DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

ANNUAL REPORT

State Medicaid Fraud Control Units

FISCAL YEAR 2002

(October 1, 2001 – September 30, 2002)

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Introduction

This is the thirteenth Office of Inspector General (OIG) Annual Report on the performance of the state Medicaid Fraud Control Units (Units). This report covers the federal Fiscal Year (FY) 2002, commencing October 1, 2001 and ending September 30, 2002.

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 Units. The Units' mission is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect. Forty-one of these Units are located within the Office of State Attorneys General. The remaining seven Units are located in various other agencies. 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 2002, the program had granted more than $116 million in federal funds to the Units, with a cumulative total of more than $1.3 billion in federal grant funds awarded to the Units from FY 1978 through FY 2002.

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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 below the maximum allowable under the state's public assistance program or for those with too much income who "spend down" to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their excess income. 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 (HCFA).

By 1977, the Medicaid program had expanded significantly, costing federal and state governments $19 billion a year. Estimates also showed that fraud and abuse caused the Medicaid program to lose at least $653 million a year. Among the types of health care providers committing Medicaid fraud were nursing homes, hospitals, clinics, physicians, dentists, psychiatrists, podiatrists, pharmacists, durable medical equipment suppliers, laboratories and medical transportation companies. Concerned by the increase of suspected fraud and abuse against both Medicare and Medicaid, Congress passed legislation to stem the rising tide of criminal activity against the two largest federal health care programs. On October 25, 1977, the President signed into law the Medicare/Medicaid Anti-Fraud and Abuse Amendments. As cited in Public Law (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. 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 these 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.

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 3 years of a Unit's operation and 75 percent thereafter.

OVERSIGHT OF THE UNITS

In 1976, the Office of Inspector General (OIG) was established within the Department of Health, Education and Welfare (DHEW). As "an independent and objective unit," the OIG's mission was: "(1) to conduct and supervise audits and investigations relating to programs and operations of the DHEW; (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."

The HCFA/CMS was responsible for administering the federal Medicaid fraud control grant program. The HCFA/CMS' major tasks included monitoring and overseeing the overall activities of the Units as well as annually certifying the Units to receive federal grant funding. It was later determined that the activities and operations of the Units were more closely related to the OIG's investigative function. In 1979, federal oversight and administration of the Units were transferred from the HCFA/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 federal regulations (Appendix A).

Currently, the OIG, Office of Investigations, Medicaid Oversight Staff (MOS), is primarily responsible for overseeing the activities of the 48 Units.

CERTIFICATION/RE-CERTIFICATION

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 the application is approved. Initial application approval and certification by the Secretary is valid for a 1-year period.

For an established Unit to continue receiving federal certification and grant funding from DHHS, the Unit must submit an annual re-application 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 re-certification, the MOS thoroughly reviews the re-application documentation submitted. The MOS assesses whether the Unit seeking re-certification 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 will 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 re-certification 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 General 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 2002, the OIG excluded a total of 3,448 individuals and entities from participating in the Medicare/Medicaid programs and other federally sponsored health care programs. Of this number, 566 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 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 B).

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 the following: (1) to 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 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. In most states, the cooperation

between the Unit and the SURS 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 and the number and quality of the referrals sent to the Units by the SURS.

GRANT EXPENDITURES

In FY 2002, DHHS awarded the Units over $116.9 million in federal grant funds. The total number of individuals employed by the Units at the end of FY 2002 was 1,452 (Appendix C). Since the inception of the program, the federal grant funds awarded to the Units have increased from a total of $9.1 million in FY 1978 to a cumulative total of over $1.3 billion through FY 2002.

STATISTICAL ACCOMPLISHMENTS

Collectively, the Units recovered over $288 million in court-ordered restitutions, fines, penalties and civil settlements in FY 2002. The total number of convictions achieved for the period was 1,147. Appendix C shows each Unit's accomplishments for FY 2002. Appendix D is a list of Unit 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 2002:

BILLING SERVICES

In Texas, the operator of a medical billing service was convicted of 32 counts of heath care fraud, sentenced to 17 ½ years imprisonment and ordered to pay restitution in the amount of $9,348,654. In the course of the investigation, investigators seized personal and real property owned by the defendant to offset the losses incurred. The defendant fraudulently obtained physician provider numbers and billed both government and private health insurers for medical treatments not rendered. The joint investigation was conducted by the Texas Medicaid Fraud Control Unit (MFCU), the DHHS OIG, the Federal Bureau of Investigation (FBI) and the Texas Department of Insurance.

CLINICS

In Nevada, a medical services clinic pled guilty to a single count of felony Medicaid fraud and conspiracy to commit Medicaid fraud. The clinic's president and her brother, an officer of the clinic, were originally charged with four counts of felony Medicaid fraud and two counts of gross misdemeanor Medicaid fraud. The clinic president pled no contest to one count of gross

misdemeanor Medicaid fraud and was ordered to pay $400,000 in restitution, penalties and associated costs. Her brother fled, and a warrant was issued for his arrest. The investigation found that the clinic billed for services not rendered and that the services were provided by a person other than the person(s) identified on the billing claims. Under Nevada law, a company can be charged criminally.

In California, the owner of two "ghost patient" clinics pled guilty to defrauding Medi-Cal, was sentenced to 3 years imprisonment and ordered to pay $1.1 million in restitution. The defendant and his staff purchased Medi-Cal beneficiary cards, created falsified patient charts and then submitted claims to Medi-Cal for payment.

DENTISTS

In South Carolina, a dentist pled guilty to five counts of filing false Medicaid claims, was sentenced to 3 years imprisonment and 5 years probation and ordered to pay a total of $310,403 in restitution, fines and assessments. Review by the MFCU of over 400 patient records for services allegedly provided from January 2000 through December 2001 found that the defendant billed for services not rendered.

In Ohio, a dental office assistant was convicted of Medicaid fraud and sentenced to 2 years of community control. The defendant, a Russian immigrant and single mother of three, who desperately needed to remain gainfully employed, learned that her employer was closing his dental practice due to financial difficulties. In an attempt to ease the dentist's financial difficulties and keep the office open, the defendant forged patient dental treatment records and billed the Medicaid program for services not rendered and electronically credited the program funds to the dental office accounts. The loss to the state's Medicaid program was in excess of $100,000. The dentist repaid Medicaid the funds that his office assistant illegally obtained.

DURABLE MEDICAL EQUIPMENT (DME)

In Kentucky, the former owner and operator of a DME company was sentenced to 5 years imprisonment and ordered to pay restitution in the amount of $100,000 for defrauding the state's Medicaid program. The defendant obtained referrals through his company from local physicians for DME supplies, including nebulizer circuits. The defendant subsequently arranged for an out-of-state supplier to ship disposable nebulizer circuits, worth about $1, to Medicaid recipients. The defendant then billed Medicaid for non-disposable circuits at a rate of $25 each. In addition, in several cases, the nebulizer circuits were not provided. It was estimated that the defendant falsely billed Medicaid $10,000 per month for phantom DME supplies.

In North Carolina, a DME supplier was convicted of three counts of mail fraud, sentenced to 13 months imprisonment for each of the three counts and 3 years supervised release, to be served concurrently on each count, and was ordered to pay restitution in the amount of $200,300. The defendant was also ordered to abstain from the use of alcohol. The defendant approached

Medicaid beneficiaries in large stores and told the beneficiaries that he could provide them with a powered wheelchair or scooter. The defendant actually provided the beneficiaries with a three-wheel powered scooter and billed the affected health care program(s) for a more expensive powered wheelchair. The MFCU, DHHS OIG and the North Carolina Department of Insurance jointly investigated this case.

In Montana, a joint investigation conducted by the Montana and Florida MFCUs, the DHHS OIG and the FBI, resulted in a DME company and its affiliates reaching a settlement agreement with the Department of Justice (DOJ) in the amount $17.5 million for health care billing fraud. The DME (owner's company) is based in Florida and its parent company is located in Maryland. Prior to reaching a settlement agreement, the DOJ filed a $48 million federal false claim suit against the owner and parent companies. As part of the settlement agreement, the Montana MFCU recovered $526,000. This was the largest settlement for the Montana MFCU since the establishment of the Unit in 1995.

In Ohio, the owner of a "sham" DME company pled guilty to Medicaid fraud and money laundering, was sentenced to 3 years imprisonment and 3 years community control and ordered to pay restitution and costs of prosecution in the amount of $929,952. From January 1995 through May 1999, the defendant billed the state's Medicaid program over $900,000 for medical equipment and supplies that were not provided. The defendant utilized recipient identification numbers stolen from his former employer and formed his company for the sole purpose of defrauding the Medicaid program, with no intention of providing services.

HEALTH CARE CENTERS

In New York, the owner of a substance abuse treatment center and his business associate were found guilty of grand larceny, conspiracy and offering a false instrument. The defendants conspired to steal nearly $3 million from the Medicaid program. The defendants routinely submitted false claims to Medicaid for reimbursement for alcoholism outpatient services. The owner was sentenced to 2 ½ to 7 years imprisonment. His business partner was sentenced to 2 to 6 years imprisonment. Both defendants were ordered to make restitution to the state's Medicaid program.

In Massachusetts, a home health agency agreed to repay the state's Medicaid program over $35,000 for overpayments made after the agency submitted claims based on a registered nurse's fraudulent patient reports. The nurse was an employee of the agency. After conducting an internal probe of the nurse's fraudulent activities, the home health agency notified the MFCU, the state's Division of Medical Assistance and federal Medicare officials. The investigation revealed widespread falsification of patient reports perpetrated by the nurse over a 2-year period. In 2001, the nurse pled guilty to federal health care fraud charges, was sentenced to 4 years of supervised probation and ordered to serve 500 hours of community service. The nurse was excluded from the Medicare/Medicaid program and, as a further condition of her probation, was barred from reapplying for her nursing license until 5 years after the expiration of her probation period. In

2002, the nurse entered a second guilty plea in state court. The state added no additional time to the original sentence and did not impose any additional fines.

HOME HEALTH SERVICES

In Kansas, a home heath care attendant pled guilty to one felony count of Medicaid fraud, was sentenced to 1 year supervised probation and ordered to pay $11,248 in restitution and investigative costs. Between February 1998 and April 2001, the defendant submitted false time sheets to Medicaid for reimbursement for providing services to her grandmother. The investigation revealed that, during the time period in question, the grandmother was either hospitalized or a nursing home resident and the defendant provided no services.

In Oregon, a former employee of a Tillanook County senior services agency was convicted on 12 felony counts including submitting false claims for health care payments, aggravated theft, identity theft and computer crime. The employee was sentenced to 93 months imprisonment and 3 years post-prison supervision and ordered to pay restitution in excess of $250,000. As an office specialist with the county agency, the defendant entered claims data from invoices submitted by in-house care givers. The claims data entered was electronically transmitted to the state's Medicaid agency which, in turn, processed the claims and issued checks to payee care givers. The defendant established a fraudulent vendor account listing her teenage daughter as a care giver of Medicaid services. From 1992 through 2001, the defendant repeatedly created and entered claims data into the system showing her daughter as providing services to numerous Medicaid recipients. During this time period, it was estimated that the defendant stole more than $250,000 from the state's Medicaid program.

HOSPITALS

In Michigan, as a result of a civil settlement reached with a hospital which fraudulently billed claims to Medicaid, the program received $651,000 in restitution and civil penalties. In addition, criminal charges were filed against the home health director and two subordinate supervisors. The hospital fraudulently billed Medicaid for home health services rendered to psychiatric patients and other non-homebound patients not qualified to receive services under the state's Medicaid plan. The investigation revealed that over 50 percent of the hospital's billings for home health services for these patients were fraudulent.

In New York, three hospitals agreed to repay $3.3 million to the Medicaid program for improperly billing the state for outpatient clinical services provided to patients. The outpatient clinical services allegedly provided included occupational and physical therapy and psychological services. As part of the agreement reached with the MFCU, one hospital agreed to provide $1 million in free services to indigent patients for 5 years. A second hospital agreed to provide $500,000 in free care and services to the indigent for a 7 year period.

IDENTITY THEFT

In Mississippi, a hospital employee obtained the identity and credit information of a hospital patient and used that information to obtain a credit card in the patient's name. The defendant then gave the card to an accomplice who used the credit card to purchase merchandise. Both co-conspirators were convicted of two counts of forgery. The hospital employee, who cooperated with the MFCU, agreed to testify against his accomplice. The employee was sentenced to 3 years imprisonment with 2 years suspended, 1 year house arrest, 2 years supervised probation and fined $1,000, plus court costs. The accomplice was sentenced to serve concurrent sentences of 2 years imprisonment and 1 year of post release supervision.

In California, a 41-count complaint was filed by the Bureau of Medi-Cal and Elder Abuse against four co-conspirators who engaged in a 3-year long scheme to defraud the state's Medicaid program of approximately $1,775,000. Using both the stolen identification information of thousands of patients and seven dentists, the four set-up phony dental clinics that operated for the intended purpose of making false claims to Medi-Cal for payment of non-rendered dental services. Phantom clinic employees were also used to successfully launder the Medicaid monies received. The main defendant and his key accomplice both pled guilty to charges of conspiracy to commit grand theft and to cheat and defraud the Medi-Cal Dental Program. The main defendant also pled guilty to identity theft charges and health benefits fraud. He was sentenced to a 3-year term in jail. His key accomplice was sentenced to 1 year in county jail. The third defendant was also sentenced to serve 1 year in county jail, perform community service and pay restitution of $400,000. The fourth co-conspirator in the case fled and remains at large. In addition, a felony settlement agreement was reached with the three defendants which totaled $2 million in restitution ($1,775,000 for the loss to the program and $225,000 for the investigative costs incurred). To date, over $1.6 million in restitution has been received.

LABORATORIES

In Utah, a nationally known laboratory was the subject of a 4-year investigation for allegedly improperly billing specimen collection fees to the state's Medicaid program. To forgo any further litigation risk, liability and other expenses, the laboratory provided a check to the MFCU in the amount of $84,617. Of this amount, a total of $77,117 was returned to the Medicaid program, and the MFCU received $7,500 in investigative costs.

MANAGED CARE

In Nevada, as part of a settlement for the overpayment of services performed by a physician's managed care group and its wholly-owned subsidiary, the MFCU collected $145,000. The two corporations specialized in pediatric and obstetric services. In the course of the investigation, the MFCU found several instances of upcoding and billing for medically unnecessary services. The settlement encompassed about $60,000 in improper billings and the remaining amount was for investigative costs and penalties.

MENTAL HEALTH SERVICES

In Louisiana, former employees of a Medicaid participating, mental health rehabilitation agency alleged that the owner/administrator and other key administrators at the facility routinely ordered employees to falsify patient service notes to reflect services that were not provided. The investigation revealed that the owner/administrator and her office manager instructed personal care attendants to falsify information to reflect dates and times of service that never occurred. The owner/administrator pled guilty to Medicaid fraud and was sentenced to 5 years imprisonment, suspended, and 2 years active supervision. She was also ordered to pay $15,125 in restitution, $15,000 in civil penalties and $4,200 in investigative costs. For cooperating fully with the investigation, the agency's office manager was not charged.

In Texas, a Licensed Professional Counselor (LPC) was convicted of theft, sentenced to 15 years imprisonment and ordered to pay restitution in the amount of $365,936. The defendant admitted that, during the period January 1996 through June 1998, she defrauded the state's Medicaid program by billing for counseling sessions with children that never occurred.

NURSES AND CERTIFIED NURSING ASSISTANTS

In Rhode Island, a registered nurse pled nolo contendere to three counts of tampering with a controlled substance, was sentenced to 6 years imprisonment, with 5 years suspended, placed on probation and ordered not to seek reinstatement of her nursing license. The defendant stole Oxyfast, a liquid form of Oxycodone, that was prescribed to three patients to alleviate pain and diluted the patient's medication with a colored water solution to conceal her theft.

In Georgia, a registered nurse, working as a Medicaid provider of perinatal and prenatal home health care, pled guilty to theft, was sentenced to 10 years imprisonment, reduced to 120 days of imprisonment and the remainder to be served on probation, ordered to pay restitution in the amount of $93,500, fined an additional $2,500 and ordered to perform 200 hours of community service. The defendant was also excluded from participation in the state's Medicaid program. The defendant submitted false claims to Medicaid for services not provided, but for which she was reimbursed $93,500 by the Medicaid program.

In Illinois, the MFCU successfully conducted an undercover operation entitled "Operation Sunset." The purpose of Operation Sunset was to arrest Certified Nursing Aides (CNAs) in the state with outstanding warrants for a variety of offenses including: drug related offenses, sex offenses, health care fraud or patient abuse and neglect offenses and offenses that would disqualify an individual from employment as a CNA in the state. As part of the operation, 450 CNAs were invited to apply for employment with a fictitious company operated by state law enforcement officials. When the CNAs appeared for job interviews, 21 CNAs with outstanding warrants were arrested. Subsequent to the on-site interviews, contact was made with some CNA applicants that did not appear in person for the interview and an additional 22 CNAs were arrested. Operation Sunset resulted in the arrest of a total of 43 CNAs with outstanding warrants.

NURSING HOMES

In New York, a husband and wife who owned two nursing homes agreed to repay more than $11 million including interest to the state's Medicaid program for improper payments made to them between 1996 and 2001. Beginning in 1994, the couple withdrew substantial amounts of money from their two businesses and classified the money as "management fees." Although these fees were deemed as non-reimbursable administrative expenses, the couple erroneously factored in a percentage of these fees into the rates charged by the health care providers who worked through the couple's two businesses. The scheme resulted in an estimated $9 million in Medicaid overpayments. No criminal charges were brought against the couple.

In Ohio, the owner of a medical staffing firm that provided personnel to nursing homes pled guilty to forgery, was sentenced to 4 years of community control and ordered to pay restitution in the amount of $12,812 to the state. The defendant knowingly forged tuberculosis tests and physical examinations that his staff never performed, defrauding the Medicaid program of more than $5,000.

In California, the assistant administrator of a skilled nursing facility, responsible for new resident admissions and providing social services to residents, was charged with felony theft and abuse. The defendant had resident's families or their representatives pay him or his business for the resident's first month's room and board at the facility. The facility never received any of these funds. The total loss to the residents was approximately $50,000.

PATIENT ABUSE AND NEGLECT

In Arkansas, the owner of a nursing home facility entered into a settlement agreement and agreed to pay $30,000 resulting from the facility's failure to provide adequate nutrition and proper hygiene care to a resident. The resident died from unrelated causes. The investigation revealed that when the coroner responded to an emergency call from the facility, he found that the decedent, his bed, his feeding tube and his immediate surroundings were infested with ants.

In Minnesota, a CNA was found guilty of criminal sexual conduct, was sentenced to 33 months imprisonment and 5 years supervised probation, ordered to pay fines and court costs in the amount of $1,000 and ordered to register as a sex offender and provide DNA samples. The defendant sexually assaulted a nursing care facility resident. He committed vile unspeakable acts against the victim.

In Tennessee, a Medicaid services care giver pled guilty to assault and patient abuse and was sentenced to 11 months and 29 days imprisonment on each charge, to be served consecutively and to pay $500 for each offense. The defendant, while working with a developmentally disabled female, assaulted and abused the victim by punching and kicking her numerous times.

In Hawaii, a 58-year old care home operator was found guilty of neglect for failing to obtain timely medical attention for an 86-year-old man who suffered a hip fracture while in the defendant's care. The investigation also showed that the elderly man had extensive bruising around his hip and groin area, small bedsores on his lower back and had contracted pneumonia resulting from his hip fracture. The victim died from the pneumonia. Prior to the defendant's sentencing, she suffered a massive stroke and died.

In Mississippi, a mental health technician working in a behavioral health setting was convicted of sexual assault and was sentenced to 20 years imprisonment. The court also imposed a fine and court costs. The defendant sexually assaulted a 13-year old patient.

PATIENT TRUST FUNDS

In Connecticut, a former attorney pled guilty to larceny, was sentenced to 5 years imprisonment, suspended after 9 months, 3 years probation and ordered to make full restitution and attend Gamblers Anonymous. While practicing as an attorney and representing a resident of a Medicaid sponsored facility, the defendant sold the beneficiary's home for $41,130 and refused to provide the proceeds of the sale to the beneficiary. The beneficiary needed the funds to decrease a debt of $95,000 that she owed to the state for medical treatment that she received.

In Montana, a bookkeeper pled guilty to theft, was sentenced to 20 years imprisonment, suspended, and ordered to pay restitution in the amount of approximately $100,000. The bookkeeper worked in a hospital and nursing home and routinely withdrew cash from patient trust accounts for her own use. The trust accounts were set up to cover the resident's share of living expenses at the facility. For over 2 years, the bookkeeper adjusted the facility's accounting records and increased the amount the facility wrote off in adjustments from Medicare, Medicaid and other health care insurers. The bookkeeper then used these funds to replace funds that she stole from the patient trust accounts.

In Arizona, the contractor hired by a health care billing service to manage the funds of Medicaid and non-Medicaid vulnerable adults pled guilty to one count of fraudulent schemes and one count of theft, was sentenced to 7 years imprisonment, placed on probation for an additional 7 years and ordered to pay restitution in the amount of $1,233,362. The loss to the victims exceeded $1 million.

In South Dakota, the business manager of an elder care facility pled guilty to grand theft and forgery, received 15 years probation and was ordered to pay $75,000 in restitution. The investigation revealed that, during a 2-year period, the defendant stole from the trust accounts of facility residents and that the defendant altered the facility's accounting records to conceal her crimes. On several occasions, the defendant also forged the signature of the wife of an Assistant Attorney General who was an authorized signatory on the resident trust accounts.

In North Carolina, an individual with authorized access to both patient trust and facility accounts at a senior citizen rest home was convicted of forgery and uttering, was sentenced to 90 days imprisonment, suspended for 2 years, placed on unsupervised probation, and ordered to pay $100 in court costs, a $100 community service fee and to complete 72 hours of community service. The investigation revealed that the defendant wrote checks from a resident's personal account to herself and the church where she served as treasurer. To cover the costs of the resident's care at the facility, the defendant wrote checks from the facility's accounts. The defendant admitted to taking $12,947 from the resident's personal account and $10,228 from facility funds. Prior to being convicted, the defendant reimbursed both the resident and the facility in the amount of $23,175.

PHARMACIES

In Wyoming, the owner and operator of a prescription center pled guilty to obtaining property by false pretenses and was ordered to pay restitution in the amount of $104,474 and a $35,000 fine. From 1997 through 2001, the defendant billed Medicaid for brand name prescriptions when he actually dispensed and sold generic medications to beneficiaries. The investigation was conducted jointly with the DHHS OIG.

In California, a pharmacy owner was convicted of grand theft of Medicaid funds, disability fraud and conspiracy to obstruct justice. The defendant was sentenced to 3 years imprisonment, with all but 9 days imprisonment suspended, and 5 years probation and ordered to complete 250 hours of community service. The defendant also agreed to cooperate with the state's Department of Justice. Finally, the defendant was ordered to pay restitution in the amount of $37,700 to Medi-Cal and to pay $11,700 to the Franchise Tax Board and $6,000 to the state's Employment Development Department. The defendant paid kickbacks for referrals for prescriptions that were not filled, filed false partnership tax returns and failed to file individual tax returns. The defendant received an estimated $340,000 in Medi-Cal payments for his fraudulent activities.

PHYSICIANS

In Colorado, a former physician pled guilty to theft, was sentenced to 60 days in jail, 8 years of supervised probation and ordered to pay approximately $26,000 in restitution to the state and the federal government for fraudulently billing both Medicaid and Medicare. The defendant also surrendered her medical license in an unrelated matter involving the improper possession and use of a prescription drug. The defendant billed the Medicare and Medicaid programs for medical services not rendered and at a higher level of service than was actually delivered. Her scheme was to continue billing for home visits after she stopped seeing the patients. The joint MFCU/DHHS OIG investigation revealed that the physician knowingly engaged in fraudulent Medicaid and Medicare billing from October 1998 through January 2000.

In Maryland, a physician agreed to pay $32,000 to settle allegations that she failed to account for the disposition of almost 2,500 doses of vaccine furnished to her through the Vaccines For

Children (VFC) Program. Under the agreement, the $32,000 payment served as compensation to the state for the unaccounted for vaccines. The VFC Program provides free vaccines to physicians who administer the vaccines to their eligible Medicaid patients. The investigation revealed that the physician ordered and received over 5,500 vaccine doses from the VFC Program during the time period July 1997 through October 2000. However, the physician was unable to provide documentation accounting for the 2,491 missing doses and denied any intentional wrongdoing in the matter.

PSYCHIATRISTS

In Georgia, a psychiatrist and an accomplice pled guilty to submitting false claims to Medicaid for services that were not rendered. The psychiatrist was sentenced to 10 years probation and ordered to pay $20,000 in restitution and to complete 50 hours of community service. The psychiatrist's accomplice was sentenced to 10 years probation, reduced to 19 months, and ordered to pay restitution in the amount of $40,000 and to complete 100 hours of community service. The psychiatrist was hired by her accomplice to provide psychotherapy services to Medicaid recipients; however, neither defendants could produce documentation to support their Medicaid claims.

TRANSPORTATION

In Virginia, the president of a transportation company that provided services to Medicaid recipients was sentenced to 37 months imprisonment for fraudulently billing the Medicaid program for an estimated $1.4 million dollars and ordered to pay a fine of $375,000. The joint investigation, conducted by the MFCU, the FBI, the state's Division of Medical Assistance Services and the U.S. Attorney's Office, resulted in the seizure of assets totaling approximately $1.4 million that were turned over to the Virginia Medicaid program.

In Maine, an ambulance transportation company and its owner pled guilty to Medicare and Medicaid fraud, money laundering, obstructing a federal audit and fraud against a health maintenance organization. The company's owner was sentenced to 49 months in jail and 3 years supervised released and the company was placed on 5 years probation. The defendants were also ordered to pay restitution in the amount of $729,875 to the Medicare and Medicaid programs. Additionally, in a civil settlement agreement reached between the defendants and the state and federal government, the defendants were barred from participation in the Medicare, Medicaid and other federal health care programs for a 15-year period and agreed to pay civil penalties in the amount of $300,000. The defendants falsified mileage records, received payments for non-reimbursable trips to physician's offices by falsely depicting the trips as hospital trips and submitted bills for ambulance services when only wheelchairs were provided.

In Minnesota, the owner of a medical transportation company was convicted of committing fraud against the state's Medicaid program, sentenced to 51 months imprisonment and 36 months probation and ordered to make restitution to the Medicaid program in the amount of $412,438

and assessed a special fine in the amount of $4,100. The defendant falsely billed for transportation services provided to clients on weekends and while the clients were hospitalized. The defendant also continued to bill for services after clients requested discontinuation of the transportation company's services.

In Virginia, six foreign nationals were convicted of billing Medicaid for transportation services that were not provided and for transportation services provided to deceased persons. They were ordered to repay the Medicaid program $3.7 million. Five of the six defendants received prison terms and will be deported upon completion of their imprisonment. During the course of the investigation, investigators seized the defendants' homes, vehicles, businesses, bank accounts and travelers checks. The forfeited assets totaled $2.6 million and were relinquished as restitution to the state's Medicaid agency. The investigation was conducted jointly by the MFCU, the FBI, the Internal Revenue Service, the U.S. Attorney's Office and the state's Department of Medical Assistance Services.

In Wisconsin, the two owner/operators of a medical transportation service pled guilty to felony racketeering. One co-owner/operator was sentenced to 5 years imprisonment, 5 years supervised release and ordered to pay restitution in the amount of $500,000. The other co-owner/operator was sentenced to 3 years imprisonment, 3 years supervised release and ordered to pay restitution in the amount of $500,000. The defendants submitted false Medicaid claims for services provided to hospitalized beneficiaries and deceased persons. The defendants fraudulently billed the program through two separate companies. When the defendants' first company was decertified by the state and was no longer eligible to receive Medicaid payments, the defendants started to submit false billings through their second company's corporate name and license. When their business was raided by MFCU investigators, and other law enforcement authorities, evidence was found that the defendants had formed yet a third operation.

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 2002, federal prosecutors filed 361 criminal indictments in health care cases. A total of 480 defendants were convicted for health care fraud related crimes in FY 2002. Additionally, 221 civil cases were filed and 1,529 civil matters remained pending during the year. In FY 2002, 3,448 individuals and entities were excluded from participating in the Medicare, Medicaid and other federally sponsored health care programs.

Figures available at the time of this publication showed that in FY 2002, the federal government won or negotiated more than $1.8 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 $1.5 billion in FY 2002. More than $1.2 billion of the funds collected and disbursed in FY 2002 were returned to the Medicare Trust Fund. An additional $59 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 2002 through heightened data sharing, joint training and the continued efforts of the National Health Care Fraud Task Force. 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.

Health plans and federal and state governmental agencies can 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 of $5.00.

The DHHS, Health Resources and Services Administration, Division of Quality Assurance, Bureau of Health Professions, 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 committed against individuals in non-Medicaid "board and care" facilities, thus fulfilling an important need of this most vulnerable population.

APPENDICES

APPENDIX A

Performance Standards

Appendix A - Performance Standards

With the cooperation of the Units, the OIG developed 12 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

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

TO: All Medicaid Fraud Control Units

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

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

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

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

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

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

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

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

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

TO: All Medicaid Fraud Control Units

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

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

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

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

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

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

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

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

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

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 C

Unit Statistics for Fiscal Year 2002

Appendix C - Unit Statistics for the Fiscal Year 2002

State	Unit Cost	Staff	Convictions	Recoveries
Alabama	$721,000	10	3	$1,261,812
Alaska	$480,000	5	2	$650,816
Arizona	$1,032,000	13	18	$2,015,929
Arkansas	$1,508,000	21	19	$912,148
California	$15,878,000	167	173	$24,735,894
Colorado	$798,000	11	9	$1,819,462
Connecticut	$722,000	9	5	$1,121,699
D. C. Unit	$1,265,000	16	3	$361,097
Delaware	$863,000	13	10	$42,136
Florida	$8,390,000	131	124	$19,585,981
Georgia	$3,525,000	45	22	$2,681,716
Hawaii	$980,000	16	6	$603,853
Illinois	$5,404,000	71	42	$11,279,413
Indiana	$2,439,000	22	7	$8,204,742
Iowa	$668,000	9	21	$527,936
Kansas	$722,000	10	7	$2,068,150
Kentucky	$1,190,000	19	8	$3,479,474
Louisiana	$1,422,000	24	36	$2,868,911
Maine	$360,000	6	6	$1,268,827
Maryland	$1,552,000	20	14	$1,931,440
Massachusetts	$2,200,000	24	10	$6,328,930
Michigan	$3,352,000	36	43	$4,186,102
Minnesota	$1,074,000	13	21	$18,081,109
Mississippi	$1,309,000	24	61	$1,851,622
Missouri	$1,412,000	19	9	$2,162,369
Montana	$367,619	7	8	$912,631

State	Unit Cost	Staff	Convictions	Recoveries
Nevada	$994,000	13	11	$1,272,389
New Hampshire	$456,000	8	3	$1,136,008
New Jersey	$2,302,000	36	21	$5,490,621
New Mexico	$822,000	13	7	$21,371,997
New York	$30,125,000	301	69	$46,996,239
North Carolina	$1,876,000	26	25	$10,810,879
Ohio	$2,799,000	37	55	$5,759,369
Oklahoma	$893,000	18	35	$1,426,598
Oregon	$718,000	12	6	$2,315,044
Pennsylvania	$3,526,000	51	27	$14,020,104
Rhode Island	$678,000	12	10	$171,582
South Carolina	$881,000	13	29	$6,531,210
South Dakota	$234,000	5	2	$252,454
Tennessee	$2,041,000	37	23	$14,134,505
Texas	$2,996,000	32	44	$17,389,083
Utah	$939,000	9	12	$344,433
Vermont	$421,460	6	11	$221,389
Virginia	$1,024,000	16	20	$9,875,409
Washington	$1,648,000	16	18	$1,024,768
West Virginia	$737,000	15	9	$3,774,079
Wisconsin	$910,000	11	21	$2,789,964
Wyoming	$325,000	4	2	$263,201
TOTAL	$116,979,079	1452	1147	$288,315,524

APPENDIX D

MEDICAID FRAUD CONTROL UNIT DIRECTORY

Appendix D - Medicaid Fraud Control Unit Directory

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