DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

ANNUAL REPORT
State Medicaid Fraud Control Units

FISCAL YEAR 2001
(October 1, 2000 – September 30, 2001)

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Introduction

This is the twelfth Office of Inspector General (OIG) Annual Report on the performance of the state Medicaid Fraud Control Units. This report covers the federal Fiscal Year (FY) 2001, commencing October 1, 2000 and ending September 30, 2001.

During this reporting period, there were 47 states and the District of Columbia (D.C.) participating 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 and neglect. Forty-two of these Units are located within the Office of State Attorneys General. The remaining five Units are located in various other state agencies. The D.C. Unit is placed under the D.C. Office of Inspector General. The Units' authority to investigate and prosecute cases involving Medicaid provider fraud and patient abuse and neglect 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 2001, the program had granted more than $106 million in federal funds to the Units, with a cumulative total of more than $1.2 billion in federal grant funds awarded to the Units from FY 1978 through FY 2001.

TABLE OF CONTENTS

BACKGROUND 4

OVERSIGHT OF THE UNITS 5

CERTIFICATION/RECERTIFICATION 5

EXCLUSION AUTHORITY 6

CIVIL REMEDIES 6

SURVEILLANCE AND UTILIZATION REVIEW SUB-System (SURS) 7

GRANT EXPENDITURES 8

STATISTICAL ACCOMPLISHMENTS 8

CASE NARRATIVES 8

NATIONAL HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM 15

HEALTHCARE INTEGRITY AND PROTECTION DATA BANK (HIPDB) 16

EXPANDED AUTHORITY - PUBLIC LAW 106-170 17

AWARD RECOGNITION 17

AWARD RECIPIENTS 18

APPENDICES

Appendix A - Performance Standards 22

Appendix B - Unit Statistics for the Fiscal Year 2001 27

Appendix C - State Fraud Policy Transmittals 30

Appendix D - Medicaid Fraud Control Unit Directory 32

STATE MEDICAID FRAUD CONTROL UNIT
ANNUAL REPORT FOR FISCAL YEAR 2001

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 Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration.

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, clinics, physicians, dentists, psychiatrists, podiatrists, pharmacists, durable medical equipment (DME) 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 (P. L.) 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 for states to establish Medicaid fraud and abuse control units that met certain standards. Initially, the CMS 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 P. L. 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, P. L. 96-499. This law made federal grant funds available at a rate of 90 percent for the first three 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 OIG was established within DHEW. As "an independent and objective unit," the OIG's missions were: (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 to: (A) promote economy and efficiency in the administration of; and (B) 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 CMS had the 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 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 CMS to the OIG. The Secretary of the Department of Health and Human Services (DHHS), 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 Medicaid Oversight Staff (MOS) has the 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 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, MOS, at least 60 days prior to the end of its current 12-month certification period. In considering a Unit's eligibility for recertification, the MOS thoroughly reviews the reapplication documentation submitted. The MOS assesses whether the Unit seeking recertification has fully complied with the 12 Performance Standards and whether the Unit utilized federal resources effectively in detecting, investigating and prosecuting Medicaid fraud and patient abuse and neglect cases. If applicable, the MOS would also evaluate the results of any on-site Unit reviews conducted during the preceding 12 months. Once reviewed and assessed, the MOS 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, P. L. 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. Public 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, P. L. 100-93 gave the Secretary of DHHS the authority to exclude those persons or entities who have been 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 2001, the OIG excluded a total of 3,756 individuals and/or entities from participating in the Medicare/Medicaid programs and other federally sponsored health care programs. Of this number, 551 were based on referrals made to the OIG by the Units.

CIVIL REMEDIES

The Civil Monetary Penalties Law (CMPL) of 1981 authorizes the Secretary of DHHS to impose administrative monetary penalties and assessments against individuals 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 the 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 individuals from participation in the Medicare and Medicaid programs.

Over the years some Units have increased the use of their state's civil statutes in prosecuting civil cases involving Medicaid providers. Issues arise 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), which is an automated claims payment and information retrieval system. 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 that guide Medicaid program managers; and (2) to identify the providers (and recipients) most likely to commit fraud against the Medicaid program. In addition, the single state Medicaid agencies are required by federal law to enter into a Memorandum of Understanding (MOU) with their respective state Unit. The purposes for developing and implementing an MOU are 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. Most Units rely on referrals received from the SURS (or the Medicaid agency) 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 2001, DHHS awarded the Units over $106.6 million in federal grant funds. The total number of individuals employed by the Units at the end of the period was 1,463. (Appendix B) Since the inception of the program in 1978, the cumulative grant funds awarded to the Units have increased from $9.1 million to over $1.2 billion.

STATISTICAL ACCOMPLISHMENTS

Collectively, the Units recovered over $252.5 million in court-ordered restitutions, fines, and penalties in FY 2001. The total number of convictions achieved for the period was 1,002. Appendix B shows each Unit's individual accomplishments for FY 2001. Appendix D is a comprehensive list of directors, their addresses and contact information.

CASE NARRATIVES

In addition to statistical accomplishments, the following are representative samples of successful Medicaid fraud and patient abuse and neglect cases conducted by the Units in FY 2001:

CLINIC

- ❑ One of the nation's largest, privately owned psychiatric chains paid $2.18 million to settle allegations that it defrauded the Nevada Medicaid program. The case originated when a former employee filed a whistle blower complaint under the federal False Claims Act. The employee alleged that the organization billed for services that were not rendered and for services that were provided by students rather than by licensed professionals. The Medicaid Fraud Control Unit (MFCU) and the Federal Bureau of Investigation assisted the Department of Justice in the investigation of the case, which resulted in a total settlement of $7 million. The Medicare program, the TRICARE program and the Medicaid program in Indiana and Virginia also participated in the settlement.

DENTISTS

- ❑ In Florida, 17 dentists, along with 89 other individuals, were arrested for participating in an organized Medicaid and provider fraud scheme that involved the exploitations of thousands of children living in some of the poorest neighborhoods in South Florida. The scheme involved recruiters, some with prior convictions for narcotics, child molestation and even murder, who transported van loads of children to various dental clinics. The dentists paid the recruiters $20 to $35 for each child that was transported to the clinics. The parents of many of the children, some as young as 2 years old, were unaware that the recruiters had taken their children from area street corners, school bus stops and in one instance, a day-care summer camp. The children were lured into the vans with the promise of receiving $5, toys, or food at fast food restaurants.

At the clinics, the children were first x-rayed by untrained personnel and then received unnecessary dental work, including tooth extractions that were performed by the dentists. The same children were then shuttled to other clinics where the dentists conducted their own x-rays until the Medicaid benefits ran out. The alleged ringleader, a former dentist whose license was previously revoked by the state of New York, was arrested for hiring licensed dentists and paying them $500 a day to treat the young Medicaid recipients. The ringleader and his two accomplices defrauded the Medicaid program of approximately $10 million. Thus far, four of the 17 dentists have been sentenced on Medicaid fraud charges. One dentist was sentenced to 3 years probation; two were sentenced to 4 years probation; and the fourth dentist was sentenced to 2 years house arrest. In addition, the defendants were ordered to pay a total of $325,000 in restitution and to surrender their dental licenses. This action was the result of the work of a 2-year task force dubbed "Operation Tooth Decoy" by the Florida MFCU.

- ❏ A dentist was convicted in Ohio on misdemeanor charges relating to Medicaid and insurance fraud. The dentist was charged with submitting false claims by falsifying entries in dental charts, and billing Medicaid for dental services that were not rendered. The dentist was sentenced to 2 years probation and ordered to pay $3,650 in restitution to the Medicaid program and $1,264 to the Dayton Area Health Plan. In addition, he was ordered to pay $10,500 to the state for prosecuting the case.

DURABLE MEDICAL EQUIPMENT

- ❏ A New Mexico couple, who owned a DME company, pled guilty to defrauding the Medicaid program of approximately $20 million over a 4 year period. Investigation revealed that the couple submitted false claims for oxygen refills for 600 Medicaid recipients, although in most instances, the oxygen was never provided. The husband was sentenced to serve 30 months incarceration and his wife received a 70-month jail term. In addition, both were ordered to pay full restitution.

- ❏ A DME supplier operating in Washington and Oregon, was sentenced to 5 years probation and ordered to pay $400,000 in restitution after being convicted in Washington on charges of mail fraud. An investigation by the Oregon and Washington MFCUs and the OIG revealed that the DME company submitted upcoded claims for supplies that were not medically necessary, and frequently falsified telephone prescriptions and certificates of medical necessity to the Medicare and Medicaid programs. Earlier, the company was convicted in Oregon on charges of filing false claims and was ordered to pay $600,000 in restitution and court costs. As part of the Oregon conviction, the owners/operators of the company agreed to enter voluntary exclusion agreements with the OIG.

- ❏ In Minnesota, a DME company owner pled guilty to a misdemeanor charge of theft by swindle. The owner defrauded Medicaid by submitting and receiving payment on a claim for a new motorized wheelchair when it was actually a used motorized wheelchair. He was ordered to pay $1,386 in restitution and a court fine of $930. He was also sentenced to probation for a period to be determined at a later date.

HEALTH CARE CENTER

- In New York, the owner/operator of an adult day/health care center pled guilty to two counts of grand larceny in the first degree, two counts of conspiracy in the fourth degree and 11 counts of offering a false instrument for filing in the first degree. In order to increase his Medicaid income, the defendant took advantage of elderly Russian immigrants. He enticed them by serving food at his facility and then offered $50 to participants who referred other Medicaid recipients to the facility. Although the facility was only authorized to operate two shifts, it was routinely operating three shifts and billing Medicaid for approximately 975 people per day. In addition, the participants were not receiving genuine medical care as mandated by the Medicaid program. Instead, they were receiving free meals, English lessons, and social activities. On multiple occasions, the defendant falsified records and attempted to deceive state inspectors. As part of his plea, the defendant agreed to pay restitution of $25 million to the Medicaid program, and his facility agreed to have $23.4 million in funds withheld from its future Medicaid reimbursements as part of a rate readjustment for the years 2000 and the first quarter of 2001. The defendant was sentenced to serve a concurrent 3 years in jail.

MANAGED CARE

- In New York, a former physician assistant and his corporation pled guilty to stealing more than $275,000 from taxpayers through the Medicaid program. In 1995, the defendant's corporation contracted through a health maintenance organization (HMO) to provide primary-care physicians to Medicaid recipients. Under the contract, the defendant also subcontracted through the HMO to operate two medical clinics that provided patients with 24-hour medical coverage and physicians who were required to be available 20 hours a week. The defendant, however, admitted that physicians at his clinics did not provide adequate medical care, medical services were performed by unsupervised physician's assistants and nurse practitioners, and patients did not receive visits or services by physicians on a frequent basis. The physician assistant also admitted stealing money from the payroll account before clinic employees were paid. The HMO failed to take corrective action when it discovered that the clinics did not meet the needs of the patients. After an audit revealed that the HMO received $1.7 million in Medicaid reimbursement for services the clinics never provided, the HMO agreed to repay $2 million, including interest, to the Medicaid program. The physician assistant was sentenced to a maximum of 3 years in prison, fined $130,000, and was ordered to pay full restitution of $275,000. In addition, the state Health Department revoked his medical license. The corporation was fined $10,000.

MEDICAL TRANSPORTATION

- The owner/operator of one of the largest Medicaid-funded, non-emergency transportation companies in Georgia was indicted and charged with defrauding the Medicaid program, mail fraud, conspiracy and money laundering. The owner and his company submitted numerous false Medicaid claims for transportation services that were never provided to

recipients, and claims in which the mileage was grossly exaggerated. The total amount of fraudulent Medicaid billing was more than $15 million. Court evidence showed that the owner laundered more than $3 million of the money through a series of separate bank accounts. He used some of the proceeds of the fraud to purchase a home in Canada and a home and property in Mississippi. After the court verdicts, the owner was ordered to forfeit his home and property in Mississippi, his mortuary and adjacent property, and close to $9 million. He was sentenced to 96 months in prison, followed by 3 years supervised release, and 60 hours community service. In addition, he was ordered to pay $12.7 million in restitution and an $8,000 special assessment.

- A former owner of an Arkansas cab company agreed to plead no contest to the charge of theft of public benefits. Over a two-year period, the owner submitted inflated mileage claims for cab services that were never provided to Medicaid recipients and knowingly collected fraudulent vouchers from cab drivers to receive higher reimbursement. The company charged drivers 20 percent of the face value of each voucher as a "processing" fee, along with fees for operating fictitious cabs supposedly performing the services. It was determined that of the $5.9 million the cab company billed Medicaid, $4.3 million was for transportation services that were never provided. The owner was sentenced to 60 months probation, 120 days electronic monitoring, a suspended fine of $15,000 and was ordered to pay $430,000 in restitution. Other individuals involved in the scheme have been sentenced to prison or placed on probation.

NURSES

- In Kansas, a licensed practical nurse pled guilty to one felony count of drug possession, one misdemeanor count of mistreatment of a dependent adult and two misdemeanor counts of adulteration of a drug for incidents involving OxyContin prescriptions for two nursing home residents. In one instance, the nurse took OxyContin pills from the resident's medication supply and replaced them with another drug. On another occasion, she diluted a resident's prescribed liquid OxyContin with water. The nurse, who surrendered her license, was sentenced to 7 months in jail and 1 year supervised probation.

- In Connecticut, a woman was convicted of forgery in the second degree and practicing nursing without a license. Although she was not a registered nurse and had no educational background in nursing, the defendant practiced as a licensed nurse for two Medicaid providers by submitting a forged nursing license with her employment application. She was sentenced to 2 years incarceration, with 2 years probation. In addition, she was ordered not to provide any direct or indirect health care treatment to patients and ordered to perform 100 hours of community service.

NURSING HOMES

- In Montana, a nursing home administrator and administrative assistant were charged with theft from a health care facility, theft of federal government money and theft from an Indian tribal organization. The administrator and administrative assistant opened an "Employee Incentive Fund" account, with their signatory authority on the account. Funds were received into the account from Medicaid, Medicare, the U.S. Treasury and patient's personal money. Over a one-year period, however, the defendants withdrew a total of $30,553 as an emergency loan from the account. Initially, the account was designated to allow employees of the nursing home to receive cash awards for being chosen employee of the month. The administrator was sentenced to 12 months in prison, ordered to pay $33,814 in restitution, and $100 in court costs. The administrative assistant pled guilty to three counts of theft and was sentenced to 15 months in prison on each count, and was ordered to pay full restitution.

- In California, a nursing home chain and its owner/operator agreed to pay the government $360,000 in civil monetary penalties for defrauding the Medicaid program. An investigation by the Bureau of Medi-Cal Fraud and Elder Abuse revealed that over a 3 year period, numerous quality of care and other violations occurred at the nursing homes. Among the violations found were patients receiving substandard health care and inadequate personal hygiene care; patients suffering from malnutrition; lack of adequate staff; and employees causing accidents and injuries to patients, falsifying medical records, and misusing funds from patients' trust accounts. The defendants also agreed to pay $25,000 in restitution to the Medi-Cal program, $50,000 for partial reimbursement of investigative costs, and $40,000 to implement a comprehensive program to ensure proper training of employees and qualify of care reforms.

- A nursing home entered into a civil settlement agreement to pay the Arkansas MFCU $10,000 for patient negligent resulting in a death. A patient sustained injuries, including fractures to his skull, upper extremities and mouth, while allegedly being transferred from his bed to the bathroom by an employee. The patient was transferred to a hospital where he later died of intercranial hemorrhage and closed-head injury. Investigators found that the nursing home was negligent in the care of the patient.

PATIENT ABUSE AND NEGLECT

- In Tennessee, eight individuals were convicted of the beating death of a 38 year old male resident of a state-run facility for the developmentally disabled. A five-year investigation concluded that the victim bled to death after being hit in the stomach approximately 15 times. Three of the accused individuals were granted immunity in exchange for their testimony. Four others pled guilty to civil rights violations and/or conspiracy to violate civil rights. Of these four, one individual was sentenced to 5 years incarceration in a federal prison and 3 years probation; another to 5 years and 3 months incarceration in a federal prison and 3 years probation; and the remaining two were each sentenced to 11 years and 3 months incarceration in a federal prison, followed by 3 years supervised

release. A jury found the eighth individual guilty of conspiracy to violate the civil rights of the resident, which resulted in his death, and was sentenced to 15 years in prison, followed by 3 years of supervised release.

- In Ohio, a nursing assistant was convicted on a state charge of involuntary manslaughter of an 83 year old female patient. The nursing assistant, while working in a nursing home facility, repeatedly slammed the victim's head onto a bed because she would not lie down. As a result of the abuse, the victim died of a heart attack. The nursing assistant was sentenced to 3 years imprisonment, followed by 5 years supervised probation.

- In Massachusetts, a health care corporation agreed to pay $660,000 to settle allegations that its subsidiary, a nursing home, neglected their residents and improperly billed Medicaid for skilled nursing services that were not provided. Although the nursing home was receiving hundreds of thousands of dollars from the state's Medicaid program, the care being provided was inadequate, and the residents were often neglected. Investigation found that inadequate staffing led to high rates of medication errors, large numbers of accidents and failure to provide proper fluids, nutrition and general care to patients.

- Two nursing home direct care workers were sentenced in Mississippi for felonious abuse of a vulnerable adult. One of the defendants allegedly hit the patient with his fists and then sat on the victim resulting in the victim's death. He denied hitting the victim but admitted sitting on the victim and holding him down while his co-defendant hit and kicked the victim. The defendant was sentenced to 3.5 years imprisonment and 5 years probation. The co-defendant was sentenced to 5 years in jail, with 4 years suspended, and 5 years probation. They each were ordered to pay $848 in court costs.

- In Kentucky, a management corporation was convicted of filing false Medicaid claims and neglecting patients in a nursing home. The corporation, the former management company of a nursing home center, pled guilty earlier to intentionally making false statements to receive Medicaid benefits. The guilty plea was part of a $1.2 million settlement following a 1998 criminal and civil investigation involving the center allegedly committing multiple patient neglect violations. During the time of the allegations, the corporation was responsible for hiring medical employees and filing Medicaid claims for the center. Some Medicaid patients, however, did not receive adequate services from the medical staff and, as a result, suffered from decubitis ulcers, compromised nutrition and dehydration. Although corporate officials were aware of the violations, they continued to bill fraudulent claims to the Medicaid program. As part of the plea agreement with the MFCU, the corporation agreed to pay $254,000 in restitution; $20,000 in fines; $43,000 in investigative costs; and $500,000 to the Kentucky Nursing Incentive Scholarship Fund. As part of the federal civil settlement, the corporation agreed to pay $386,000 in restitution and to be excluded from participating in the Medicaid program. The corporation also entered into a corporate integrity agreement with DHHS.

PATIENT TRUST FUNDS

- ❏ In Delaware, an administrative employee pled guilty to two counts of theft and one count of exploiting an infirmed adult at a nursing home over a 20-month period. An investigation by the Smyrna Police Department and the MFCU revealed that the defendant diverted a resident's pension checks to her personal bank accounts. The pension funds were to supplement Medicaid payments for the care of the resident, as well as provide spending money for the resident. As a condition of the plea, the employee received a sentence of probation with the agreement to make full restitution of $5,800 and was prohibited from having contact with the facility.

- ❏ A caregiver and her husband were sentenced in Arizona for stealing $10,320 from the checking account of an elderly resident of an assisted living facility. The investigation revealed that the caregiver, while employed at the facility, stole one of the victim's checkbooks. The caregiver unlawfully cashed the victim's checks on eight different occasions, while her husband cashed additional checks on 10 different occasions. The defendant was sentenced to 5 months in jail and supervised probation. The defendant's husband was sentenced to 60 days in jail and supervised probation.

- ❏ The grandson of an elderly Utah couple was sentenced to 15 years imprisonment and ordered to pay $59,306 in restitution for exploiting and pocketing funds that were to pay the housing costs of his ailing grandparents who resided in a nursing home. The couple was asked to leave the nursing home facility after the grandson failed to pay $15,000 in incurred expenses. Another nearby nursing home agreed to take in the couple based on a promise, made by the grandson, to pay the facility nearly $50,000. The grandson, however, failed to pay the facility the agreed upon amount.

PHARMACIES

- ❏ A national pharmaceutical company agreed to pay $4 million to the state of Hawaii, Medicaid Investigation Division, for illegal pharmacy and billing practices against the Medicaid program. The case was initiated after two employees reported illegal pharmacy and billing practices conducted by a pharmacy owned by the company. The pharmacy supplied drugs to the majority of long-term care facilities in Hawaii. The investigation revealed, however, that the pharmacy overbilled for medical services, recycled prescription drugs and participated in schemes to circumvent the Medicaid and Medicare programs. This settlement was the largest Medicaid fraud recovery in the state's history. In addition to the settlement agreement, the company agreed to provide a computer database to the state and to support elder abuse and fraud prevention training for law enforcement entities statewide. Three of the participants in the scheme entered no contest pleas to misdemeanor charges of deceptive business practices, and each agreed to pay $10,000 to a charity. The criminal investigation of other participants in the scheme is ongoing.

- ❑ As a result of a joint investigation by the North Carolina MFCU, the Drug Enforcement Administration (DEA) and the state Bureau of Investigation, a pharmacy and a registered pharmacist pled guilty to unlawfully distributing controlled substances and submitting false Medicaid claims. Evidence obtained from an earlier DEA audit showed that the pharmacy was unable to account for over 23,386 units of hydrocodone over a 15-month period. When interviewed by agents, patients stated that they received drugs from the pharmacy without legitimate prescriptions. Moreover, approximately 50 physicians and office staff employees confirmed that they filed prescriptions without a doctor's authorization. The pharmacist was sentenced to 5 years imprisonment, 5 years probation, and ordered to pay restitution in the amount of $159,459 and a $200 assessment. The pharmacy was ordered to pay an assessment of $525, a fine of $1,500 and restitution of $159,459 to the state Medicaid program.

PHYSICIANS

- ❑ A medical doctor was convicted in Alaska of 73 crimes including sexual assault, drug distribution, theft and fraudulent Medicaid claims. Over a two-year period, the doctor engaged in a pervasive pattern of prescribing unnecessary drugs such as Roxicet, Demerol, Meperidine and other controlled substances to vulnerable female patients in exchange for various sexual acts. The doctor used the prescriptions to improperly bill Medicaid for medical services that were not provided or not medically necessary. The doctor was ultimately sentenced to 34 years imprisonment, with 15 years suspended, followed by 10 years supervised probation upon release. In addition, he voluntarily surrendered his medical license to the state medical board.

- ❑ In Illinois, a physician who owned two medical clinics, along with two unlicensed clinic employees, pled guilty to Medicaid fraud, theft, and other related crimes. An investigation conducted by the MFCU revealed that the doctor knowingly allowed the two unlicensed employees to practice medicine in his clinics, but billed Medicaid as though he performed the services. The doctor pled guilty to vendor fraud and theft and was sentenced to 48 months probation, 750 hours of community service and ordered to pay $100,216 in restitution to the Illinois Department of Public Aid. One of the employees was sentenced to 30 months probation for committing criminal sexual assault while examining patients. The other employee was charged with practicing medicine without a license, practicing under an assumed name and diagnosing patients without a license. He was sentenced to 45 days in jail, 30 months probation and fined $10,000.

PODIATRIST

- ❑ A former podiatrist pled guilty in Indiana for participating in a health care fraud scheme that resulted in a $2.6 million loss to the Medicaid program. The podiatrist billed Medicaid for numerous services and procedures that were improper or not medically necessary. He was sentenced to 68 months imprisonment, 3 years supervised release and ordered to pay full restitution, a $600 special assessment and $230,409 in investigative costs.

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 DHHS, acting through the DHHS, OIG. The Program was designed to coordinate federal, state and local law enforcement activities with respect to health care fraud and abuse.

In FY 2001, federal prosecutors filed 445 criminal indictments in health care cases. A total of 465 defendants was also convicted for health care fraud related crimes in FY 2001. Additionally, 188 civil cases were filed, and 1,746 civil matters remained pending during the year. In FY 2001, 3,756 individuals and entities were excluded from participating in the Medicare, Medicaid or other federally sponsored health care programs. This record number of exclusion actions is the result of successful collaboration with the Units and the OIG.

In FY 2001, the federal government won or negotiated more than $1.7 billion in judgments, settlements and administrative impositions in health care fraud cases and proceedings. As a result of these activities, as well as prior year judgments, settlements, and administrative impositions, the federal government collected more than $1.3 billion in 2001. More than $1 billion of the funds collected and disbursed in 2001 were returned to the Medicare Trust Fund. An additional $42.8 million was recovered as the federal share of Medicaid restitution. This is the largest return to the government since the inception of the Program.

The Program continues to maximize the effectiveness and efficiency of law enforcement efforts by promoting information sharing and collaboration between federal, state and local agencies. Such collaborations increased in FY 2001 through heightened data sharing, joint training and the continued efforts of the National Health Care Fraud Task. 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 AND PROTECTION DATA BANK (HIPDB)

The HIPAA called for the establishment of a national health care 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 health care practitioners, providers and suppliers to the new Healthcare Integrity and Protection Data Bank (HIPDB).

The HIPDB provides a resource for federal and state agencies and health plans to check 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 health care practitioners, providers and suppliers in federal or state courts, related to the delivery of health care items or services;

2) federal and state criminal convictions against health care practitioners, providers or suppliers, related to the delivery of health care items or services;

3) Actions taken by federal or state agencies responsible for licensing and certification of health care practitioners, providers and suppliers;

4) Exclusions of health care practitioners, providers and suppliers from participation in federal or state health care 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 $5.00 per name. The HIPDB information is not available to the general public. Health care practitioners, providers or suppliers however, 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 DHHS manages 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, P. L. 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 allows 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 most vulnerable population.

AWARD RECOGNITION

Each year, the OIG selects at least one Unit to receive the Inspector General's state Fraud Award. The selection is based on the Unit's effectiveness and efficiency in combating fraud and abuse in the Medicaid program. For FY 2000, the California Bureau of Medi-Cal Fraud and Elder Abuse

was selected to receive the award. For FY 2001, the Arizona Medicaid Fraud Control Unit was selected to receive the award.

During the FY 2000 reporting year, the California Unit demonstrated its exceptional ability to detect, investigate and prosecute Medicaid provider fraud while maintaining an average of 152 staff each quarter. There were 139 criminal convictions over this period.

The Unit's federal funding level for FY 2000 was approximately $10 million. Medicaid recoveries for this time period were approximately $35 million.

During the FY 2001 reporting year, the Arizona Unit stood above its peers with the efficiency of its operation. With a staff of 13, the unit produced 32 criminal convictions. The unit was also commended for its timely reporting.

Arizona's federal funding level for FY 2001 was approximately $1 million while its Medicaid recoveries totaled over $7 million.

AWARD RECIPIENTS

The 2000 Inspector General's State Fraud Award was presented to Collin Wong (center), the Director of the California Medicaid Fraud Control Unit by Inspector General Janet Rehnquist (fourth from the right). Pictured from the left are Mr. D. McCarty Thornton, Chief Counsel to the Inspector General; Mr. George F. Grob, Deputy Inspector General for Management and Policy; Mr. Claude A. Allen, Deputy Secretary of the Department of Health and Human Services; Mr. Wong and Inspector General Rehnquist; Mr. Robert Richardson, former Acting Deputy Inspector General for Investigations; Mr. Thomas D. Roslewicz, former Deputy Inspector General for Audit Services; and Mr. Michael F. Mangano, Principal Deputy Inspector General.

The 2001 Inspector General's State Fraud Award was presented to Pamela Svoboda (center), the Director of the Arizona Medicaid Fraud Control Unit by Deputy Inspector General for Investigations Vicki Shepard (left). John Bettac, Director of the Medicaid Oversight Staff is on the right.

APPENDICES

APPENDIX A

Performance Standards

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.

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?

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?

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?

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?

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 number of administrative sanctions imposed.

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?

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?

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 Medicaid 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?

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?

12. A Unit should maintain an annual training plan for all professional disciplines. In meeting this 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 for the training requirements 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 2001

Appendix B - Unit Statistics for the Fiscal Year 2001

State	Unit Cost*	Staff	Convictions	Recoveries
Alabama	$709,000	10	7	$821,866
Alaska	$476,000	5	3	$494,117
Arizona	$966,000	13	32	$7,286,795
Arkansas	$1,408,000	22	21	$731,413
California	$13,025,693	171	148	$47,482,802
Colorado	$763,000	11	15	$2,002,827
Connecticut	$718,512	9	7	$154,098
D. C. Unit	$1,116,000	15	0	$352,076
Delaware	$811,000	14	23	$12,672
Florida	$7,395,000	143	62	$55,461,457
Georgia	$3,168,000	43	33	$15,775,116
Hawaii	$982,000	16	9	$6,839,939
Illinois	$4,819,213	66	30	$8,153,788
Indiana	$1,416,000	24	14	$27,988,327
Iowa	$740,000	11	15	$253,161
Kansas	$732,000	10	6	$75,849
Kentucky	$1,234,000	18	5	$2,792,300
Louisiana	$1,323,000	24	42	$3,488,475
Maine	$347,000	6	3	$600,286
Maryland	$1,513,087	19	15	$1,384,403
Massachusetts	$1,856,000	27	7	$2,599,316
Michigan	$3,128,000	39	50	$1,225,166
Minnesota	$999,000	14	15	$2,969,648
Mississippi	$1,214,000	20	52	$3,746,970
Missouri	$1,404,000	23	12	$963,796
Montana	$360,000	5	6	$384,702
Nevada	$888,000	13	2	$3,640,233

State	Unit Cost*	Staff	Convictions	Recoveries
New Hampshire	$520,000	8	5	$749,750
New Jersey	$2,413,000	36	13	$1,422,424
New Mexico	$920,000	13	8	$142,307
New York	$28,695,000	292	67	$9,919,758
North Carolina	$1,629,000	22	20	$7,371,278
Ohio	$2,633,000	42	55	$1,938,279
Oklahoma	$885,000	18	28	$1,216,441
Oregon	$620,000	8	10	$8,956,293
Pennsylvania	$3,358,000	52	17	$5,051,244
Rhode Island	$699,000	12	6	$557,405
South Carolina	$859,000	13	24	$1,138,215
South Dakota	$240,000	5	7	$392,079
Tennessee	$1,954,000	37	22	$1,040,728
Texas	$2,398,000	34	27	$2,463,121
Utah	$983,000	12	11	$600,097
Vermont	$379,000	6	6	$201,773
Virginia	$947,000	17	8	$2,299,295
Washington	$1,414,000	17	13	$1,302,414
West Virginia	$634,000	15	3	$3,620,537
Wisconsin	$720,000	9	16	$4,501,242
Wyoming	$288,000	4	2	$19,145
TOTAL	$106,699,505	1,463	1,002	$252,585,423

APPENDIX C

State Fraud Policy Transmittals

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.

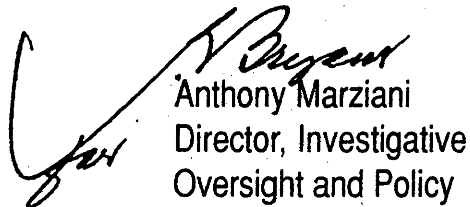
In determining how to use program income, Units may use the funds to meet the cost sharing requirements of the grant (typically 25 percent) pursuant to section 92.25(g)(3), provided the MFCU has a letter from OIG allowing retention of those funds. A copy of the approval letter should be attached to the 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

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. 99-02
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.

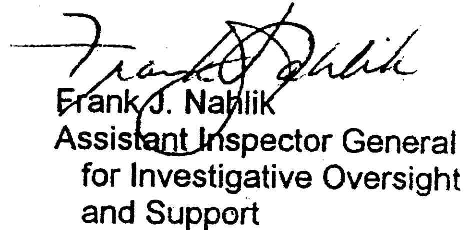
A MFCU should immediately contact the Director of the OIG State Medicaid Oversight and Policy Staff in the following situations:

- 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.



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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

SEP 7 2000

TO: All Medicaid Fraud Control Units

SUBJECT: State Fraud Policy Transmittal No. 2000-1
Extended Investigative Authority for
the State Medicaid Fraud Control Units

The Ticket to Work and Work Incentives Improvement Act of 1999, P.L. 106-170, included an amendment which extended the jurisdiction of the State Medicaid Fraud Control Units (MFCUs) to include investigations and prosecutions of: (1) Medicare or other Federal health care cases which are primarily related to Medicaid and (2) patient abuse and neglect in non-Medicaid board and care facilities. The purpose of this policy transmittal is to provide information on the extension of investigative authorities and outline procedures to request permission from the Department of Health and Human Services (DHHS), Office of the Inspector General (OIG) to investigate Medicare and other DHHS health care cases. Requests to investigate health care cases for non-DHHS programs must be directed to the Inspectors General of those other agencies.

The amendment provides that upon approval of the Inspector General of the relevant federal agency, MFCUs can investigate and prosecute any aspect of the provision of health care services and activities of providers of such services, under any Federal health care program including Medicare or the Children's Health Insurance Program (CHIP)(title XXI of the Social Security Act), if the suspected fraud or violation of law in such cases or investigations is primarily related to Medicaid.

Additionally, the MFCUs have the option to investigate complaints of abuse or neglect of patients residing in board and care facilities (regardless of the source of payment), from or on behalf of two or more unrelated adults who reside in such facilities. Board and care facilities include residential settings where two or more unrelated adults reside and receive one or both of the following:

(1) Nursing care services provided by, or under the supervision of, a registered nurse, licensed practical nurse, or licensed nursing assistant.

(2) A substantial amount of personal care services that assist residents with the activities of daily living, including personal hygiene, dressing, bathing, eating, personal sanitation, ambulation, transfer, positioning, self-medication, body care, travel to medical services, essential shopping, meal preparation, laundry, and housework.

The authority to approve requests to investigate and prosecute Medicare or CHIP cases covered by this extended jurisdiction has been delegated to the DHHS/OIG Regional Inspectors General for Investigation (RIGI). No OIG approval is required for patient abuse investigations in board and care facilities.

Requests must be in writing from the MFCUs to the appropriate Office of Investigations Field Office (OIFO), and should generally include the following information:

(1) The nature of the complaint and the date received by the MFCU.

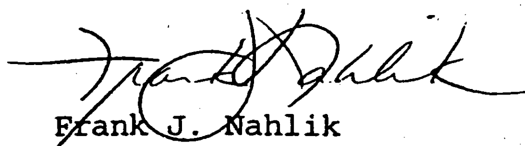
(2) A brief description of how the complaint is covered under the expanded investigative authority.

(3) Name and phone number for the lead investigator or supervisor and any special requests or information.

The RIGI will provide a written response to the MFCU within 15 working days (in most cases) of receipt of the request. The OIFO will also provide a copy of the response and the MFCU's original request to the Director, State Medicaid Oversight and Policy Staff.

The total number of hours spent investigating cases covered under this expanded authority should be included with the MFCU's annual report.

Any questions concerning this policy should be directed to Joseph Prekker, Director, State Medicaid Oversight and Policy Staff at (202) 619-3557.



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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

DEC 7 2000

TO: All Medicaid Fraud Control Units

Subject: State Fraud Policy Transmittal Number 2000-2 Rescission of State Fraud Policy Transmittal Number 92-2

This transmittal rescinds State Fraud Policy Transmittal Number 92-2, which canceled on-site recertification reviews of the Medicaid Fraud Control Units (MFCU). The State Medicaid Oversight and Policy Staff (SMOPS) will be resuming limited on-site reviews in an effort to help the Units become more efficient and effective in fulfilling their mandate of investigating and prosecuting Medicaid provider fraud and patient abuse. The Office of Inspector General (OIG) performance standards will be used in conducting the on-site reviews. The directors of the sites chosen for reviews will be notified prior to arrival, and a preliminary list of materials and files needed for the review will be sent to the Unit.

These reviews do not obviate the need for the annual, quarterly statistical and financial reports submitted by the MFCUs to determine eligibility for recertification. The reports are still required as a condition of the legislation, and must be submitted at the intervals as specified in 42 CFR Ch. V, Part 1007. Information regarding the requirements and due dates for each MFCU is provided in the recertification letter issued by the SMOPS.

Any questions or comments about this policy should be directed to Joseph Prekker, Director, SMOPS at (202)619-3557.

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

APPENDIX D

MEDICAID FRAUD CONTROL UNIT DIRECTORY

Appendix D - Medicaid Fraud Control Unit Directory

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