

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



**State Medicaid Fraud Control Units  
Annual Report  
Fiscal Year 2006**

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## Summary

This is the 16th Office of Inspector General (OIG) Annual Report on the State Medicaid Fraud Control Units (MFCU). This report covers the Federal fiscal year (FY) 2006, commencing October 1, 2005, and ending September 30, 2006.

During this reporting period, 48 States and the District of Columbia participated in the Medicaid fraud control grant program through their established MFCUs. 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-two of the MFCUs are located within Offices of State Attorneys General. The remaining seven MFCUs are located in various other State agencies.

In FY 2006, MFCUs recovered more than \$1.1 billion in court-ordered restitution, fines, civil settlements, and penalties. They also obtained 1,226 convictions in FY 2006. MFCUs reported a total of 676 instances in which civil actions were undertaken that resulted in successful outcomes. Of the 3,425 OIG exclusions from participation in the Medicare and Medicaid programs and other Federal health care programs in FY 2006, 731 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 2006**

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### **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 (FMAP) 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 a 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 to correct 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 49 MFCUs.

The Omnibus Budget Reconciliation Act of 1993, section 13625, as codified in section 1902(a) (61) of the Act, required 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 a 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 2006, HHS awarded MFCUs more than \$159 million in Federal grant funds. The number of individuals employed by MFCUs in FY 2006 was 1,825. Since the inception of the Medicaid fraud control grant program in FY 1978, Federal grants awarded to MFCUs have totaled more than \$1.9 billion.

## **Accomplishments**

Collectively, in FY 2006, the number of convictions obtained by the 49 MFCUs was 1,226. Also in FY 2006, the MFCUs claimed total recoveries of more than \$1.1 billion in court-ordered restitution, fines, civil settlements, and penalties. Of the 3,425 OIG exclusions of individuals and entities from participation in the Medicare, Medicaid, and other Federal health care programs in FY 2006, 731 were based on referrals made to OIG by MFCUs. The number of civil actions that resulted in successful outcomes was 676.

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) participation in joint case investigations/prosecutions involving both 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 2006.

### **Certified Nursing Assistants**

In Alabama, a certified nursing assistant (CNA) pleaded guilty to one count of reckless abuse of a protected person, a class C felony. The investigation revealed that the CNA dropped a nursing home resident while providing routine care, causing the resident to suffer a broken leg. Subsequent investigation revealed that the CNA was under the influence of alcohol at the time of the incident. The defendant was sentenced to 1 year and 1 day in jail, suspended, and placed on 2 years of supervised probation. As a condition of probation, the defendant was ordered to complete an alcohol rehabilitation program. Also, the defendant was barred from future employment with nursing homes or other long term care facilities.

In the District of Columbia, a CNA was found guilty of two counts of attempted misdemeanor sexual abuse and two counts of simple assault perpetrated on two female residents of a nursing home. The defendant received consecutive sentences totaling 400 days in jail and 3 years of supervised probation and was ordered to stay away from the two victims, the nursing home, and all statutorily defined vulnerable adults. In addition, the defendant was ordered to register as a sexual offender. The defendant was suspended from participation in all Federal health care programs for 5 years.

### **Clinical Social Workers**

In Missouri, a licensed clinical social worker admitted billing the State's Medicaid program for therapy services that were not provided. The worker pleaded guilty to two counts of stealing by deceit and one count of making a false statement to receive a health care payment. The defendant's sentences were to run concurrently for 7 years on the two counts of stealing by deceit and 4 years on the false statement charge. However, the court suspended execution of the sentences and placed the defendant on supervised probation for 5 years. The defendant was ordered to make restitution to the Medicaid program in the amount of \$17,690 and to pay investigative costs of \$10,000.

In New Hampshire, settlements totaling more than \$42,000, relating to clinical social worker services provided to Medicaid-eligible schoolchildren, were reached with three providers. The School Administrative Unit (SAU) repaid the Medicaid program \$24,300 for improperly allowing an outside vendor to bill for services directly to Medicaid instead of through the SAU's provider number. As part of this same investigation, the clinical social worker involved and the mental health center where the services were provided agreed to pay a total of \$18,600 to resolve allegations that Medicaid was improperly charged for individual therapy sessions, when in fact less expensive group therapy was provided.

In Texas, a licensed professional counselor pleaded guilty to felony theft charges for fraudulently billing the Medicaid program. The defendant billed the program approximately \$344,000, of which approximately \$200,000 was identified as claims for counseling services that were not provided. The defendant was sentenced to serve 10 years in prison.

In Pennsylvania, a Behavioral Specialist Consultant (BSC), who was employed by four health service agencies to provide BSC services to Medicaid recipients, pleaded guilty to committing theft by deception, forgery, and fraud against the Medicaid program. Encounter forms were used to verify that BSC services were rendered to clients. Between September 2000 and February 2003, the defendant submitted numerous fraudulent encounter forms to Medicaid for payment. The court sentenced the defendant to serve 11.5 to 23 months in prison on the theft by deception charge and 5 years of consecutive probation on the fraud and forgery charges. The defendant was ordered to pay \$135,500 in restitution to the Medicaid program and \$5,657 for the cost of prosecution. In addition, as a result of the conviction, the defendant was excluded from participating in the State's Medical Assistance program for a period of 5 years.

### **Dentists**

In Maryland, a dentist was sentenced to serve 6 months in jail for committing fraud against a Medicaid Health Maintenance Organization (HMO). The defendant, with the assistance of his wife, knowingly defrauded the HMO of approximately \$282,000 by billing for dental services that were never performed. Nearly 1,500 claims were submitted to the HMO. For her part in the fraud, the defendant's wife was sentenced to 5 years in jail, suspended, and ordered to serve 15 months of home confinement. The court also ordered the defendants to repay to Medicaid a total of \$300,000 in restitution.

In Nebraska, a dentist submitted more than 100 false claims to the State's Medicaid program. The total of the overpayment was \$7,260. Although the overpayment was relatively small, the case settled for \$50,000 because additional civil penalties were assessed and because some of the false claims were submitted during a time when the dentist was operating under a previous compliance agreement. The settlement also called for the dentist to voluntarily and permanently surrender his license.

### **Durable Medical Equipment Supplier**

In Texas, an owner/operator of a durable medical equipment (DME) company pleaded guilty to one count of health care fraud for submitting false claims to Medicare and Medicaid. The defendant submitted claims indicating that motorized wheelchairs and accessories had been furnished to beneficiaries, but the claims were false in that less expensive scooters were provided in some instances and none were provided in other instances. Between August 2001 and June 2003, the defendant billed Medicare and Medicaid \$6,746,001 in claims. The defendant was paid \$4,218,444 by Medicare and \$478,274 by Medicaid. For submitting the false claims, the defendant was sentenced to 63 months in Federal prison, to be followed by



3 years of supervised release. The defendant was also ordered to make full restitution to both Medicare and Medicaid. The case was conducted jointly by HHS OIG, the FBI, and the U.S. Department of Justice (DOJ).

### **Home Health Agencies**

In Virginia, the owner of a home health agency pleaded guilty to one count of health care fraud and one count of possession with the intent to distribute cocaine. The defendant fraudulently billed the State's Medicaid program \$2.5 million for home health care services allegedly provided to Medicaid recipients. The defendant was sentenced to serve 71 months in prison and was ordered to repay \$2.5 million to the Medicaid program. This case was a joint investigation conducted by the MFCU, the FBI, and DOJ.

In Wyoming, the owner/operator of a home health agency that provides both health and case management services to Medicaid recipients entered a nolo contendere plea that resulted in a conviction for defrauding the State's Medicaid program. It was alleged that both the defendant and agents of the defendant had failed to make scheduled home visits for several months. They also failed to perform necessary case management services. It was also alleged that the defendant was responsible for fraudulently predating and postdating the agency's home visit provider logs. After conducting several interviews and completing a full audit analysis of the provider's records, the MFCU concluded that services that had not been provided by the defendant were billed to Medicaid. The defendant was ordered to pay \$41,176 in restitution to the State's Medicaid program and was sentenced to supervised probation for 5 years.

In Missouri, the manager of a group home facility pleaded guilty to involuntary manslaughter in connection with the death of one of the facility's residents. The defendant admitted to making inadequate provisions for appropriately treating the decubitus ulcers (bedsores) that the resident-victim suffered from prior to death. The resident-victim, who was confined to a wheelchair, also suffered from cerebral palsy and was physically and mentally disabled. The negligence perpetrated by the defendant, in relation to the resident-victim's death, resulted in the court sentencing the defendant to serve 5 years in prison.

In the District of Columbia, a caregiver working in an adult group home entered a guilty plea to one count of misdemeanor criminal negligence. The caregiver, while caring for one of the home's residents, caused the resident-victim to be severely burned with scalding water. The resident-victim received second-degree burns to the buttocks and legs. After accepting the guilty plea, the defendant was sentenced to the maximum 180-day term of imprisonment, which was suspended. The court placed the defendant on 3 years of supervised probation, with the conditions that he perform 100 hours of community service and refrain from working as a caregiver or provider in the health-care industry. Pursuant to a request made by the MFCU, the defendant was suspended from participation in all Federal health-care programs for 5 years.

## **Hospital**

In New York, a not-for-profit hospital paid \$9 million to the State's Medicaid program to settle allegations that it had operated 14 part-time clinics in excess of the 60-hour-per-month maximum permitted by law and that two of those clinics had submitted false claims to Medicaid for services not performed and for services provided by unlicensed persons. In addition to obtaining the civil settlement, the MFCU obtained indictments against the administrator and the medical management company that operated another of the hospital's part-time clinics, charging that the defendants submitted false claims through the hospital and then fraudulently billed Medicaid for medically unnecessary treatments and phantom procedures. The State also alleged that the two defendants falsified medical charts to correspond to the false claims submitted to Medicaid.

## **Nurse**

In Wisconsin, a registered nurse who was hired to help provide 24-hour nursing coverage for a client suffering from muscular dystrophy pleaded guilty to a one count misdemeanor for submitting fraudulent claims to Medicaid. The claims were submitted after the defendant had been terminated. Under the plea agreement, the defendant had to permanently surrender her Medicaid provider number. In addition, the defendant must make restitution in the amount of \$32,330, pay a \$2,500 fine, and perform 100 hours of community service.

## **Nursing Homes**

In Georgia, a nursing home's failure to provide proper care to its residents resulted in a \$2.5 million civil settlement. In one example of egregious care rendered by the facility, a resident on coumadin medication died of toxic poisoning because the facility staff failed to check his blood levels. In another instance, a resident fell four times during her 4-month stay and fractured and refractured her hip. In another instance, a resident developed maggots in her mouth and died of larvae infestation because the facility staff failed to provide basic oral hygiene care. In addition to being assessed the civil damages, the facility entered into a 5-year corporate integrity agreement with OIG that requires the facility to pay for independent nurse monitors appointed by OIG to visit the facility regularly over a 3-year period and report on the level of care given in compliance with the agreement. The case was a joint investigation conducted by the MFCU, HHS OIG, and DOJ.

In Missouri, the owners of a nursing home management company and three nursing facilities agreed to pay \$1.25 million in civil damages to resolve allegations of false and fraudulent billing to Medicare and Medicaid, which stemmed from complaints of poor quality of care. It was alleged that numerous residents at their facilities suffered from dehydration and malnutrition and went for extended periods of time without being properly bathed. Allegations were made that some residents had contracted preventable pressure sores. Another allegation was that the owners had failed to hire sufficient staff to provide the level of care to residents that was required by Federal and State regulations. In addition to agreeing to pay civil damages, as part

of the settlement agreement, the company and its nursing facilities agreed to be permanently excluded from the Medicare and Medicaid programs. Also, the principal owners of the companies agreed to be excluded from the Medicare and Medicaid programs for 20 years. The case was a joint investigation conducted by the MFCU, HHS OIG, and DOJ.

In Vermont, a nursing home revealed that it had failed to provide routine care to an elderly resident who had broken her ankle. A pneumatic walker air cast was placed on the resident's foot. Despite knowing that the resident suffered from diabetes, dementia, and vascular disease, the nursing home's staff provided no follow-up care after the placement of the cast. When the cast was removed after 23 days, it was discovered that the resident's foot had developed a Stage III decubitus ulcer, which resulted in her leg having to be amputated below the knee. Consequently, the nursing home entered into a settlement agreement with the MFCU to reimburse the Medicaid program \$60,000 for the additional care that the resident received. The agreement also mandated that the nursing home develop and implement policies, procedures, and training to prevent future instances of substandard wound care management.

In Alabama, a bookkeeper employed at a nursing home pleaded guilty to theft of property in the first degree, a class B felony. From August 2003 to March 2005, the defendant had diverted \$18,905 from the facility's accounts for her personal use. The defendant was sentenced to 2 years in jail, suspended, and placed on 10 years of probation. The defendant was also ordered to make restitution in the amount of \$18,905.

### **Personal Care Attendants**

In New Hampshire, a personal care attendant (PCA) was convicted of abusing two nursing home residents. In both instances, the defendant stole narcotic pain medication from the residents and substituted it for blood pressure medication that was similar in appearance. The defendant used the diverted narcotic to satisfy her own substance abuse problem. The defendant received a 6-month suspended sentence and was barred from providing facility or home-based care.

In Iowa, a PCA pleaded guilty to a charge of fraud practice in the third degree, a class D felony. While serving in a provider capacity, the defendant made claims to Medicaid and was paid over \$5,000 for supposedly delivering 56 days of personal (home) care services to a recipient while that recipient was hospitalized. The court sentenced the defendant to serve 180 days in jail, suspended, and the defendant received 2 years of probation. The defendant was ordered to repay Medicaid \$5,328 and also pay \$690 in court costs and fines.

## **Pharmaceutical Manufacturer**

As a result of a joint multi-State investigation conducted by multiple MFCUs, in collaboration with HHS OIG, the FBI, DOJ, the FDA, the U.S. Postal Service and the Department of Labor, a settlement agreement was reached with a national pharmaceutical company to resolve criminal charges and civil allegations that relate to illegal schemes to promote, market, and sell its AIDS medication. In the agreement, the company and its associated subsidiaries and entities agreed to repay affected State Medicaid Programs and the Federal Government a total of \$704 million. The company also agreed to plead guilty to conspiring with a medical device manufacturer to market an AIDS diagnostic device that had not yet been approved by the FDA. As a result of the criminal conviction, the pharmaceutical company was excluded from participation in all Federal health care programs for 5 years. A strict corporate integrity agreement was also imposed on both the company and its affiliates for a period of 5 years.

## **Pharmacies/Pharmacists**

In Texas, an investigation revealed that a pharmacist/pharmacy owner was committing fraud against the Medicaid program between April 1999 and August 2000 by billing the program for prescriptions that were not authorized by physicians. Typically, the pharmacist would receive a legitimate prescription from a Medicaid recipient, fill the prescription as written, and then rewrite another prescription for a more expensive medication. He would then submit the claim to Medicaid for payment. Investigators reviewed inventory records of the pharmacist's business and found no justification for Medicaid to be billed for the more expensive medications. The pharmacist was convicted of first-degree felony theft and was sentenced to 23 years in prison. He was also ordered to make restitution to the Medicaid program in the amount of \$676,347. In addition, the court imposed a \$10,000 fine on the defendant.

In Missouri, a pharmacist/pharmacy owner was found guilty of committing fraud against the Medicaid program by billing the program for prescriptions that were never filled or prescribed by physicians. During a 1-year period between January 2003 and January 2004, the defendant defrauded Medicaid in the amount of an estimated \$20,000. The court sentenced the defendant to 1 year in jail. The court also ordered the defendant to pay restitution to Medicaid in the amount of \$49,732, with double damages imposed totaling \$99,464. Additional civil penalties of \$130,000 were also imposed on the defendant.

In Michigan, the president of the largest pharmacy in the State that supplies medications to long term care facilities, such as nursing homes, was charged with 148 counts of Medicaid fraud. The investigation found that the pharmacy allegedly billed the Medicaid program for: (1) medications that were not used but were returned to the pharmacy, (2) medications for patients who were deceased, and (3) medications prescribed for patients who resided in hospices(s). In August 2006, criminal charges were filed against the accused and are pending. In a companion civil action filed against the pharmacy and its parent company, a civil settlement was reached which totaled \$52 million. It is the largest Medicaid fraud case ever initiated in Michigan. The investigation was conducted jointly by the Michigan Department of Community Health, HHS OIG, and the FBI.

## **Physicians**

In Kentucky, a joint investigation conducted by the MFCU, HHS OIG, the FBI, and the U.S. Attorney's Office found that a physician/anesthesiologist who owned a pain management clinic committed fraud against the Medicare and Medicaid programs by billing for services that were never delivered, for treatments using a bioelectric device that was not federally approved, and billing for services on dates when not in the Commonwealth of Kentucky. The physician entered into a pretrial diversion program. The defendant's wife and father-in-law, who assisted the defendant, also pleaded guilty to felony fraud charges. They were sentenced to 2 years and 22 months in Federal prison, respectively. Restitution was ordered in the amount of \$350,000.

In Texas, a joint investigation conducted by the MFCU and the FBI revealed that a physician who saw no patients had been signing preprinted prescriptions and Certificates of Medical Necessity (CMN) for motorized wheelchairs and was paid \$250 by Medicare/Medicaid for each CMN. Several beneficiaries testified at trial that they had never received any treatment from the physician. From 2002 through 2004, the physician's fraudulent prescriptions resulted in about \$10 million in false claims being made to Medicare and Medicaid. The physician was convicted on 12 counts of health care fraud and 1 count of conspiracy. The defendant was sentenced to 120 months' imprisonment on the fraud charges and 60 months on the conspiracy charges, to be served concurrently. The defendant also received 3 years of supervised probation. In addition, the defendant was ordered by the court to pay \$7.9 million in restitution to the Medicare and Medicaid programs. The court also ordered that the defendant not practice medicine again without first getting written permission from the court.

## **Psychiatrist**

In Maryland, a psychiatrist pleaded guilty to defrauding the Medicaid program in the amount of \$200,000. From January 2002 to May 2004, the defendant billed Medicaid for nearly 6,500 psychiatry sessions with recipients. The investigation revealed that these sessions never occurred. The defendant was sentenced to 5 years in jail, with all but 12 months suspended; those were to be spent in home confinement. The defendant was also placed on 2 years of probation. In addition, the defendant was ordered to pay \$400,000 in restitution and penalties.

## **Transportation Providers**

In Wisconsin, the owner of an ambulance service was convicted of four counts of felony forgery and two counts of felony medical assistance fraud. The defendant altered inspection documents to show that the company's vehicles had been properly inspected by the appropriate State agency, when in fact they had not. The defendant received a sentence of 5 years of imprisonment, with 2 years of confinement and 3 years of extended supervision and 3 years of probation. The ambulance service (corporation) was convicted of four forgery counts and three fraud counts.

In Vermont, a transportation provider pleaded guilty to one count of Medicaid fraud for submitting false claims in excess of \$10,000 to the State's Medicaid program for services that were not rendered. The defendant claimed that she drove her granddaughter daily to a methadone maintenance program in a neighboring State when, in fact, the investigation revealed that the granddaughter actually drove herself. The defendant was sentenced to 1 to 2 years in jail, suspended with probation, and ordered to pay restitution in the amount of \$10,080 to the Medicaid program.

Questions and comments regarding this report should be directed to:

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