

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



**State Medicaid Fraud Control Units
Annual Report
Fiscal Year 2003**

Summary

This is the Office of Inspector General's (OIG) Annual Report on the performance of the State Medicaid Fraud Control Units (MFCU). This report covers the Federal fiscal year (FY) 2003, commencing October 1, 2002 and ending September 30, 2003.

During this reporting period, 47 States and the District of Columbia (DC) participated in the Medicaid fraud control grant program through their established MFCUs. The MFCUs' mission is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect. Forty-one of these MFCUs are located within Offices of State Attorneys General. The remaining seven MFCUs are located in various other State agencies. The MFCUs' authority to investigate and prosecute cases involving Medicaid provider fraud and patient abuse and neglect varies from State to State. Each MFCU operates within the framework of its respective State laws and prosecutorial guidelines.

During FY 2003, the MFCUs recovered \$268 million in court ordered restitutions, fines, civil settlements, and penalties and were instrumental in obtaining 1,096 convictions. A total of 538 individuals and entities were excluded from participating in the Medicare and Medicaid programs based on referrals made to OIG by the MFCUs. In addition, during FY 2003, the MFCUs opened 5,570 patient abuse and neglect cases.

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State Medicaid Fraud Control Units

Annual Report for Fiscal Year 2003

Background

Medicaid, the program governed by Title XIX of the Social Security Act, is the result of legislation enacted in 1965, which provides for State-administered and Federally-monitored financing of medical services for needy individuals. 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.

On October 25, 1977, the President signed into law the Medicare and Medicaid Anti-Fraud and Abuse Amendments, Public Law 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. . . .” Section 17 of the amendments provided 90 percent Federal matching funds for a 3-year period for States to establish Medicaid fraud and abuse control units that met certain standards.

In order to promote and fulfill the long-term goals of Public Law 95-142, permanent Federal funding of the State Medical Fraud Control Units (MFCU) beyond the initial 3-year period was enacted into law as part of the Omnibus Reconciliation Act of 1980, Public Law 96-499. This law made Federal grant funds available at a rate of 90 percent for the first 3 years of a MFCU’s operation and 75 percent thereafter.

Oversight of the Medicaid Fraud Control Units

In 1976, the Office of Inspector General (OIG) was established. The mission of OIG is to protect the integrity of Department of Health and Human Services (HHS) programs. OIG has a responsibility to report, both to the Secretary of HHS and to the Congress, program and management problems and recommendations to correct them. OIG’s duties are carried out through a nationwide network of audits, investigations, inspections, and other mission-related functions.

The Omnibus Budget Reconciliation Act of 1983, Section 13625, as codified in Section 1902 (a)(61) of the Social Security Act, required OIG to develop 12 performance standards for assessing the MFCUs that were made effective on September 26, 1994. OIG uses these

12 standards as guidelines to assess the effectiveness and efficiency of the MFCUs and to determine whether the MFCUs are carrying out their duties and responsibilities as required by Federal regulations (see Appendix A).

OIG's Medicaid Fraud Units Oversight Division (MFUOD), contained within the Office of Evaluation and Inspections, is responsible for overseeing the activities of the 48 MFCUs.

Certification/Recertification

Each State interested in establishing a MFCU must submit an initial application for certification to the Secretary of HHS. When establishing a MFCU, a State must also meet several major requirements to obtain both Federal certification and grant funding for the proposed MFCU. Among the requirements, the MFCU must be a single, identifiable entity of the State government composed of (1) one or more attorneys experienced in the investigation or prosecution of civil fraud or criminal cases, who are capable of giving informed advice on applicable law and procedures and providing effective prosecution or liaison with other prosecutors, (2) one or more experienced auditors capable of supervising the review of financial records and advising or assisting in the investigation of alleged fraud, and (3) a senior investigator with substantial experience in commercial or financial investigations who is capable of supervising and directing the investigative activities of the MFCU. The Secretary of HHS will notify the State whether their application meets the Federal requirements for initial certification and if the application is approved. The initial application approval and certification by the Secretary are valid for a 1-year period.

For an established MFCU to continue receiving Federal certification and grant funding from HHS, the MFCU must submit an annual reapplication to OIG's MFUOD at least 60 days prior to the end of its current 12-month certification period. In considering a MFCU's eligibility for recertification, the MFUOD thoroughly reviews the reapplication documentation submitted. The MFUOD assesses whether the MFCU seeking recertification fully complied with the 12 performance standards and whether Federal resources expended by the MFCU were effectively utilized in detecting, investigating, and prosecuting Medicaid fraud and patient abuse and neglect cases. If applicable, it will also evaluate the results of any on-site reviews that were conducted during the preceding 12 months. Once reviewed and assessed, the MFCU is notified in writing that its reapplication for recertification is approved.

Exclusion Authority

Under the Social Security Act, OIG, through a delegation from the Secretary of HHS, is required to exclude certain individuals and entities from participation in Federal health care programs as the result of certain criminal convictions (mandatory exclusions) and has the authority to exclude other individuals (permissive exclusions). The most common mandatory exclusion authority is for an individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under Medicare or a State health care program. Mandatory exclusions are for

a minimum term of five years, but may be longer based upon consideration of aggravating factors.

The most common permissive exclusion authority is for an individual or entity that has had its license to provide health care revoked or suspended by a State licensing authority or otherwise lost for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity. The term of permissive exclusions varies, and in the case of an exclusion based on loss of license, is coterminous with the period of time the license was lost. The effect of exclusion is that no payment may be made by Medicare, Medicaid, or any other Federal health care program for items or services furnished, ordered, or prescribed by an excluded individual or entity. Once the period of exclusion has ended, the individual or entity must apply for reinstatement - it is not automatic.

Civil Remedies

The Civil Monetary Penalties Law of 1981, as amended (Section 1128A of the Social Security Act), authorizes the Secretary of HHS to impose administrative monetary penalties and assessments against individuals and entities 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. 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 and entities from participation in the Medicare and Medicaid programs. In addition, over the years, some MFCUs have increased the use of their State's civil statutes in prosecuting civil cases involving Medicaid providers.

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). HIPAA established a National Health Care Fraud and Abuse Control Program (Program) under the joint direction of the Attorney General and the Secretary of HHS, acting through OIG. This program was designed to coordinate Federal, State, and local law enforcement activities with respect to health care fraud and abuse. 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 are heightened through data sharing, joint training sessions, and the continued efforts of the National Health Care Fraud Task Force. The many joint health care investigations undertaken, through collaborative efforts, are continuing to produce effective fraud prevention efforts and techniques, as well as new beneficiary outreach programs.

Additional Authority

On December 16, 1999, the President signed into law the Ticket to Work and Work Incentives Improvement Act of 1999, Public Law 106-170, which, in Section 407, expanded the jurisdiction of the MFCUs in two ways. First, the law allows MFCUs, with the approval of OIG, to investigate fraud in the Federal Medicare program in limited situations where the case is “primarily related to Medicaid.” This allows the MFCUs, 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 do so. Secondly, the law allows the MFCUs to investigate and prosecute patient abuse or neglect committed against individuals in non-Medicaid assisted living or “board and care” facilities, thus allowing the MFCUs to use their considerable expertise with elder abuse cases to protect this most vulnerable population.

Surveillance and Utilization Review Sub-System

The State Medicaid agencies, with a few exceptions, are required to maintain a Medicaid Management Information System (MMIS). The MMIS is a claims payment and information retrieval system. A vital part of the MMIS is the Surveillance and Utilization Review Sub-system (SUR/S). SUR/S has two primary purposes (1) to process information on medical and health care services that guide Medicaid program managers, and (2) to identify the providers (and recipients) most likely to commit fraud against the Medicaid program. In addition, the MFCUs and their respective State Medicaid agencies are required to enter into a Memorandum of Understanding (MOU). The purposes for developing and implementing an MOU are to (1) implement the requirement for the Medicaid agency to refer all suspected cases or incidences of provider fraud to the MFCU, and (2) facilitate the exchange of information between the Medicaid agency and the MFCU.

When providers with aberrant patterns or practices are identified by the State Medicaid agency, and, more specifically the SUR/S, that information should then be made available to the MFCU. Most MFCUs rely on referrals received from the SUR/S, or the Medicaid agency, to generate many of their case investigations. This process is aided immensely when an effective MOU is in place between a MFCU and the single State Medicaid agency. In most States, the cooperation between the Unit and the SUR/S usually leads to a more efficient process of identifying and prosecuting fraud in the Medicaid program. OIG encourages the MFCUs and the SUR/S to continue their ongoing dialogue, including holding regularly scheduled meetings to discuss the MFCUs’ progress in investigating cases referred to them by the SUR/S and discuss the number and the quality of referrals sent to the MFCUs by the SUR/S.

Grant Expenditures

In fiscal year (FY) 2003, HHS awarded the MFCUs more than \$119.8 million in Federal grant funds. The total number of individuals employed by the MFCUs at the close of FY 2003 was 1,507 (see Appendix B). Since the inception of the program, the Federal grant funds awarded to

the MFCUs have increased from a total of \$9.1 million in FY 1978 to a cumulative total of more than \$1.5 billion through FY 2003.

Accomplishments

Collectively, in FY 2003, the MFCUs claimed total recoveries of more than \$268 million in court-ordered restitutions, fines, civil settlements, and penalties. The total number of convictions obtained for the period was 1,096. Appendix B shows each MFCU's accomplishments in FY 2003. In FY 2003, OIG excluded a total of 3,275 individuals and entities. Of this number, 538 were based on referrals made to OIG by the MFCUs.

Case Narratives

The following are representative samples of successful Medicaid fraud and patient abuse and neglect cases conducted by the MFCUs in FY 2003.

Billing Services

In Colorado, a medical billing company owner was convicted of computer crime theft, which constitutes a felony charge. The billing company served as the billing agent for a Denver hospital. The defendant directed employees to change dates of service on claims being processed to comply with Medicaid's timely filing requirements to enable the company to receive payment. The illegal date-changing was prompted due to a heavy backlog of unprocessed claims. For each claim processed and filed within the required time frame, the billing company received a 15-percent commission. The owner/defendant was sentenced to 6-months probation, 45 days in jail, and ordered to pay court and probation costs. The Medicaid program was reimbursed \$108,679 by the providers.

In New York, the owner of a billing company who was hired by a Pennsylvania hospital pled guilty to a nine count indictment, which included theft and filing a false or fraudulent tax return. On behalf of the hospital, the defendant billed New York's Medicaid program nearly \$500,000 for services that were not provided. The investigation revealed that the defendant used the stolen funds to purchase three new cars, pay off a mortgage, and pay school tuition. The defendant was sentenced to serve 3 to 9 years in prison. Restitution to the New York Medicaid program was ordered in the amount of \$571,706. In addition, the defendant was ordered to pay \$33,231 to the State's Department of Taxation and Finance.

Certified Nursing Assistants

In Florida, a nolo contendere plea was entered by a certified nurse aide on charges of abusing an elderly resident in a nursing facility. The investigation revealed that the defendant entered the room of an 85-year-old resident and exposed himself. The defendant was placed on probation for 5 years, with the first 2 years of probation to be under community control.

In Wisconsin, a certified nurse assistant was convicted of intentionally abusing a mentally retarded nursing home resident. The defendant ordered the resident to drink a hot-sauce-like substance. The resident immediately began to choke and sputter. In response to the resident's obvious distress, the defendant laughed and threw a cup of ice water in the resident's face. The defendant was sentenced to 14 days imprisonment. The nursing home's parent company pled guilty to six counts of intentional abuse of a patient, four counts of intentional neglect of a patient, and one count of second-degree sexual assault. The company was fined \$100,000 and excluded from participation in the State's Medicaid program.

Dentists

In Maine, a civil settlement was reached between a dentist and the State of Maine on allegations of Medicaid fraud. As part of the settlement, the dentist admitted to knowingly filing false claims to the Medicaid program for oral examinations that were not performed by a licensed dentist as required by law. The dentist agreed to pay restitution in the amount of \$28,524 and to pay penalties and associated costs pursuant to a consent decree. The consent decree also permanently enjoins the dentist from submitting future claims to the State's Medicaid program.

In South Carolina, a dentist pled guilty to three counts of filing false claims and one count of obstruction of justice. A review of the defendant's patient records revealed that the defendant had engaged in a widespread pattern of falsifying patient dental records related to x-ray services performed and fraudulently billing Medicaid for payment. A plea agreement was entered into by the defendant whereby the defendant would pay \$60,000 restitution to the Medicaid program. Because of the age of the defendant, the judge in the case imposed a sentence of 3 years imprisonment on the false claims violation and 5 years probation on the obstruction of justice charge. However, the sentence was suspended upon the defendant paying fines and investigative costs and complying fully with the plea agreement.

Durable Medical Equipment (DME) Companies

In Montana, the owner of a DME company pled guilty to one count of felony theft for billing Medicaid for services not provided. The defendant billed and received reimbursement for approximately 1,000 cases of enteral feeding supplements, when in fact the defendant only purchased and dispensed approximately 300 cases of the supplements. The defendant was sentenced to 6 years imprisonment, deferred, fined \$1,000, and ordered to pay restitution in the amount of \$53,543. The investigation also resulted in an additional recovery of \$30,000 in overpayments being repaid by the defendant.

In Ohio, the president of a company that supplied oxygen services to Medicaid patients in nursing facilities was indicted on one count of Medicaid fraud. The defendant entered a nolo contendere plea to the indictment and was found guilty of billing Medicaid for services not provided. The defendant billed Medicaid for 24 hours of oxygen services provided to residents at the facilities regardless of the amount of oxygen that was actually used by the residents. The

defendant was sentenced to 6 months imprisonment, suspended, and placed on 1 year of probation (called community control in Ohio). As part of the plea agreement, the defendant was ordered to pay \$20,425 in restitution and \$2,200 in court costs. The defendant was also ordered to relinquish all ownership interest in the DME company and resign as president.

Home Health Care Services

In Minnesota, a jury found a State-licensed home health care agency guilty of criminal neglect. An employee of the agency, while providing home services to a client, moved the client to the employee's home, placed the client in a tent in the backyard and later moved the nonambulatory client to an upstairs bedroom. The client had a history of chronic asthma and suffered from cerebral palsy and other related medical conditions. For their negligence, the agency was fined \$3,000. In addition, both the owners of the home health care agency and the agency itself were excluded from participating in all State health care programs.

In Oregon, a home health care aide was convicted on one count of submitting a false claim to Medicaid and two counts of theft, for billing the program for in-home care services not provided. The defendant received payments to provide care to a disabled client. After the client died in June 2001, the defendant continued to submit vouchers and receive payment from Medicaid for an additional 4 months. The defendant was sentenced to 30 days imprisonment, 5 years supervised probation, and ordered to pay restitution of \$3,497. The defendant was also ordered not to work in any capacity paid with Medicare or Medicaid dollars.

Hospitals

In Florida, a hospital agreed to pay the State a total of \$356,200 in a civil settlement for committing Medicaid fraud. The MFCU investigation revealed that the hospital overbilled the program by billing for an outpatient facility fee code for multiple service encounters when only primary care was provided. The outpatient facility fee was not applicable to the provision of primary care. As a result, Medicaid paid the hospital a total of \$175,758 for the non-reimbursable fees.

Laboratories

In Ohio, a nationally recognized laboratory supplied free enteral feeding pumps to nursing homes and DME suppliers around the country, and then counseled these entities to bill both Medicare and Medicaid for reimbursement for the free pumps. The total monetary value of the civil and criminal cases nationwide, related to both the Medicare and Medicaid programs, was \$614 million. The State of Ohio served as the lead negotiator in resolving the defendant's civil liability to the various State Medicaid programs involved. The total recovery to the respective Medicaid programs nationwide was in excess of \$59 million.

Medical Centers

In West Virginia, a settlement was reached with the State's largest medical center over false claims made to the Medicare and Medicaid programs. The medical center billed for services not rendered, for services performed by unlicensed assistants and trainees, for individual therapy, when, in fact, group therapy was provided, and for up-coding and providing free laboratory services to benefit private physicians. The defendant repaid the Medicaid program \$1.3 million in restitution and entered into a corporate integrity agreement.

Nurses

In Tennessee, a registered nurse was convicted of two counts of sexual battery for assaulting a female patient in a mental health facility. The defendant was sentenced to a 2-year term, to serve 30 days incarceration with the remainder of time under supervised probation. In addition, the defendant was ordered to perform 20 days of public service, submit to a DNA sample, attend sex offender counseling, and surrender his/her nursing license during the period of probation.

In Vermont, a registered nurse working in a nursing home was convicted of abusing an 81-year-old terminally ill resident by extracting morphine out of the resident's 24-hour-per-day morphine pump, which was prescribed for the resident to relieve severe pain. The defendant was also convicted of possessing and consuming the narcotic fentanyl, found to have been diverted from the nursing home's stocked supply of fentanyl skin patches. At the sentencing hearing, the defendant pled guilty to additional charges of abusing a second resident of the home by withdrawing fentanyl from a fentanyl patch worn by the resident. The defendant was sentenced to serve 3 years of a 4-to-10-year imprisonment term, with numerous special conditions of probation to take effect after completing 3 years of incarceration. In accordance with the plea agreement, the defendant was ordered to reimburse the State's Medicaid program \$1,000, the value of the diverted drugs, and in lieu of fines make a \$5,000 donation to the State's Victims' Compensation Fund.

Nursing Homes

In New York, a nursing home chain pled guilty to one count of falsifying business records and to one count of willful violation of the public health laws. One of the chain's premier facilities admitted that during 2000 and early 2001, it knowingly operated its 224 nursing home without employing sufficiently skilled nursing staff to provide appropriate care to residents. The defendant/facility also admitted that its employees falsified business records to conceal that licensed practical nurses were unlawfully performing medical assessments. As part of a plea agreement, the defendant/facility was ordered to pay \$1 million in restitution and fines totaling \$17,000 to the State's Medicaid program. In addition, the defendant/facility and its two owners were to divest themselves from all nursing home operations. The two owners were also permanently enjoined from having any further involvement in the management, operation, or

ownership of any nursing home in the State. One of the owners was required to forfeit his/her nursing home administrator's license.

In Oklahoma, a nursing home owner and a high-ranking official of the Oklahoma Department of Health were convicted of soliciting, paying, and accepting bribes. The defendant/nursing home owner set up a brokerage account for the payment of bribes to the defendant/State official who in turn (1) provided privileged Department of Health information to the nursing home owner, (2) facilitated the inappropriate placement of Medicaid patients in deficient facilities run by the nursing home owner, (3) inappropriately provided temporary management contracts in favor of the nursing home owner over other nursing home facilities, and (4) allowed the nursing home owner inappropriate access to certain Department of Health operations and functions. The illegal activities were done in return for cash and other considerations. The State official was sentenced to 10 years imprisonment, with 2 years to serve, and 8 years supervised probation. The nursing home owner was sentenced to 5 years and 3 months imprisonment.

Optometrists

In Kentucky, an optometrist pled guilty to five felony counts, including Medicaid fraud, and was sentenced to 10 years imprisonment. From January 1998 through September 2001, the defendant operated two optometry clinics and defrauded the State's Medicaid program of nearly a quarter of a million dollars through various billing schemes. The illegal acts included billing for services not rendered, billing for higher level reimbursements for virtually all patients served, billing for unnecessary services to patients, and up-coding. In addition, the defendant failed to remit the payroll taxes, health insurance premiums, and unemployment insurance for the employees who worked for the two clinics. For several years, the defendant also failed to file both Federal and State tax returns. As part of a plea agreement, the defendant was excluded from participation in all Government health care programs and ordered to forfeit his/her license to practice optometry. Although the defendant sought bankruptcy protection prior to the inception of the criminal case, the MFCU was successful in obtaining \$43,000 in restitution from payments owed to the defendant that had been placed in escrow by the single State Medicaid agency.

Orthodontists

In Nevada, an orthodontist pled guilty to two counts of conspiracy to commit Medicaid fraud. The defendant was sentenced to 7 days imprisonment, time served. The defendant submitted long-term treatment plans to Medicaid for orthodontic services to juvenile recipients, for which the defendant received advanced payment. The investigation revealed that the services were actually performed by others and that the defendant provided no supervision nor assistance. The defendant was required to refund the advanced payments to Medicaid. A confession of judgment against the defendant was filed prior to sentencing. In addition, the defendant was ordered to pay restitution and penalties totaling \$175,000, and the defendant's license to practice dentistry was revoked.

Patient Abuse and Neglect

In Arkansas, an employee of a residential care facility raped a mentally impaired resident. The defendant had a record of several prior sexual assault convictions. The owner/administrator of the facility was aware of the defendant's prior conviction, as the defendant was the owner/administrator's spouse. The defendant pled guilty to a reduced charge of attempted rape and was sentenced to 20 years imprisonment. A no contact order was executed whereby the defendant was to have no further contact with the victim. The order also required that the defendant register as a sex offender. Adult abuse charges are still pending against the owner/administrator of the facility.

In Colorado, a certified nursing aide pled guilty to a charge of crimes against an at-risk adult-criminal negligence resulting in death. The defendant, while employed by a nursing home, transported an 84-year-old resident to the resident's physician's office. When the defendant arrived at the physician's office, the defendant used a wheelchair to transfer the resident from the vehicle to the office. In the defendant's attempt to guide the wheelchair down a flight of stairs, the resident fell out of the wheelchair and landed at the bottom of the stairs sustaining injuries to both the head and shoulder. The resident subsequently died of the injuries sustained in the fall. The defendant was sentenced to 3 years probation with conditions.

In Hawaii, the operator of a residential care home that provides round-the-clock care for adults requiring minimal assistance pled guilty to assault by omission in the second degree. The case involved a 102-year-old resident of the facility who had contracted gangrene and developed decubitus ulcers (bedsores). Investigation revealed that the defendant/operator only sought medical treatment for the gangrene. The elderly resident subsequently contracted pneumonia and died. An autopsy revealed that the bedsores contributed to the resident's death. The defendant was sentenced to 3 months imprisonment, ordered to pay restitution, and serve 100 hours of community service.

In South Carolina, an employee of a community training home left a 40-year-old mentally retarded resident of the home unattended in the bathtub. The resident, who had a history of seizures, suffered an attack while bathing and subsequently drowned. The defendant was sentenced to 5 years imprisonment, suspended to 5 years probation, and ordered to perform 500 hours of community service. The defendant was prohibited from working in a health care facility while on probation.

In Wisconsin, a licensed practical nurse working in a rehabilitation center pled guilty to one count of intentionally neglecting a patient. The defendant failed to administer proper care to a 79-year-old diabetic patient whose blood sugar had dropped to a dangerously low level. The defendant was observed shoveling a gelatin-like substance into the patient's mouth. When the patient was unable to swallow the substance, the defendant then held the patient's nose closed, cutting off the airway. This caused the patient to choke and eventually lose consciousness.

Efforts to revive the patient were unsuccessful and the patient subsequently died. The defendant was sentenced to serve 13 months in prison, with 35 months of extended supervision.

Patient Funds

In Iowa, a senior accounting clerk was convicted of three counts of theft in the first degree. The defendant was employed by a company that handled financial transactions on behalf of residential care facilities in the State. The defendant diverted funds that were intended to be credited to resident's accounts. The defendant was sentenced to 10 years imprisonment on each of the three theft counts. The term was suspended and the defendant was placed on probation for 5 years. As a condition of probation, the defendant was ordered to pay restitution, court costs and surcharges in the amount of \$158,242, and fines totaling \$3,000.

In Maine, a boarding home administrator pled guilty to one felony count of theft by misapplication of property and one count of misuse of entrusted property. The defendant stole \$8,516 from a 71-year-old dependant resident. The stolen funds were proceeds derived from the sale of the resident's family home. On the theft count, the defendant was sentenced to 4 years imprisonment with all but 65 days suspended, 2 years probation and was ordered to make full restitution to the victim and pay a \$300 fine. On the second count, the defendant was sentenced to 1 year imprisonment, suspended, with concurrent periods of probation, and ordered to pay a \$150 fine.

In Montana, a nursing home administrator was convicted on two counts of felony theft and one count of felony theft by accountability. The defendant stole approximately \$45,000 from a patient trust account. The nursing home was in the process of being closed by the State when it was discovered that the patient's trust fund was almost depleted. The defendant was sentenced to 10 years imprisonment on the two felony theft counts and 6 months imprisonment on the felony theft by accountability charge. All counts were suspended in lieu of the defendant making full restitution and paying court costs.

In New Hampshire, a fiduciary responsible for the financial affairs of a disabled adult was convicted of stealing more than \$31,000 from the victim. Prior to the theft, the 63-year-old victim suffered a stroke. The stroke left the victim permanently disabled. The defendant stole the victim's monthly disability income while the victim was residing in a nursing facility. The disability income was to be used to pay the victim's bills at the nursing facility and maintain the victim's modest private residence. The victim's home was eventually sold to satisfy the victim's creditors, which left the victim destitute. The defendant was sentenced to serve 3 years imprisonment.

Personal Care Services

In Minnesota, the owner of a company that provided personal care assistance services to Medicaid recipients was charged with six felony counts of theft by false representation. It was

alleged that the owner routinely overbilled Medicaid for an excessive number of services performed. It was also alleged that the owner billed the program for services in advance of any services actually being provided. The owner pled guilty to theft charges and was sentenced to a stay of imposition, and 20 years probation. The defendant was also ordered to pay restitution in the amount of \$160,882 to the State, serve 60 days imprisonment and pay a fine and fees totaling \$500, and submit to DNA analysis.

In Montana, a personal care attendant pled guilty to one count of felony theft. The defendant was employed by a home health agency to provide personal care services to a Medicaid recipient. During the time that the defendant was providing personal care services to the recipient, the two married. The couple hid the marriage and continued to bill Medicaid for services rendered. The home health agency learned of the marriage and referred the case to the MFCU for investigation. The defendant was sentenced to 3 years imprisonment, suspended, ordered to pay restitution in the amount of \$4,257 to the State's Medicaid program and to pay fines and court costs.

In Washington, an in-home health care aide, contracted by Medicaid to provide personal care services to beneficiaries, pled guilty to one count of attempted Medicaid fraud. The investigation revealed that for a 22-month period the defendant submitted invoices to Medicaid for payment for services rendered to a deceased client. The defendant was sentenced to 3 days in jail, 12 months probation, fined \$500, and ordered to make restitution in the amount of \$14,004 to the Medicaid program.

Pharmacies

In Florida, a pharmacy and its president/owner were charged with Medicaid fraud and other related criminal offenses. The owner fraudulently billed Medicaid approximately \$900,000 for pharmaceutical drugs that were never purchased by the pharmacy nor dispensed to Medicaid recipients. The owner was convicted and sentenced to 5 years imprisonment, 20 years probation, and ordered to pay \$500,000 in restitution to the Medicaid program and \$10,000 in investigative costs. Charges against the pharmacy were dismissed.

In Indiana, the owner of a company authorized to provide pharmaceuticals to patients in the southern part of the State was convicted of defrauding the Medicaid program of approximately \$1.8 million over a 3-year period. Through the defendant's company and another provider entity for which the defendant served as office manager, the defendant routinely exaggerated the quantity of drugs that patients received, usually by a factor of 10, and improperly classified claims, resulting in elevated reimbursements. During the same 3-year time period, the defendant also defrauded Medicaid by up-coding practices. Of the \$2.6 million billed to Medicaid by the defendant, more than \$1.5 million was fraudulently obtained. The defendant was sentenced to 51 months imprisonment. The defendant's private residence, valued between \$900,000 and \$1.2 million, was seized for forfeiture along with other valuable items such as fur coats and jewelry.

In New York, a pharmacy owner and the pharmacy's parent corporation were convicted of Medicaid fraud. The pharmacy/owner falsely billed the Medicaid program for more than \$1 million in nonexistent pharmaceuticals and over-the-counter items, including more than \$500,000 worth of the nutritional supplement Ensure, that were neither stocked nor dispensed. The pharmacy/owner was sentenced to up to 12 years in prison. The parent corporation and its owner were ordered to pay restitution in the amount of \$1,166,550 to the State's Medicaid program.

In New Jersey, a pharmacist and owner of four pharmacies pled guilty to second degree health care claims fraud. The defendant submitted over 6,000 false claims to Medicaid, resulting in a loss to the program of more than \$1.3 million. The MFCU, along with the State's Civil Remedies and Forfeiture Bureau, successfully froze nine of the defendant's business accounts, restraining funds in the amount of \$367,381. During the pre-trial litigation, investigators learned that the defendant was in the process of selling the four pharmacies to a large retail chain. Under a plea agreement, the defendant was sentenced to 8 years imprisonment, ordered to forfeit all monies held in escrow from the sale of the four pharmacies and forfeit all restrained funds held by the State. These funds totaled over \$1,000,000. Additional information supplied by the defendant led to two other individuals pleading guilty to charges of Medicaid fraud and theft from the State's Unemployment Trust Fund. One of the two defendants ultimately pled guilty to engaging in kickbacks involving nursing homes and assisted living facilities operating in the State. This latter information resulted in 12 additional case investigations being opened by the MFCU.

In Oklahoma, a pharmacist pled guilty to four counts of Medicaid fraud. The defendant submitted false claims to Medicaid and submitted an inordinate number of billings for expensive drugs that are rarely prescribed to nursing home patients. The defendant was sentenced to 3 years imprisonment, suspended on each count, with the counts running consecutively, placed on 12 years probation and was ordered to pay restitution in the amount of \$131,997 to the Medicaid program. In addition, an administrative recoupment in the amount of \$250,000 was recovered.

Physicians

In Alabama, a licenced physician pled guilty to aiding in the unlicensed practice of medicine by another. A second physician, who was unlicensed in the State, was convicted of Medicaid fraud. The scheme involved claims made to Medicaid for payment for patient services that were performed by the unlicensed physician, with the full knowledge and approval of the licensed physician. Both the name and authorized provider number of the licensed physician were used in the scam. The licensed physician was sentenced to 2 years imprisonment, suspended to 6 months probation and ordered to pay restitution to the State's Medicaid agency in the amount of \$7,200. This defendant was also suspended from participation in the Medicaid program for a period of 2 years. The unlicensed physician received 6 months probation.

In Connecticut, a physician was convicted of larceny in the first degree for fraudulently billing the Medicaid program for services not rendered. The investigation revealed that many of the intended recipients at the time of service were either hospitalized out-of-State, out of the country, or at other appointments or locations. The defendant was sentenced to 3 years imprisonment, suspended after 6 months, 3 years probation, and ordered to make full restitution in the amount of \$64,275.

In Massachusetts, a physician pled guilty to four felony counts of illegally prescribing controlled substances and two counts of filing fraudulent Medicaid claims. The investigation found that over a 6-month period, the defendant prescribed, for no legitimate medical purpose, more than 1,600 doses of OxyContin, Hydrocodone, and other pain medications. The defendant admitted billing Medicaid for 744 fictitious office visits. The defendant also admitted to fraudulently billing the program an overtime fee for 168 urgent after-hours visits that never occurred. The defendant was sentenced to 1 year imprisonment, with 6 months of in-home confinement, and 6 months suspended for 3 years. As a condition of probation, the defendant was ordered to pay \$53,000 in restitution. On the day the guilty plea was entered by the defendant, an agreement for judgment in another civil case involving the defendant was filed by the Attorney General. The agreement stemmed from findings that, during a 3-year time period, the defendant improperly up-coded nearly 12,000 patient visits, the majority of which were billed to the Medicaid program. Investigators also found that the defendant did not render services for the majority of the claims made. In accord with the agreement, the defendant was to pay \$280,000 to the State's Medicaid program, withdraw from further participation in the Medicaid program, and surrender his/her Drug Enforcement Administration number. The defendant eventually ceased practicing medicine in the State.

In North Carolina, a physician was found guilty of billing for undocumented services, billing for non-covered services, billing without proper physician signatures, altering medical records, duplication of medical notes for multiple patients, and up-coding. A joint task force of the MFCU, OIG, the U.S. Attorney's Office of Eastern North Carolina, and other Government agencies conducted the investigation. The defendant was sentenced to 21 months incarceration, 2 years supervised probation and ordered to pay total restitution in the amount of \$492,792.

In Tennessee, a physician who was the owner/operator of an orthopedic clinic was found guilty on 50 counts of health care fraud and 45 counts of making false Statements. The defendant received payments from various health care benefit programs based on false and fraudulent representations. In addition, the defendant billed and was paid for level four office visits to which he was not entitled. The defendant was sentenced to 41 months imprisonment and ordered to make restitution in excess of \$3.2 million dollars. The case was a 3-year joint investigation by the MFCU and the Tennessee Bureau of Investigation, OIG, the Federal Bureau of Investigation (FBI), the U.S. Postal Inspection Services, the Tennessee Valley Authority, and BlueCross BlueShield of Tennessee.

Psychiatrists

In Massachusetts, a psychiatrist was found guilty of illegally prescribing drugs and defrauding the Medicaid program. The defendant was also convicted of prescribing and ordering medically unnecessary psychological tests for several Medicaid patients. Over a 5-year period, the defendant made false claims to Medicaid for payment for providing psychotherapy to as many as 60 patients per-day. It was estimated that the defendant was paid more than \$1 million by the Medicaid program. The defendant was sentenced to serve 2 years imprisonment and 3 years probation. As the conditions of probation, the defendant was ordered to stop prescribing medication for a 2 year period, perform 750 hours of community service, and pay a \$10,000 fine.

Psychologists

In Minnesota, a licensed psychologist pled guilty to one count of theft by swindle. The defendant billed Medicaid for patient services that were actually performed by registered nurses whom the defendant employed. Claims were made to Medicaid for payment as though the defendant provided the services. The nurses were not qualified to perform the particular services billed. The defendant was sentenced to a stay of imposition, placed on probation for 10 years, ordered to pay restitution to the Medicaid program in the amount of \$65,931, pay a fine of \$10,000, and perform 150 hours of community service.

Transportation Services

In Colorado, a provider of transportation services pled guilty to theft. The defendant billed Medicaid for mileage for ambulatory (wheelchair) transportation which is not reimbursable under the Medicaid program. The defendant was sentenced to 4 years deferred judgment and ordered to pay restitution of \$68,743 and court costs.

In Delaware, the owner and operator of a transportation company pled guilty to one count of health care fraud. The defendants overstated mileage on patient trips made and overbilled Medicaid. The defendants were both sentenced to 5 years imprisonment, which were suspended for probation and ordered to pay \$100,000 in restitution to the Medicaid program and \$12,930 in investigative costs.

In Ohio, the owner of a transportation company that provided services to Medicaid recipients was charged and convicted of a fourth degree felony for billing Medicaid for scheduled transports that were cancelled by the recipients before they actually occurred. The defendant was sentenced to 5 years of community control sanctions with the possibility of serving 18 months imprisonment if, at any time, the conditions of the community control were violated. In addition, the defendant was ordered to pay \$315,000 in restitution to Medicaid, a \$5,000 fine, and \$5,000 in investigative costs.

In Virginia, the co-owner of a company that provided transportation services to recipients was convicted of health care fraud on the State's Medicaid program. The defendant fraudulently billed the program \$857,607 and was sentenced to 71 months imprisonment and ordered to make full restitution to the Medicaid program. The MFCU's investigation was conducted jointly with the assistance of the U.S. Attorney's Office, FBI, the Department of Medical Assistance Services, and the Virginia Department of Medicaid Assistance.

In Wisconsin, the owner of a transportation company that provided services to beneficiaries was convicted of five counts of Medicaid fraud and one count of theft by fraud and racketeering. The defendant/owner's company was convicted of 15 counts of Medicaid fraud. The defendant/owner billed the program for thousands of dollars for services not rendered, including billing for transportation services to recipients who were either incarcerated or hospitalized. The defendant/owner was sentenced to 5 years imprisonment, but the sentence was stayed for 7.5 years probation, with 1 year to be served in the House of Corrections. The defendant/owner was also ordered to pay restitution in the amount of \$123,688.97 to the State's Medicaid program. In addition, the defendant/owner was barred from working for or being involved with any program conducting business with the Medicaid or Medicare programs. The defendant/owner's company was ordered to pay restitution and fines in the amount of \$498,668.

Other Cases

In California, a former physician who headed a massive health care fraud ring was convicted on four felony counts that included one count of conspiracy to cheat, defraud, and commit acts injurious to the public health, and three counts of tax evasion. The defendant was sentenced to 16 years imprisonment, ordered to pay \$2.5 million in restitution to the State, and pay back taxes totaling \$124,000. The ring stole patient and physician identity information and trafficked in human blood to give the appearance of running legitimate clinical laboratories. The defendant and his co-conspirators laundered \$15.5 million in illegally-obtained proceeds through a small neighborhood market in New Jersey. The Medi-Cal Fraud Unit conducted the 4-year joint investigation with assistance from OIG, the New Jersey Attorney General's Office, and the State's Franchised Tax Board. The defendant, along with 28 co-conspirators, was charged with a total of 104 felony charges, including endangering the public health, submitting false claims to Medi-Cal, money laundering, identity theft, conspiracy, tax evasion, and grand theft. Most of the defendants were convicted and sentenced, with the remainder awaiting trial. Of particular note is the doctor's chief co-conspirator who was convicted at a jury trial and sentenced to 18 years, 8 months State imprisonment, a record sentence for a health care fraud case in California. The co-conspirator was also fined \$5 million and ordered to pay restitution in the amount of \$2.5 million to Medi-Cal.

In Mississippi, a bookkeeper working at a long-term care facility pled guilty to 23 counts of embezzlement for stealing funds from the residents' trust funds. The defendant was sentenced to 30 years imprisonment, with the first year on home arrest and the remaining 29 years on

probation. The defendant was also ordered to pay a fine of \$5,000, court costs in the amount of \$649, and to make full restitution to the victim's family.

In Missouri, the operator of a church-affiliated child day care learning center pled guilty to 19 counts of making a false Statement to receive a health care payment and 2 counts of stealing by deceit. The defendant made false representations to the Medicaid program by submitting claims for therapy services that were not provided to children who were program recipients. The investigation revealed that the defendant fraudulently obtained the provider numbers of both physical and occupational therapists in order to make false claims to Medicaid. Fraudulent documentation was created to support the submitted claims. The church center was named as the intended payee. The defendant was sentenced to 4 years imprisonment on each of the false statement counts and 7 years imprisonment on the two stealing by deceit counts, which were to run concurrently. The sentence was suspended, the defendant was placed on 5 years probation, and was ordered to make restitution in the amount of \$100,000 to the State's Medicaid program.

In North Carolina, a professional pathology association was found liable under the False Claims Act for billing Medicaid for laboratory tests that were performed by the servicing hospital. The association entered into a civil settlement agreement with the State, resulting in the repayment of \$900,000 to the Medicaid program.

Performance Standards

With the cooperation of the Units¹, 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?

¹ Units refer to Medicaid Fraud Control Units (MFCU).

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 the 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 reassess their effectiveness and applicability. Additional or revised performance standards will be proposed when deemed appropriate.

MFCU Statistics in Federal Fiscal Year (FY) 2003

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<u>Staff</u>	<u>*Federal Grant Funds</u>	<u>Staff</u>	<u>Convictions</u>	<u>Recoveries</u>
Alabama	\$766,000	10	2	\$1,644,739
Alaska	\$493,000	5	2	\$101,217
Arizona	\$936,000	13	22	\$550,567
Arkansas	\$1,560,000	21	10	\$2,029,782
California	\$16,158,000	189	132	\$39,382,986
Colorado	\$824,000	11	7	\$501,448
Connecticut	\$772,000	9	1	\$699,544
District of Columbia	\$1,244,000	16	4	\$13,048,538
Delaware	\$863,000	14	26	\$254,400
Florida	\$8,646,000	127	109	\$20,983,473
Georgia	\$3,373,000	56	22	\$2,741,904
Hawaii	\$988,000	15	8	\$2,386,459
Illinois	\$5,681,000	72	25	\$1,679,685
Indiana	\$2,376,000	44	9	\$3,319,014
Iowa	\$610,000	8	12	\$183,588
Kansas	\$750,000	7	2	\$304,658
Kentucky	\$1,199,000	17	3	\$1,673,960
Louisiana	\$1,586,000	29	42	\$3,396,623
Maine	\$366,000	5	9	\$733,749
Maryland	\$1,503,000	20	15	\$966,922
Massachusetts	\$1,991,000	24	5	\$4,476,733
Michigan	\$3,513,000	33	32	\$6,548,997
Minnesota	\$1,114,000	11	21	\$1,629,817

<u>Staff</u>	<u>*Federal Grant Funds</u>	<u>Staff</u>	<u>Convictions</u>	<u>Recoveries</u>
Mississippi	\$1,668,000	24	57	\$1,659,210
Missouri	\$1,388,000	17	16	\$3,332,441
Montana	\$469,000	8	11	\$1,270,834
Nevada	\$1,055,000	13	8	\$544,708
New Hampshire	\$520,000	8	4	\$1,399,777
New Jersey	\$2,170,000	36	15	\$42,646,504
New Mexico	\$842,000	13	5	\$896,674
New York	\$30,624,000	295	78	\$24,387,578
North Carolina	\$1,773,000	26	31	\$14,077,280
Ohio	\$2,799,000	38	90	\$4,714,459
Oklahoma	\$895,000	17	45	\$755,969
Oregon	\$963,000	12	6	\$1,238,106
Pennsylvania	\$3,683,000	50	20	\$5,036,300
Rhode Island	\$711,000	10	5	\$170,046
South Carolina	\$911,000	13	39	\$1,534,659
South Dakota	\$241,000	5	2	\$94,782
Tennessee	\$2,156,000	35	16	\$860,724
Texas	\$2,811,000	43	38	\$31,043,055
Utah	\$754,000	9	17	\$539,628
Vermont	\$467,000	8	13	\$459,657
Virginia	\$1,979,000	27	13	\$15,619,468
Washington	\$1,676,000	16	11	\$1,535,116
West Virginia	\$737,000	15	3	\$3,625,833
Wisconsin	\$902,000	9	30	\$1,537,679
Wyoming	\$325,000	4	3	\$262,371
TOTAL	\$119,831,000	1,507	1,096	\$268,481,661

*Federal grant awards that the MFCUs received in FY 2003 under the program.

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