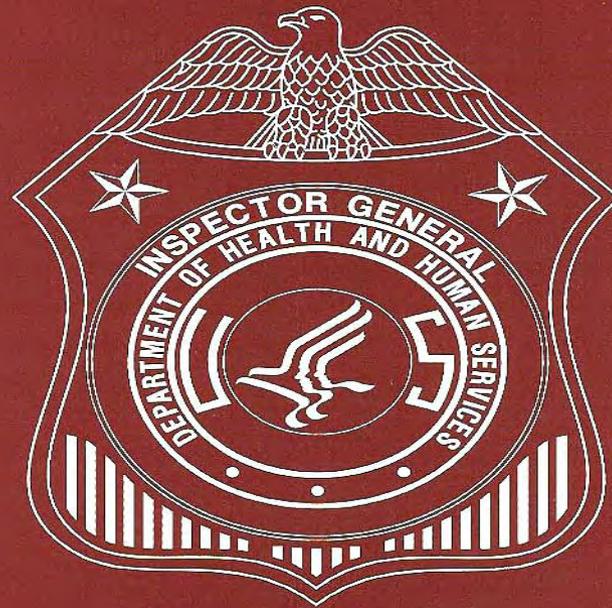


**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL**

**ANNUAL REPORT
State Medicaid Fraud Control Units**



Fiscal Year 2000

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Inspector General
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INTRODUCTION

This is the eleventh Office of Inspector General (OIG) Annual Report on the performance of the State Medicaid Fraud Control Units. This report includes Federal Fiscal Year 2000 and covers the period spanning from October 1, 1999 through September 30, 2000.

In Fiscal Year (FY) 2000, 47 States and the District of Columbia participated in the Medicaid fraud control grant program through their established Medicaid Fraud Control Units (Units). The Units' missions are to investigate and prosecute Medicaid provider fraud and patient abuse. Forty-two Units were located within the Office of State Attorneys General. The remaining six Units were located in various other State agencies. The Units' authority to investigate and prosecute cases involving Medicaid provider fraud varies from State to State. Each Unit operates within the framework of its respective State laws and prosecutorial guidelines.

At the inception of the program in FY 1978, \$9.1 million in Federal grant funds were awarded to the 17 Units established at that time. By the end of FY 2000, the program had expanded to 48 Units and had awarded over \$95 million in Federal grants, with a cumulative total of over \$1 billion in Federal grant funds awarded to the Units from FY 1978 through FY 2000.

In FY 2000, the Units received over \$180.9 million in recoveries, an increase of more than twice the amount of recoveries received in FY 1999. In FY 2000, the number of convictions increased to 970. This number represents an increase in convictions of 9.5 percent over FY 1999.

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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 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, dentists, physicians, 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 the Medicare/Medicaid Anti-Fraud and Abuse Amendments into law. 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 to States that 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 within DHEW was established. 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 DHEW; (2) to provide leadership and coordination and recommend policies for activities designed to: (A) promote economy and efficiency in the administration, and (B) prevent and detect fraud and abuse in such programs and operations, and (3) 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 responsibility for administering the Federal Medicaid Fraud Control Grant Program, their major tasks included monitoring and overseeing the overall activities of the Units, as well as, annually certifying them to receive Federal grant funding. However, it was later deemed that the functions and activities of the Units were more closely related to the OIG's investigative function. In 1979, the Federal oversight and administration of the Units were transferred from 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 State Medicaid Oversight and Policy Staff (SMOPS) 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 who are 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. The initial application approval and certification by the Secretary are 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, SMOPS, at least 60 days prior to the end of its current 12-month certification period. In considering a Unit's eligibility for recertification, the SMOPS thoroughly reviews the reapplication documentation submitted. The SMOPS assesses whether the Unit seeking recertification has fully complied with the 12 Performance Standards, and whether the Unit utilized Federal resources effectively in detecting, investigating and prosecuting Medicaid fraud and patient abuse cases. If applicable, the SMOPS would also evaluate the results of any on-site Unit reviews conducted during the preceding 12 months. Once reviewed and assessed, the SMOPS notifies the Unit in writing if their application for recertification is approved.

EXCLUSION AUTHORITY

In order to encourage the States to refer civil fraud cases involving Medicare and Medicaid to DHHS, the Congress adopted the Medicare and Medicaid Patient and Program Protection Act of 1987, 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 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 2000, the OIG excluded 3,350 persons and/or entities from participation in Medicare, Medicaid and other Federally sponsored health care programs. Of this number, 709 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 on 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.

More recently, some Units have increased the use of their State's civil statutes in prosecuting civil cases involving Medicaid

providers. Issues arise, however, when States and their respective Units reach settlement agreements with these providers without adequately or appropriately coordinating their efforts with DHHS or other affected Federal agencies. Such agreements, when reached without the involvement and/or concurrence of either the OIG or other concerned Federal authorities, move to circumvent the purposes for which the Federal CMPL was enacted with regard 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

The State Medicaid agencies, with few exceptions, are required to maintain a Medicaid Management Information System (MMIS). A vital part of the MMIS is the Surveillance and Utilization Review Sub-system (SURS). The SURS has two primary purposes: (1) to process information on medical and health care services that guide Medicaid program managers and (2) to identify the providers (and recipients) most likely to commit fraud against the Medicaid program. Additionally, 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 a 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) affirm that all such requests made by the Unit to the Medicaid agency for needed provider records and/or computerized information maintained by the Medicaid agency will be adequately furnished to the Unit.

When providers with aberrant patterns or practices are identified by the State Medicaid agency, and more specifically, the SURS, that information should then be made available to the Unit. Many Units rely on referrals received from the SURS in generating the majority of their case investigations. This process is aided 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 2000, DHHS awarded approximately \$95.9 million in Federal grant funds. At the end of the period, the number of personnel employed by the Units totaled 1,379. Since the inception of the program in 1978, the cumulative grant funds awarded to Units have increased from \$9.1 million to almost \$1.1 billion. (Appendix B)

STATISTICAL ACCOMPLISHMENTS

Collectively, in FY 2000, the Units recovered over \$180.9 million in court ordered restitution, fines and penalties. In this same period, a total of 970 convictions was achieved. (Appendix B)

NATIONAL HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM

Federal efforts to combat health care fraud and abuse were consolidated and strengthened by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HIPAA established a National Health Care Fraud and Abuse Control Program (NHCFAU) 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 relating to health care fraud and abuse.

In FY 2000, Federal prosecutors filed 457 criminal indictments in health care cases, a 23.2 percent increase over FY 1999. A total of 467 defendants were convicted for health care fraud related crimes and 233 civil cases were filed during the year. Additionally, in FY 2000, 3,350 individuals and entities were excluded from participating in Medicare, Medicaid and other Federally sponsored health care programs.

In FY 2000, the Federal Government won or negotiated more than \$1.2 billion in judgments, settlements and administrative impositions in health care fraud cases and proceedings. As a result of these activities and prior year judgments, settlements and administrative impositions, the Federal Government collected \$717 million in FY 2000. Nearly \$577 million of the funds collected and disbursed in FY 2000 were returned to the Medicare Trust Fund. An additional \$96 million were recovered as the Federal share of Medicaid restitution.

The NHCFAAC continues to maximize the effectiveness and efficiency of law enforcement efforts by promoting information sharing and collaboration among Federal, State and local agencies. Such collaborations increased in FY 2000, through heightened data sharing and 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.

HEALTH CARE INTEGRITY PROTECTION DATA BANK

The HIPAA called for the establishment of a national health care fraud and abuse data collection program for the reporting of specific final adverse actions against health care practitioners, providers and suppliers. 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 Healthcare Integrity and Protection Data Bank (HIPDB).

The HIPDB provides a resource to assist Federal and State agencies and health plans in checking the qualifications of the health care practitioners, providers or suppliers 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 unreported action.

Beginning in January 2000, health plans and Federal and State governmental agencies were able to request the disclosure of information from the HIPDB for a query fee of \$4 per name. The HIPDB information is not available to the general public; however, a health care practitioner, provider or supplier may request the disclosure of their own information for a fee. The Division of Quality Assurance, Bureau of Health Professions, Health Resources and Services Administration of the 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 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 providing an additional safeguard for this vulnerable population.

AWARD RECOGNITION

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

For FY 1999, the Louisiana Medicaid Fraud Control Unit was chosen to receive the Inspector General's State Fraud Award. During FY 1999, the Louisiana Unit demonstrated its ability to effectively and efficiently detect, investigate and prosecute Medicaid provider fraud. With only a moderately sized staff of 24, the Unit managed to obtain a total of 42 convictions, considerably more than other comparable Units.

Moreover, the funding level for the Louisiana Unit in FY 1999 was over \$1.1 million, while the total amount of recoveries achieved by the Unit exceeded \$1.2 million for that same period.



The Louisiana Medicaid Fraud Control Unit receives the 1999 Inspector General's State Fraud Award. Above right (front row), a delegation from the State of Louisiana accepts the 1999 State Fraud Award. On front row, from left to the right is *Mr. George Campagna*, Chief Investigator; *Mr. Donald Wall*, former Unit Director and *Ms. Constance Koury*, first Assistant Attorney General.

The 1999 award was presented to the Louisiana Unit by *Mr. Michael F. Mangano*, Principal Deputy Inspector General (second row, second from left). To the left of *Mr. Mangano* is *Mr. George F. Grob*, Deputy Inspector General for Evaluations and Inspections. To the right are *Mr. Thomas D. Roslewicz*, Deputy Inspector General for Audit Services; *Mr. D. McCarty Thornton*, Chief Counsel to the Inspector General and *Mr. John E. Hartwig*, former Deputy Inspector General for Investigations.

CASE NARRATIVES

AMBULANCE SERVICES

In Maryland, the owner of a Baltimore County ambulance company was sentenced to 5 years imprisonment, 5 years probation and ordered to pay restitution in the amount of \$245,000 for defrauding the State's Medicaid program. The defendant routinely billed Medicaid for ambulance transportation services that were not necessary and/or not provided and for persons who did not qualify for ambulance transportation. In addition, the ambulance company was fined \$100,000.

COUNSELORS

In Texas, a counselor convicted of felony theft was sentenced to probation, 500 hours of community service and ordered to pay restitution in the amount of \$256,155. The defendant billed Medicaid and the Crime Victims' Assistance Program for professional counseling services that were never provided. In addition, although the defendant held a marriage and family therapist license, she did not have a valid license to practice as a licensed professional counselor as required by the State.

DENTISTS

In South Carolina, a dentist pled guilty to criminal conspiracy, computer crime and filing false Medicaid claims. During the time period, January 1, 1996 through December 31, 1996, the dentist filed false and upcoded claims for emergency dental examinations and behavior management services to Medicaid. In several instances, the dentist billed the Medicaid program for as many as 20 hours of behavior management. The dentist was sentenced to 10 years imprisonment, suspended to 5 years probation, and ordered to pay restitution in the amount of \$107,000 to the State Medicaid program and \$25,000 for investigative costs.

In Connecticut, a dentist, convicted of larceny, was sentenced to 2 years imprisonment and 2 years probation and ordered to pay restitution in the amount of \$42,000. The dentist fraudulently billed Medicaid for medical procedures that were performed by non-licensed dentists.

In California, a Los Angeles dentist and 19 codefendants were charged with conspiracy to commit fraud and grand theft, paying and receiving unlawful remuneration, practicing dentistry without a license and battery. A subsequent amended complaint charged an

additional 14 defendants. The dentist, an owner/operator of three dental offices, his brother and father, implemented a scheme that: (1) paid individuals unlawful remuneration based upon the quantity of dental services provided to Medi-Cal patients who these individuals delivered by vans to the dental offices; (2) used foreign born and foreign trained unlicensed individuals to provide dental services to certain patients; (3) hired licensed dentists on a per diem basis who allowed the defendants to use their Medi-Cal provider numbers to bill Medi-Cal for services and (4) billed the Medi-Cal program for the dental services of both the licensed and unlicensed dentists using the per diem dentists' provider numbers. To date, 20 defendants have been convicted and ordered to pay over \$2.2 million in restitution and \$390,000 in investigative costs.

DEVELOPMENTALLY DISABLED RESIDENCES

In Oregon, the executive director and another employee of a nonprofit organization, providing group homes and other services to developmentally disabled adults living in two Oregon counties, were indicted on charges of racketeering and other related crimes. The indictment alleged that the executive director and another employee failed to reveal certain transactions with related parties to the organization's board of directors. The transactions included the sale of a van owned by one of the defendants to the nonprofit organization at an 800 percent markup; the leasing of houses owned by a third employee and the nonprofit's director to be used as group homes; and the loan of the nonprofit's van to another company owned by the director. The indictment also alleged that the director paid the employee more than \$23,000 for work purportedly done for her company while that employee was employed at the nonprofit organization, and that the director paid the same employee for full time work while the employee was actually working at her own company.

DRUG DIVERSION

A New Jersey man was sentenced to 5 years in State prison after admitting that he defrauded the Medicaid program of more than \$200,000 through a drug diversion scheme. The defendant purchased and stole Medicaid eligibility cards and accessed and used blank prescription pads. The defendant wrote prescriptions in the name of Medicaid card holders for the expensive cancer treatment drugs, Neupogen and Epogen, knowing that the prescriptions would be billed to the Medicaid program. He subsequently sold the drugs to street dealers for a fraction of the cost to Medicaid. The defendant was prosecuted under the New

Jersey Health Care Claims Fraud Act which mandates a prison sentence for knowingly committing health care claims fraud.

DURABLE MEDICAL EQUIPMENT

In Maine, a settlement agreement was finalized with the owner of a DME company that received in excess of \$360,000 in improper Medicare and Medicaid payments. The payments were the result of company employees falsifying certificates of medical necessity, billing Medicaid for retail prices rather than allowable costs plus 40 percent and other corporate schemes. The owner cooperated with the investigation and subsequently fired the employees. The owner will pay restitution in the amount of \$177,480 to the Medicaid program and in the amount of \$260,720 to the Medicare program. The company will also pay \$25,000 for investigative costs.

In Utah, the owner of a DME company that supplied oxygen to Medicaid and Medicare patients, was convicted of communications fraud. An investigation revealed that the owner defrauded Medicaid of almost \$2,000 and Medicare in excess of \$117,000. The defendant forged physicians' signatures on certificates of medical necessity and billed Medicaid and Medicare for oxygen supplies that were never delivered or provided to patients. The investigation also revealed that the owner billed Medicaid for oxygen purportedly supplied to a patient who had died 6 months earlier. The owner was sentenced to a suspended prison term of 1 to 15 years, with 180 days in jail, and ordered to pay restitution in the amount of \$18,181 and fines and surcharges in the amount of \$3,000. Civil charges were also filed against the owner to recover treble damages for the illegally obtained Medicare funds.

HOME HEALTH CARE AGENCIES

In Rhode Island, the office manager of a home health care agency (HHCA) pled guilty to charges of obtaining money under false pretenses, Medicaid fraud and conspiracy. Employed by a provider of home health care aides, the manager admitted to billing the Rhode Island Medicaid program for services authorized by Medicaid, but not actually performed by the HHCA. Medicaid payments received for the fraudulent billings were then added to other employees' paychecks. Subsequently, the employees would then return the extra money to the office manager. The manager was sentenced to 5 years imprisonment, with 3.5 years suspended, and ordered to pay restitution in the amount of \$3,753.

HOSPITALS

A New York City hospital agreed to pay a record \$84 million for submitting improper Medicaid claims and receiving approximately \$1.6 million in Medicaid funds. Under the terms of the agreement, the hospital agreed to pay a \$4.5 million cash settlement, \$40.5 million over a 20-year period and to provide \$39 million in uncompensated and free services to indigent patients over the next 20 years. The hospital submitted claims for providing outpatient services to developmentally disabled residents living in adult homes and group residences in the New York City metropolitan area. The hospital also over billed for services provided by more than 500 part-time clinics. The investigation revealed that the clinics were actually rooms in the residential facilities that subcontracted with the hospital as part of the hospital's outreach program.

In a separate investigation, a Buffalo, New York, hospital agreed to repay more than \$2 million to the Medicaid program. The hospital billed the Medicaid program for outpatient alcoholism services that the Medicaid program funded, but the hospital failed to properly document as being provided to Medicaid recipients. As part of the settlement, the hospital also agreed to provide \$2.25 million in uncompensated care and services to indigent patients for two years.

As a result of these investigations, widespread problems with hospital billings for outpatient services in the State of New York were identified and the State Health Department issued a directive re-emphasizing the rules governing outpatient billings. The effect of the directive reduced Medicaid billings by as much as \$10 million per month.

In Georgia, administrators at a teaching hospital voluntarily disclosed to Medicaid officials that the hospital's previous Medicaid billings for its residency program did not comply with Federal billing regulations. An investigation confirmed that the disclosure was accurate and that the billings were not in compliance with certain faculty-to-resident staff ratios and documentation requirements. The investigation further confirmed that all patients whose records were examined had, in fact, received treatment. Under the terms of the agreement, the hospital was ordered to pay \$1.5 million to the Medicaid program and to enter into a corporate integrity agreement with the DHHS, OIG.

MEDICAL CLINICS

In Louisiana, the owner of a Kid-Med clinic pled guilty to Medicaid fraud and received a 5-year suspended sentence with supervised probation, conditional upon the completion of 100 hours of community service. He was also ordered to pay restitution in the amount of \$308,538 and \$19,853 in investigative costs. The owner submitted fraudulent claims for physician office visits when the clinic did not have a physician on staff and also fraudulently billed for procedures requiring equipment that the facility did not have.

In Washington, the physician owner of several medical clinics admitted to misrepresenting the services of personal trainers, acupuncturists, chiropractors and others as physician services in order to receive reimbursement from Government health care programs. The physician also admitted that he upcoded medical services to receive larger payments, employed a foreign doctor who was not licensed in the United States and billed his services to Government health care programs, and billed for his own services when he was out of the country on vacation. The physician owner was sentenced to 35 months imprisonment and ordered to pay restitution in the amount of \$400,000. In addition, the clinics' billing manager, operations manager and billing clerk pled guilty to conspiracy to commit mail fraud and health care fraud. The billing manager was sentenced to 180 days of home detention and ordered to pay restitution in the amount of \$20,000. The billing manager was sentenced to 300 days of home confinement and ordered to pay restitution in the amount of \$30,000. The billing clerk was sentenced to 5 years probation and ordered to pay restitution in the amount of \$10,000.

In Michigan, a dentist, a doctor and the owner of a medical clinic pled guilty to numerous felony charges, ranging from Medicaid fraud to conspiracy to obtain money under false pretenses. The dentist allegedly billed the Medicaid program for composite and amalgam fillings, tooth extractions and partial dental plates that were either not provided, or not covered by Medicaid. The doctor, who was not a licensed physician, and the owner signed a contract with Michigan to provide medical services to Medicaid recipients. The owner provided treatment to Medicaid patients and the doctor signed off on the patient's medical charts. The doctor also allegedly pre-signed prescription forms, allowing the owner to prescribe both regular medicines and controlled substances to patients that he was not authorized to treat.

MENTAL HEALTH CENTERS

In Kansas, a defendant pled guilty to Medicaid fraud and presenting a false claim. The defendant received a suspended sentence of 7 months imprisonment, was placed on supervised probation and ordered to pay full restitution to the Medicaid program and a community mental health center and investigative costs in the amount of \$6,125. She was paid by the Medicaid program for providing targeted case management services to children who were eligible for care from a community health center. In actuality, the defendant either did not provide those services or provided services for less time than she claimed. ^{In} addition, the defendant submitted false mileage reimbursement vouchers.

In Nevada, the owner and operator of a mental health clinic voluntarily disclosed that the clinic improperly billed for psychotherapy services and agreed to pay \$455,000 to the Nevada Medicaid program.

NURSES

In Oklahoma, a nurse pled guilty to fraudulently obtaining prescriptions. She received a suspended sentence and was ordered to surrender her nursing license, to pay court costs and \$150 per count to the victims' compensation fund and to complete a drug treatment program. The nurse, a licensed practical nurse employed by a local nursing home, allegedly obtained the drugs by telephoning fraudulent prescriptions to a drug store under the premise that the drugs were for nursing home residents.

In Arizona, a defendant who pled guilty to criminal impersonation, was sentenced to 3 years probation, ordered to complete 360 hours of community service and had his privilege to obtain a nursing license revoked. The defendant falsely represented himself as a registered nurse (RN) and presented a forged RN certificate to gain employment at a pediatrician's office that served Medicaid patients. The defendant misrepresented himself as an RN over a 3-year period.

NURSING HOMES

In North Carolina, the owner of a nursing home, his daughter and son-in-law, were indicted on multiple counts of conspiracy, filing false claims, filing false tax returns and money laundering. Predicated on a complaint involving preferential vendor treatment, the investigation revealed that the defendants

filed fraudulent cost reports resulting in the illegal receipt of Medicaid monies. A separate vendor pled guilty to filing false tax returns and agreed to cooperate with the Government. The owner of the nursing home settled with the Government and repaid \$1 million in restitution and penalties. The owner's daughter was sentenced to 140 months imprisonment, 3 years supervised probation and ordered to pay restitution in the amount of \$146,719. The owner's son-in-law was sentenced to 57 months imprisonment, 3 years supervised probation and ordered to pay restitution in the amount of \$146,719. The vendor, who had cooperated with the Government, was sentenced to 3 years supervised probation and ordered to pay restitution in the amount of \$11,327.

PATIENT ABUSE

In Delaware, a nurse's aide pled guilty to assault and patient abuse. The aide repeatedly struck a 76-year old victim in the head and caused a laceration to the victim's leg. The aide was sentenced to 24 months in prison and 12 months probation. As a condition of the plea agreement, the aide was excluded from working or volunteering in direct health care services.

In Mississippi, a defendant pled guilty to felony abuse. The defendant was taking part in an emergency crisis intervention and kicked an 11-year-old resident causing traumatic bleeding, bruises and abrasions. She was sentenced to 3 years imprisonment, with 60 days to serve, 305 days on house arrest and 2 years suspended, 3 years probation and ordered to pay court costs in the amount of \$268.

In Vermont, a maintenance worker in a residential facility was sentenced to 2 to 4 years imprisonment for sexual abuse of an elderly person. The maintenance worker molested an elderly resident suffering from Alzheimer's Disease. His sex acts with the woman were discovered when a nurse entered the woman's locked room and observed the defendant. After serving 15 months of his prison sentence, the maintenance worker will be placed on probation.

In Montana, a nursing assistant pled guilty to arson, was given a 2-year suspended sentence and ordered to pay a fine in the amount of \$200. In addition, his nursing assistant certification was revoked. Upon discovering that a 92-year-old nursing home resident had gotten out of bed, the nursing assistant sprayed and ignited flammable disinfectant on his own hands, walked toward the victim and waved his hands around in the victim's face.

In Hawaii, a former adult residential care home operator pled guilty to manslaughter for recklessly failing to provide for the health and welfare of a 79-year-old victim who died in her care. The operator was sentenced to 20 years imprisonment, and her license to operate the residential care home was revoked. The victim died as a result of sepsis, or systemic inflammatory syndrome, resulting from decubitus ulcers, commonly referred to as pressure sores.

PATIENT FUNDS

In Alabama, a bookkeeper, employed by a skilled nursing facility, was sentenced to 2 years imprisonment (and suspension), 3 years supervised probation and ordered to pay restitution in the amount of approximately \$7,000 to the facility's patient fund for embezzling funds from Medicaid recipients residing in the nursing facility. The investigation revealed that the bookkeeper embezzled \$6,974 from the residents.

In Florida, a former Leon County judge pled guilty to bank and mail fraud, was sentenced to 43 months imprisonment, 36 months probation and ordered to pay restitution in the amount of \$348,269 to the victims. While in office, the judge assumed the role of designated representative for several elderly women living in skilled nursing facilities as private pay residents. In this capacity, the judge exploited their assets and converted them to his personal use to the point that the elderly women had to be placed on Medicaid. The judge then failed to pay the patients' share of the facility's costs and provide the women with their funds, resulting in the facilities giving notice that the patients would have to be discharged or that Medicaid would have to pay the entire amount for their care.

PHARMACIES

In Kentucky, a pharmacist was sentenced to 10 years imprisonment and ordered to pay restitution in the amount of \$575,000 in a lump sum to the Commonwealth for defrauding the Medicaid program. The pharmacist misused his contract to provide medications for residents of a local nursing home and his status as a provider to the Medicaid program by billing Medicaid for large quantities of drugs neither prescribed nor provided, most prominently Triamcinolone Acetonide. Since the pharmacist billed Medicaid directly, the nursing home was not aware that the medications were being billed in their residents' names. Moreover, explanations of the benefit forms were not sent to residents of the Commonwealth. As a result, the pharmacist was able to

perpetrate the scheme for several years. The pharmacist's scheme was discovered when an auditor's review of the most frequently used drugs found that the pharmacist billed for 99 percent of the State Medicaid program's total use of Triamcinolone Acetonide.

PHYSICIANS

In Massachusetts, an orthopedic surgeon was sentenced to 6 months imprisonment and his corporation was ordered to pay a fine in the amount of \$62,500 for fraudulently billing the Medicaid program for \$50,000 in unnecessary tests and procedures. Additionally, his license to practice medicine was suspended. The surgeon performed unwarranted medical procedures on his patients and repeatedly subjected his patients to unnecessary X-rays and steroid injections.

In Pennsylvania, a physician was sentenced to 36 months probation, ordered to perform 200 hours of community service and ordered to pay restitution in the amount of \$18,000 and a fine in the amount of \$500 for improperly billing the Pennsylvania Department of Public Welfare (PDPW) for more than \$37,000. The physician allegedly submitted 1,413 false claims and improperly received \$26,868 in reimbursement. The physician also submitted bills to Medicaid for more expensive treatment to Medicaid recipients than he actually provided and to the PDPW claiming that he was providing general medical examinations at a medical office, which he listed as a health care facility.

PSYCHOLOGISTS

In Wisconsin, a psychologist was sentenced to 6 years imprisonment, 6 years probation and was ordered to pay restitution in the amount of over \$580,000 for felony theft by fraud. The psychologist repeatedly made false claims and sent fraudulent bills to the State for services she never performed. The psychologist also repeatedly billed the State as if she worked 7 days per week with clients, even though she saw them only twice a week.

SOCIAL WORKERS

In Ohio, a social worker pled guilty to false statements relating to health care issues and was sentenced to 1 year and 1 day imprisonment, 3 years supervised release and ordered to pay restitution in the amount of \$47,142. As the administrator of a clinic, the social worker billed Medicaid and Medicare for services that were not provided by his clinic.

In Minnesota, two social workers pled guilty to one aggravated count of theft by false representation. The social workers were sentenced to 1 year imprisonment and 2 years probation, subject to the conditions that they serve 90 days and pay restitution in the amount of \$48,000. In addition, they agreed to surrender their social worker licenses. The social workers fraudulently billed the Minnesota Medicaid program for services that were never provided and double and triple billed for services.

SPEECH THERAPISTS

In Missouri, a licensed speech therapist pled guilty to Medicaid fraud and stealing by deceit and was sentenced to 5 years imprisonment. In a parallel civil case, an order for a prejudgment attachment was obtained against the therapist. The prejudgment attachment ordered the therapist's home, bank accounts, 1999 BMW and 1998 Jaguar automobiles and computers be seized. The property and accounts were subsequently applied against the \$250,000 civil judgment obtained as a result of the therapist's fraudulent activities. The case developed when an auditor in the SURS Unit became suspicious of the therapist's billing practices upon discovering altered physician orders for speech therapy services and excessive claims by the therapist. In numerous instances, the investigation revealed that the therapist submitted claims indicating that she worked in excess of 24 hours per day.

TRANSPORTATION COMPANIES

In Tennessee, the executive director of a transportation company pled guilty to mail fraud, was sentenced to 5 years probation and ordered to pay full restitution in the amount of \$17,288 to the managed care organization affected by his billing scheme. The director was also ordered to pay a fine in the amount of \$5,000. The company, for which the director worked, transported TennCare beneficiaries to obtain covered health care services in accordance with a requirement of the managed care program covering their services. The executive director falsely and fraudulently inflated charges, mileage and wait time on these trips.

In Arkansas, the owner and operator of a medical transportation company pled guilty to Medicaid fraud, was sentenced to 5 years probation and ordered to pay restitution in the amount of \$75,000 and \$3,000 in investigative costs. The owner billed for multiple riders, excessive mileage and services not rendered.

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 numbers 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 the standard, the following performance indicators will be considered-
- A. Does the Unit have a training plan in place and funds available to fully implement the plan?
 - B. Does the Unit have a minimum number of hours for the training requirements of 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?

APPENDIX B

Unit Statistics for Fiscal Year 2000

Unit Statistics for the Fiscal Year 2000

State	Unit Cost''	Staff	Convictions	Recoveries
Alabama	\$ 682,000	10	2	\$ 234,604
Alaska	\$ 477,000	5	2	\$ 2,244,185
Arizona	\$ 1,005,000	13	15	\$ 275,800
Arkansas	\$ 1,391,000	22	22	\$ 489,139
California	\$ 10,307,000	152	139	\$ 35,398,918
Colorado	\$ 702,000	11	8	\$ 1,554,688
Connecticut	\$ 495,000	9	4	\$ 311,494
District of Columbia	\$ 786,000	15	0	\$ 0
Delaware	\$ 736,000	13	14	\$ 173,133
Florida	\$ 6,700,000	115	114	\$ 10,983,653
Georgia	\$ 2,773,000	43	20	\$ 8,290,242
Hawaii	\$ 949,000	16	2	\$ 176,741
Illinois	\$ 2,629,000	36	38	\$ 8,789,884
Indiana	\$ 1,602,000	23	10	\$ 8,324,920
Iowa	\$ 584,000	11	20	\$ 430,323
Kansas	\$ 747,000	10	8	\$ 119,267
Kentucky	\$ 1,164,000	19	6	\$ 1,128,990
Louisiana	\$ 1,174,000	24	33	\$ 1,972,985
Maine	\$ 322,000	6	3	\$ 245,607
Maryland	\$ 1,322,000	20	16	\$ 1,177,377

State	Unit Cost*	Staff	Convictions	Recoveries
Massachusetts	\$ 1,756,000	27	10	\$ 2,951,802
Michigan	\$ 2,793,000	39	24	\$ 3,307,327
Minnesota	\$ 900,000	14	4	\$ 2,115,636
Mississippi	\$ 1,196,000	24	65	\$ 347,458
Missouri	\$ 1,536,000	23	18	\$ 4,427,368
Montana	\$ 345,000	6	5	\$ 140,347
Nevada	\$ 788,000	13	6	\$ 609,866
New Hampshire	\$ 495,000	8	7	\$ 344,757
New Jersey	\$ 2,270,000	36	4	\$ 3,406,121
New Mexico	\$ 705,000	13	10	\$ 1,242,129
New York	\$ 26,694,000	292	68	\$54,104,712
North Carolina	\$ 1,768,000	26	8	\$ 2,284,650
Ohio	\$ 2,621,000	42	34	\$ 1,529,118
Oklahoma	\$ 839,000	17	40	\$ 1,358,698
Oregon	\$ 567,000	7	13	\$ 856,851
Pennsylvania	\$ 3,334,000	48	32	\$ 1,287,441
Rhode Island	\$ 660,000	12	11	\$ 75,661
South Carolina	\$ 824,000	13	29	\$ 889,346
South Dakota	\$ 286,000	5	2	\$ 264,124
Tennessee	\$ 1,195,000	23	17	\$ 4,312,108

State	Unit Cost*	Staff	Convictions	Recoveries
Texas	\$ 2,671,000	34	33	\$ 4,146,113
Utah	\$ 1,049,000	13	13	\$ 153,817
Vermont	\$ 345,000	6	5	\$ 338,469
Virginia	\$ 914,000	15	6	\$ 1,267,153
Washington	\$ 1,253,000	20	11	\$ 1,335,506
West Virginia	\$ 664,000	15	7	\$ 4,596,699
Wisconsin	\$ 689,000	11	12	\$ 939,671
Wyoming	\$ 275,000	4	0	\$ 22,074
TOTAL	\$95,979,000	1,379	970	\$ 180,941,872

APPENDIX C

**State Fraud
Policy Transmittals**



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



DEC 7

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.

A handwritten signature in cursive script, appearing to read "Frank J. Nahlik".

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



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.

Page 2 - Civil Fraud Cases

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.

Page 2 - Public Disclosure Requests and Privacy Rights

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



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.

Page 2 Program Income

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.

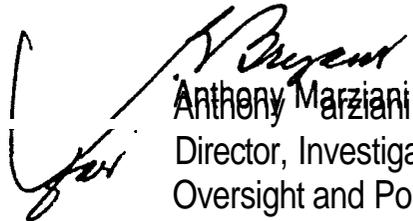
If approved by OIG in writing, any program income in excess of the State share for the fiscal year credited may be added to the funds committed to the grant agreement, in accordance with the addition method of section 92.25(9)(2). Any request for approval under the addition method must include a proposal 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(9)(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.

Page 3 Program Income

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(9)(1), 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(9)(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

APPENDIX D

Medicaid Fraud Control
Unit Directory

DIRECTORY

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of California
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