bank accounts. The investigation also established that the social worker misappropriated all of the proceeds from the sale of the resident's real property. As a result of his guilty plea, the social worker was sentenced to 3 years' imprisonment and ordered to pay restitution in the amount of \$70,000. In addition, he permanently forfeited his social worker certification.

Fraudulent Prescriptions

In Pennsylvania, a pain management physician who worked in conjunction with another pain management doctor and a chiropractor was convicted of Medicaid fraud, conspiracy, and drug act violations. He had written prescriptions for OxyContin and Percocet that were medically unnecessary and were fraudulently billed to the State Medicaid program. The defendant was sentenced to 8 ½ to 20 years' imprisonment. He was also ordered to pay approximately \$9,000 in restitution, \$100,000 in fines, and \$17,000 in investigative costs. In addition, the defendant is in the process of being excluded from the State's Medical Assistance Program for a period of 5 years and the State Board of Medicine has revoked his license to practice medicine.

Home Health Care

In Colorado, a defendant pled guilty to felony theft and felony identity theft for a scheme to defraud the Medicaid program and a personal care provider agency. The defendant submitted the personal information of an acquaintance to a personal care provider agency, advising the agency that the acquaintance would be their employee and provide personal care to the defendant, a registered recipient. In fact, the acquaintance had moved out of the country and had not agreed to employment by the agency. The defendant forged timesheets and submitted them to the agency. She received paychecks for the bogus employee at her residence and forged the employee's signature, keeping the money for herself. The defendant was sentenced to 90 days' imprisonment, with credit for 60 days served and the other 30 suspended, and 4 years' probation. The defendant was also ordered to undergo a mental health evaluation, complete 200 hours of community service, write letters of apology, and to pay restitution of more than \$20,000.

Negligent Homicide

In Wisconsin, a mental health facility in Rice Lake was convicted of one felony count of negligent abuse of a resident. The corporation failed to provide adequate training to staff members in the proper implementation of the facility's restraint policy. A facility staff member utilized an oppressive restraint, leading to the suffocation death of a 7-year-old resident. The corporation was ordered to pay the maximum fine of \$100,000 and \$12,203 in restitution.

In Alabama, two licensed practical nurses (LPNs) pled guilty to criminally negligent homicide for their role in the death of a nursing home resident. The investigation found that during a routine

medication pass at the nursing home, the LPNs mistakenly gave the victim her roommate's medication. The LPNs immediately recognized the error, but did not report the incident to their supervisor until over 2 hours had passed. The victim was transported to a local hospital, where she was pronounced dead. The defendants were each sentenced to 1 year of imprisonment, which was suspended. The defendants were also ordered to serve 2 years' supervised probation and complete 400 hours of community service.

In Wisconsin, a registered nurse working in a hospital birthing suite was caring for a 16-year-old maternity patient. The patient had a strep infection and was prescribed penicillin. Although an epidural had not been prescribed and the nurse had not been authorized to do so, she took an epidural bag from the drug closet and brought it into the patient's room. Disregarding all hospital safeguards for administering medication, she connected the epidural instead of the penicillin to the intravenous line, causing the death of the patient. The defendant pled no contest to one count of nonpharmacist dispensing of a prescription and one count of possessing/illegally obtaining a prescription. Sentence was suspended and she was placed on 2 years' probation.

Nursing Home

In Texas, a joint investigation with the Internal Revenue Service (IRS) and FBI resulted in the owner of a nursing home chain pleading guilty to one count of health care fraud and one count of money laundering. The owner was sentenced in Federal court to pay \$2.6 million in restitution to Medicaid and \$1.4 million in restitution to Medicare. This case was initiated based on allegations that the owner of the nursing homes defrauded the Medicaid program by taking Medicaid payments and diverting part of those funds for his own personal use instead of paying for required Medicaid goods and services in his nursing home chain, which included 72 homes throughout the United States and 17 in Texas. It was alleged that the owner abandoned all of his Texas nursing homes, thus causing the State to take action to care for the residents in these nursing homes.

Overpayments

In Massachusetts, an agreement was reached with an independent clinical laboratory to settle allegations of overpayment and inappropriate referrals. The company agreed to pay \$8.15 million to the Commonwealth, including the Massachusetts Medicaid program and its managed care organizations. The settlement was the result of an ongoing industrywide investigation by the Attorney General's MFCU into urine drug tests billed by independent clinical laboratories to the State Medicaid program. The investigation found that the company billed Medicaid for urine drug and alcohol tests that were not properly ordered by a physician or other authorized prescriber. The tests were often inappropriately ordered for nonmedical purposes, such as probation, parole, or residential sobriety monitoring. The investigation also found evidence that the laboratory made inappropriate payments to a third party in order to obtain additional Medicaid business, as well as payments to some substance abuse treatment programs, halfway houses, shelters, and sober houses in the form of free urine drug-screen services. These alleged violations of State law and Medicaid rules and regulations resulted in significant Medicaid overpayments.

Patient Abuse

In Arkansas, the sister of a nursing home resident made a complaint to the Office of Long Term Care that her brother, a 59-year-old resident and noninsulin-dependent diabetic who also had diagnoses of schizophrenia, hypertension, and congestive heart failure, had open wound on his left ankle. The facility telephoned the resident's sister to inform her that the resident was being sent to the hospital because his wound had become infected. When the treatment nurse at the facility removed a bandage from the resident's leg, "white moving things that appeared to be maggots" were discovered in the wound. After he was sent to the hospital, hospital personnel found maggots still in the wound. Following a thorough investigation into the care and treatment of the resident, the MFCU entered into a civil settlement with the facility, with the facility being obligated to pay a total of \$50,000 in civil monetary penalties.

In Oklahoma, a Certified Nurse Aide (CNA) pled guilty to two counts of caretaker neglect. The defendant left a resident alone in the shower for an undetermined amount of time. The resident was found to have suffered a stroke, fallen, and hit his head. When help arrived, the resident had second-degree burns over 20 percent of his body. A check of another resident that the defendant had also showered that day showed second-degree burns over 6 percent of his body. The defendant admitted that both residents were left alone in the shower and the water temperature was found to be 126 degrees. In addition to fines and court costs, the defendant was sentenced to 6 years' imprisonment on each count, to run concurrently.

Pharmaceutical Manufacturers

In Virginia, the MFCU conducted a joint criminal investigation with numerous Federal and State law enforcement agencies, including the United States Attorney's Offices, HHS-OIG, IRS and State police into allegations of fraud committed by the Purdue Pharma Company. The investigation revealed that Purdue fraudulently misbranded the drug OxyContin by marketing the drug to physicians as a slower release, less addictive drug than other prescription opioids. Purdue's claims were either not supported by the research conducted or contrary to that research. As a result, of this joint investigation and plea agreement, the Purdue Frederick Company pled guilty to felony misbranding of the drug, and three of its corporate officers pled guilty to misdemeanor misbranding of the drug in the United States District Court for the Western District of Virginia. The Purdue Frederick Company and three of its corporate officers were ordered to pay fines and penalties, as well as to reimburse the Medicaid and other Federal health care programs a total of \$634.5 million. The corporate officers were also ordered to perform community service and successfully complete supervised probation.

Physicians

In Tennessee, a physician who was practicing medicine without a license pled guilty to one count of reckless endangerment, fraudulent insurance claims, and impersonation of a licensed professional. This case was based on a referral from the FBI and information from BlueCross/BlueShield. It was alleged that the defendant was practicing medicine without a license and that patients were harmed due to a number of misdiagnoses. The investigation showed that the defendant received his medical degree from St. George's University in Granada in 1996 or 1997 and that the defendant's father was a licensed physician who owned and operated a private medical practice. Six years after his retirement, the defendant's father allowed his unlicensed son to see and treat patients. During the time the defendant treated patients, he functioned like a medical doctor, performed exams, misdiagnosed several conditions, and was paid approximately \$440,000 by BlueCross/BlueShield and Medicaid. The original indictment charged the defendant with theft of property fraudulent insurance claims, and impersonating a licensed professional. After more evidence was gathered, the defendant was reindicted and charged with 15 counts of rape and one count of impersonating a licensed professional. The defendant was sentenced to 6 years' imprisonment, of which he must serve 9 months before release on probation. In addition, he was ordered to pay restitution in the amount of \$30,000 to Medicaid.

In Oklahoma, an undercover operation conducted by a multiagency task force resulted in a physician pleading guilty to one count of distributing a controlled dangerous substance and one count of Medicaid fraud. The investigation revealed that the defendant was prescribing excessive amounts of narcotics to patients with no medical necessity and no medical diagnosis or treatment, including providing OxyContin and other highly addictive drugs to an undercover officer with no physical exam. Several of the defendant's patients were on Medicaid and used their Medicaid cards to fill prescriptions that were medically unnecessary and deemed to be beyond the scope of good medical practice. One recipient, having already failed a drug test administered in the defendant's clinic, died from a drug overdose 8 days after receiving her final prescription.

The defendant was sentenced to a 5-year suspended sentence, with an exception for the first 90 days, for distribution of a controlled dangerous substance. The sentence was to run consecutively with a 3-year suspended sentence for Medicaid fraud—a total of 8 years' probation. An additional condition was placed on the probation requiring that the defendant not practice medicine and not seek a profession that involves, or causes the defendant to associate with, the dispensing of prescription drugs. The defendant was also ordered to pay \$13,485 in investigative costs along with fines and court costs.

Sexual Abuse of a Vulnerable Adult

In Texas, a CNA was sentenced to 99 years' imprisonment based on charges of sexual assault after the CNA was found by nursing home staff to be barricaded in the room of a resident. When facility staff entered the resident's room, the staff noticed that the CNA was pulling up his pants. The resident was later examined and evidence of sexual assault was obtained.

In Ohio, a State-tested nurse's assistant at a nursing facility admitted to sexual contact with five elderly female residents, whose diagnoses ranged from mild dementia to advanced Alzheimer's disease. He further admitted that he knew his actions were inappropriate, given that his victims lacked the mental and physical capacity to prevent them. The defendant was convicted of felony counts of gross sexual imposition, sentenced to 5 years' imprisonment and an additional 5 years of postrelease community control, and labeled a "sexual predator."

Questions and comments regarding this report should be directed to:

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