TESTIMONY
OF
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BEFORE

U.S. SENATE FINANCE COMMITTEE

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Mr. Chairman and Members of the Committee, Thank you for the opportunity to appear before you today to discuss the role of the states in investigating and prosecuting Medicaid fraud. I am Nick Messuri, Director of the Massachusetts Medicaid Fraud Control Unit. I am very pleased to speak to you today as the representative of the National Association of Medicaid Fraud Control Units, which I currently serve as President.

INTRODUCTION

The Medicare-Medicaid Anti-Fraud and Abuse Amendments, enacted by Congress in the 1970s, established the state Medicaid Fraud Control Unit Program and provided the states with incentive funding to investigate and prosecute Medicaid provider fraud, to prosecute the abuse and neglect of patients in all residential health care facilities which are Medicaid providers, and to investigate fraud in the administration of the Medicaid program. The Ticket to Work and Work Incentives Improvement Act of 1999 authorizes the Units, with the approval of the Inspector General of the relevant federal agency, to investigate fraud in other federally-funded health care programs if the case is primarily related to Medicaid. This law authorizes the Units, on an optional basis, to investigate and prosecute resident abuse or neglect in non-Medicaid board and care facilities, and emphasizes the necessity of having an integrated multi-disciplinary team of attorneys, investigators, and auditors working full-time on Medicaid fraud cases in order to successfully prosecute these complex financial crimes. The Units are required to be separate and distinct from the state Medicaid programs to avoid institutional conflicts of interest, and are usually located in the state Attorney General's office, although some Units are located in other state agencies with law enforcement responsibilities, such as the state police or the state Bureau of Investigation.

Because the federal government provides 75% of each Unit's costs, with the remaining 25% funded by the state, each Unit operates under the administrative oversight of the Inspector General of the U.S. Department of Health and Human Services and must be recertified annually. This funding formula allows the federal government to ensure that each Unit's activities are directed exclusively at provider fraud, fraud in the administration of the program, and resident abuse or neglect, and not at crimes lacking inappropriate Medicaid nexus.

State Medicaid Fraud Control Units are federally funded state-based law enforcement agencies entrusted with the responsibility of ridding the nation's Medicaid program of fraud and nursing home abuse. Since the inception of this national program in 1978, the forty-nine Medicaid Fraud Control Units have obtained thousands of convictions, recovered hundreds of millions of dollars in restitution, and perhaps even more important than any specific prosecution or recovery, demonstrably deterred the loss of many more hundreds of millions of dollars in Medicaid overpayments.

The need for the MFCUs became evident in the 1970s when the public and Congress realized that too many nursing home patients were held hostage by the greed of a small number of facility operators and other dishonest health care practitioners who saw fit to use the Medicaid program as

their own private "money machine." To better understand how such a scandalous situation could have developed, one must first look at the structure of the Medicaid program. Medicaid was enacted by Congress in 1965 to provide a comprehensive range of medical services to people with disabilities and America's poorest citizens. It is sometimes confused with Medicare, the federal health insurance program for people sixty-five years of age and older and their eligible dependents. Unlike Medicare, however, which is federally funded and provides the same benefit coverage throughout the United States, Medicaid is financed by federal and state funds and is administered by each state. In addition to all fifty states, the District of Columbia and the territories participate in the Medicaid program.

Although Medicaid benefits might differ from state to state, a common problem that has plagued the program since the mid-1960s has been its skyrocketing costs. The reasons are many; pay and chase claims processing, increased enrollment, rising costs of medical care and prescription drugs, the frequency with which the services are used, and the lack of explanation of benefit forms sent to Medicaid recipients. Although most taxpayer dollars go directly toward providing needed medical care for the intended beneficiaries of the program, a tremendous amount of money is lost to fraud, waste and abuse.

The lack of comprehensive safeguards in the initial Medicaid legislation gave a small but greedy group of individuals free rein to steal millions of taxpayer dollars during Medicaid's first decade of operation. Functioning with few controls to prevent fraud, and without any specific state or federal law enforcement unit responsible for monitoring criminal activity, Medicaid faced expenditures that had already begun their upward spiral. If there was any question that fraud was hidden in this rapid cost increase, those doubts were put to rest when Congress conducted hearings and documented evidence of widespread misappropriation of taxpayer funds by a handful of unscrupulous health care providers.

While numerous Congressional hearings were bringing such abuses to light, it became clear that states such as New York, where a separate statewide investigative entity had been established, were able to increase substantially the rate of prosecutions and convictions and the recovery of taxpayer dollars.

As the law enforcement agencies primarily responsible for monitoring each state's Medicaid program, the MFCUs have uncovered some of the largest and most sophisticated frauds ever committed against the program. The MFCUs have seen wave after wave of fraud sweeping through nursing homes and hospitals, clinics and pharmacies, podiatrists and medical equipment vendors, radiology providers and labs, home health care providers and durable medical equipment vendors and, more recently, pharmaceutical companies. Each surge has brought its own special brand of profiteer in search of the next great loophole in the Medicaid program.

In addition to fulfilling their primary investigative and prosecutorial functions, the MFCUs work to identify and implement systemic reform initiatives in the administration of the Medicaid program. In an effort to maximize their effectiveness in detecting and preventing fraudulent practices within the Medicaid programs, the MFCUs have:

- Identified pharmaceutical products not subject to federal upper limit pricing, leading to the imposition of state upper limits on the pricing of many high-volume and high-cost prescription drugs;

- Developed and implemented changes in the approval process for Medicaid payments for durable medical equipment (including wheelchairs, specialty beds and therapeutic footwear) to ensure that expenditures for these goods are made only when they are medically necessary and accurately coded;

- Identified, investigated and remedied abusive patterns and practices in the submission of fraudulent expenses in the nursing home cost reporting system;

- Implemented computer edits and controls in the automated Medicaid payment process as a safeguard against improper disbursements;

- Redefined Program Integrity protocols;

- Identified computer software problems in Medicaid pharmacy billing programs;

- Provided training and technical assistance to improve fraud detection methods utilized by medical peer review organizations employed by the Medicaid program;

- Recommended and implemented changes in Medicaid provider enrollment screening processes to provide for effective background checks; and

- Identified improper billing for clinical laboratory testing that was not medically necessary.

- Developed a computerized tracking system to identify and prevent the rehiring of perpetrators of resident abuse;

- Worked with the HHS Office of Inspector General to develop protocols and procedures for a voluntary disclosure program to provide ongoing guidance to the health care industry and to encourage provider self-evaluation, prompt reporting of overpayments and voluntary disclosure of improper conduct;

- Drafted and successfully advocated for passage of legislation requiring background checks of home health aides and nursing home employees; and

- Assisted investigators from the Offices of the State Auditor and the United States Attorney in the investigation of mental health counseling corporations.

NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS (NAMFCU)

The National Association of Medicaid Fraud Control Units (NAMFCU) was established in 1978 to provide a forum for the nationwide sharing of information concerning the problems of Medicaid fraud control, to foster interstate cooperation on law enforcement and federal issues affecting the MFCUs, to improve the quality of Medicaid fraud investigations and prosecutions by conducting training programs and providing technical assistance to Association members, and to provide the public with information on the MFCU program. Of the 49 MFCUs that comprise the Association, 42 are located in the Office of the Attorney General and seven are located in other state agencies.

The Association gathers, coordinates and disseminates information to the various Units, maintains a library of resource materials and provides informal advice and assistance to its member Units and to those states considering the establishment of a Unit. NAMFCU conducts several training conferences each year and is called upon regularly to supply speakers for numerous health care fraud seminars. The *Medicaid Fraud Report*, the Association's newsletter, is published ten times a year and contains information concerning prosecutions by various states and reports of legal decisions affecting fraud control. Beginning with the first global settlement case in 1992, NAMFCU has worked effectively to coordinate multistate/federal investigations and settlements.

PROVIDER FRAUD SCHEMES

In the past decade, the MFCUs have seen a rapid increase in both the number of fraudulent schemes targeting Medicaid dollars and the degree of sophistication with which they are committed. Although the typical fraud schemes – billing for services never rendered, double-billing, misrepresenting the nature of services provided, providing unnecessary services, submitting false cost reports and paying illegal kickbacks – still regularly occur, new and often innovative methods of thievery continue to appear.

Perpetrators of Medicaid fraud run the gamut from the solo practitioner who submits claims for services never rendered to large institutions that exaggerate the level of care provided to their patients and then alter patient records in order to conceal the resulting lack of care. MFCUs have prosecuted psychiatrists who have demanded sexual favors from their patients in exchange for prescription drugs, nursing home owners who steal money from residents, and even funeral directors who bill the estates of Medicaid patients for funerals they did not perform.

SELECTED STATE MEDICAID FRAUD INVESTIGATIONS, PROSECUTIONS, AND SETTLEMENTS

The Units have identified serious fraud problems in numerous sectors of the health care industry, including hospitals, home health care agencies, medical transportation and durable medical equipment companies, pharmacies and medical clinics, and have prosecuted individual providers such as physicians, dentists and mental health professionals.

Examples of recent Medicaid Fraud cases follow:

HOSPITALS

- Two medical doctors who were faculty members at the University of Washington were convicted of felonies and the University hospital agreed to pay $35 million to settle the allegations. A *qui tam* complaint had been filed in federal court alleging that the University and its related physician billing groups billed Medicare and Medicaid for services performed by university residents and not the named physicians.

- In a *qui tam* case filed by two former employees of a Minnesota hospital, the employees alleged that the hospital home health services did not qualify for reimbursement. Negotiations between the U.S. Attorney's Office and the defendant resulted in a settlement of $500,000 for Medicare and Medicaid. The case was investigated by the U.S. Department of Health and Human Services, Office of Inspector General and the Minnesota MFCU.

PHYSICIANS

- A Texas physician was found guilty by a federal jury of Health Care Fraud, Mail Fraud, and Conspiracy. The defendant was sentenced to ten years in federal prison and ordered to pay $8.4 million in restitution. He operated a walk-in clinic, from which he billed Medicare, Medicaid, TriCare and the Federal Employee Health Benefits plans for treating as many as 200 patients a day. This case was worked jointly by the F.B.I., Defense Criminal Investigative Service (DCIS), the Office of Personnel Management (OPM), and the Texas MFCU.

- A Washington State physician pleaded guilty to one count of Health Care Fraud in U.S. District Court after submitting false claims for medical services to government sponsored health care benefit programs. The physician would see patients for a brief appointment or not at all, but then bill Medicaid for a comprehensive visit. She also routinely handed out prescriptions for highly addictive medications such as OxyContin without conducting any physical examination. She was sentenced to serve one year of incarceration, two years probation and ordered to make restitution in excess of $850,000 and to pay a $110,000 fine.

- The Oregon MFCU participated in a health care fraud investigation of a urologist who was accused of improperly billing Medicare and Medicaid for drugs received as free samples from the manufacturer. This case arose from information related to the settlement reached between the U.S. Department of Justice and the states with TAP Pharmaceutical Products, Inc. over TAP's marketing of the drug Lupron. The physician paid fines and penalties totaling $213,198.

- An Ohio physician billed for approximately 70 office visits per day while using a code indicating that the visits were substantial in length and involved complex diagnosis and treatment. The defendant pleaded to a bill of information of felony Medicaid fraud and paid $215,003 in restitution, $400,000 in forfeiture and was placed on probation for three years. He was also required to surrender his medical and DEA licenses. In addition to the Ohio MFCU, the investigating team included a number of state and federal agencies as well as private insurance companies.

- A physician in East Tennessee who submitted false claims, upcoded claims, misrepresented services, and billed for services not rendered was indicted by a federal grand jury on 95 counts of health care fraud and false statements. After a two week trial, the doctor was convicted on all counts, sentenced to 42 months in federal prison and three years supervised probation upon his release, and ordered to pay restitution of over $3,000,000.

- A Utah physician defrauded the Medicaid program by billing for IV therapy when in fact he was providing chelation therapy that is not covered by Medicare, Medicaid or private insurance. He has entered a plea of guilty to one count of the indictment and will pay restitution, surrender his medical and DEA licenses and be permanently excluded from the Medicare, Medicaid, TriCare and all other federal health care programs. This case was the result of a cooperative investigation and prosecution involving the HHS Office of Inspector General, the U.S. Attorney's Office and the Utah Medicaid Fraud Control Unit.

- The Vermont MFCU joined forces with the U.S. Attorney's Office and the HHS Office of Inspector General to investigate and prosecute an ophthalmic surgeon. The physician who was indicted by a federal grand jury on 80 criminal counts of healthcare fraud and falsifying medical records for allegedly performing unnecessary cataract surgeries over a period of 20 years on approximately 200 patients.

- A Kentucky anesthesiologist and his pain management corporation were indicted on allegations that the bilked the Medicare, Medicaid and other health benefits programs of $3.5 million. This was a joint investigation conducted by the Kentucky MFCU, the U.S. Attorney's Office, the Federal Bureau of Investigation and U.S. Department of Health and Human Services Office of the Inspector General.

PHARMACISTS

- A Kentucky pharmacist was indicted and convicted of multiple Medicaid fraud counts involving billing for high end cancer medications long after the recipients ceased using the drugs. He was sentenced to five years in prison and ordered to pay $40,000 in restitution.

- A Massachusetts pharmacist and his pharmacy corporation pleaded guilty to fraudulently submitting claims to Medicaid on behalf of ten patients for 89 prescriptions that were never ordered by physicians. The defendant was sentenced to 18 months and ordered to pay $85,746 in restitution.

- A New York pharmacist pleaded guilty to unlawfully selling more than 100,000 powerful painkillers and other drugs to addicts. To conceal his crime the defendant falsified the pharmacy's business records to make it appear that he was refilling the prescriptions according to their terms.

- A South Dakota pharmacist was employed at a hospital and also operated a private pharmacy. Throughout his employment at the hospital, he was able to purchase various drugs at an extremely reduced rate, then sold the drugs he purchased through the hospital at his own pharmacy. The pharmacist was able to realize a substantial profit because the state's Medicaid reimbursement is not based on actual price. The matter resulted in a federal conviction, including restitution in the amount of $82,798.

- A Pennsylvania pharmacist was charged with submitting pharmacy bills for high cost HIV medications that were not prescribed by physicians and/or never supplied to the patients. The indictment included 112 counts of Mail Fraud, Wire Fraud, Health Care Fraud and Tax Fraud. The case was jointly investigated by the Pennsylvania Medicaid Fraud Control Unit and the Pittsburgh Office of the F.B.I.

NURSING HOMES

- A nursing home management contractor who prepared cost reports each year for multiple owners of various nursing facilities in Mississippi pleaded guilty to Medicaid fraud for his preparation of a nursing home cost report. The contractor knowingly included the costs of personal goods and services of the facilities' owner and represented them as legitimate and allowable expenses of the nursing home. As a result of these misrepresentations, the owner was overpaid approximately $560,000 and used the funds to pay expenses for farm supplies, veterinary supplies, cell phones and improvements at his personal residence. The cost report also fraudulently claimed $447,280 in bogus management fees that were kicked back to the owner, and the owner has been charged with knowingly submitting a fraudulent cost report.

- The New York MFCU convicted a Pennsylvania nursing home and its owner of stealing millions of dollars over a ten year period by fraudulently billing for services not provided and for improperly obtaining payments from New York for services that Pennsylvania was already paying for. These services included basic dental treatment and occupational and speech therapy.

- A co-administrator of an Oklahoma nursing home pleaded guilty to charges of embezzlement and received a five year sentence. She was ordered to pay $37,000 restitution for stealing from patient trust funds and placing the money in her checking account for her personal use. She also pleaded guilty to Obtaining Money By False Pretenses by conspiring with two other employees of the nursing home to place the employees' relatives on the payroll and paying them for no-show jobs. The principal target was sentenced to a five year deferred sentence, while the two other employees pleaded guilty and paid restitution.

- A financial manager of two Colorado nursing homes embezzled approximately $97,000 from the personal needs account of nursing home residents. The manager was also convicted of several other schemes and sentenced to ten years in the Department of Corrections and ordered to pay restitution in the amount of $675,240.

DURABLE MEDICAL EQUIPMENT

- Two DME companies in Tennessee allegedly waived patient co-pays, gave kickbacks to doctors for certificates of medical necessity, billed for higher priced walkers than were supplied, and falsified prescriptions for specialty shoes for diabetic patients. The sales manager was indicted by a federal grand jury and pleaded guilty to one count of health care fraud for completing and causing to be completed sections of the medical necessity forms that should have been completed by the nursing staff.

- A Massachusetts durable medical equipment company paid $336,000 to the state Medicaid program for inflating the cost of its products.

- An Oklahoma provider of durable medical goods prepared false certificates of medical necessity for electric wheelchairs and then delivered power scooters to recipients instead of wheelchairs. Reimbursement for the wheelchairs was $5,000, compared to $1,500 for the scooters. The provider was sentenced to five months in federal prison, five months home detention, three years supervised probation, and ordered to pay $348,711 in restitution. This was a joint investigation conducted by the Oklahoma Medicaid Fraud Control Unit, the F.B.I. and HHS/OIG. The case was prosecuted by the U.S. Attorney's Office for the Northern District of Oklahoma.

- A Colorado provider of durable medical goods was prosecuted for obtaining the names and Medicaid patient numbers of elderly clients in the Denver area and billing Medicaid for thousands of dollars of durable medical equipment for each patient. The defendant was ordered to pay $45,350 in restitution.

LABORATORIES

- The California MFCU worked closely with a number of agencies on an investigation of a sophisticated scheme involving 29 defendants who:

  - stole the identities of several thousand beneficiaries and more than two dozen physicians;

  - bilked more than $20 million from California's Medicaid program (Medi-Cal) and approximately $1 million from Medicare; and

  - endangered the public's health and welfare through the creation of a black market for blood.

  Between 1997 and 2000, this crime ring used more than 15 clinical labs in Los Angeles, Orange and Riverside Counties to illegally bill Medi-Cal and Medicare for tests that were not authorized by doctors and never performed. In order to evade detection, the defendants created the facade of a legitimate business operation by having testing equipment and blood specimens available on site, then billed Medi-Cal using stolen confidential information that was shared among the labs. To date, 23 of the 29 defendants have been convicted. The first ring leader was sentenced to 16 years in prison and ordered to pay $2.5 million in restitution, and $124,000 in back taxes to the state. The second ring leader was sentenced to 18 years and eight months in state prison and ordered to pay criminal penalties of $5 million, $2.5 in restitution to Medi-Cal and $903,000 in back taxes to the state.

MENTAL HEALTH PROVIDERS

- The executive director of a New Jersey mental health clinic was sentenced to three years in state prison for inflating patient billings to the Medicaid program and for submitting phony invoices for mental health counseling and psychological services that were never rendered.

- The co-owners of a Texas Licensed Professional Counselor group billed the Medicaid program for services that were not rendered and were indicted on charges of stealing approximately $646,000 in 2002 and 2003 from the Medicaid program by billing for services of counselors they no longer employed. Both of the defendants

were found guilty of the same charges; one was sentenced to 35 years incarceration and the second received a record prison sentence of 63 years confinement.

- An Arkansas mental health provider reached a settlement agreement with the MFCU to repay the Arkansas Medicaid Program Trust Fund $120,000 for services that could not be verified by documentation.

- The Illinois Medicaid Fraud Control Unit obtained a guilty verdict against a mental heath provider for improperly billing Medicaid in excess of $400,000 for psychiatric services. The investigation revealed that the defendant billed for services that were never provided or were provided by unlicensed counselors.

- After a week-long trial, a Minnesota jury found an unlicensed psychologist guilty on two counts; theft by swindle over $35,000 and misrepresentation of her credentials as a licensed psychologist. She was sentenced to 27 months of incarceration and placed on probation for 20 years.

MEDICAL CLINICS

- A physician and the co-owners and managers of a now defunct infectious disease clinic in Miami were arrested on racketeering charges after they improperly billed the Florida Medicaid program for over $1.1 million. The scheme involved the use of the physician's provider number with his knowledge when he was not present at the clinic and therefore could not have provided the treatment in question. In addition, they billed Medicaid more than$4.7 million for pharmaceuticals that were never administered to patients at the clinic. The investigation also resulted in arrests and convictions of the clinic's president and director of nursing.

- Two Ohio medical clinics required patients to be seen every two weeks as a condition of receiving prescriptions. Office visits usually lasted for approximately two to three minutes but were billed as 45-60 minute visits. Additionally, the patients were required to have physical therapy, and would be refused their prescriptions if they did not cooperate. A task force of MFCU and HHS OIG agents conducted a joint investigation, and the owner and the corporation were convicted of three felonies and ordered to pay $3,500,000 in restitution and to sell the clinics.

- The prosecution of a Louisiana registered nurse and her husband, former owners of a now-defunct clinic, resulted in convictions on nine felony counts of Medicaid fraud, felony theft and money laundering of $100,000 or more. The MFCU investigation revealed that the clinic fraudulently billed the Louisiana Medicaid Program more than $400,000 for fictitious services for indigent children, including well-care nursing and nutritional consultations.

DENTISTS

- A dentist in the District of Columbia pleaded guilty to one count of health care fraud. The defendant was a participating provider in a number of dental care programs, and although she was paid a fixed fee for providing routine services to patients, she was entitled to supplemental reimbursement for providing more invasive procedures. In her guilty plea, the defendant admitted billing for these invasive procedures for at least 60 Medicaid recipients when she had not performed the work. As part of her plea, the defendant paid $15,374 to the Medicaid program, was sentenced to two years of probation, and was ordered to undergo evaluation and treatment for drug abuse. The MFCU has requested that the defendant be excluded from participation in all federal health care programs.

- A New York dentist admitted to stealing more than $50,000 from Medicaid by fraudulently billing Medicaid for dental services not performed. The defendant was sentenced to five years probation and ordered to pay $175,000 in restitution.

- A South Carolina dentist was convicted of two counts of Filing False Claims with the South Carolina Medicaid program for services that had not been provided and was sentenced to a three year suspended sentence and a $1,000 fine.

HOME HEALTH

- A Pennsylvania provider of home health services forged time sheets and inflated hours as a basis for submission of claims to the Medicaid program. The defendant was convicted of Medicaid Fraud, Perjury, Theft by Deception, Forgery, Tampering with Public Records and Criminal Conspiracy. The provider's husband was also sentenced to two to four years in the state Correctional Institution for his role in the scheme.

- An owner of a home health care franchise pleaded guilty to felony theft from the Maryland Medicaid program and was sentenced to eight years incarceration, with 27 months to be served. He was ordered to pay $250,000 in restitution to Medicaid, and an additional $750,000 in penalties. The defendant had operated a home health care franchise in Maryland and inflated the cost reports he submitted by including expenses incurred by an unrelated business.

OTHER PROVIDERS

- The Massachusetts MFCU recovered $50,000 from an optometrist who submitted improper claims for services for elderly nursing home residents.

- In a joint investigation by the federal government and the Virginia MFCU, the owner/operators of an intensive in-home mental health services provider were convicted of fraudulently billing the Virginia Medicaid program for approximately $2.5 million. They had billed for services that were not provided, upcoded and billed at higher reimbursement levels, and billed for services that were not covered as part of Medicaid's reimbursement policies. One of the defendants was sentenced to six months incarceration and six months of electronic monitoring, and the second was sentenced to 46 months incarceration. They were jointly ordered to pay the Virginia Medicaid program $2.5 million, the largest case for the Virginia MFCU to date.

- The Rhode Island MFCU's recent Medicaid Fraud settlements have resulted in the return of approximately one million dollars to the Medicaid Program. One such case involved Coram, a home-based therapeutic company that submitted false invoices on behalf of two recipients from April 1995 through April 2002. Coram paid $195,000 to the Department of Human Services and $5,000 to the MFCU for investigative costs.

- Maine settled charges of illegal drug switching by Omnicare of Maine, a pharmacy that serves clients in long-term care facilities statewide. The Complaint alleged that Omnicare of Maine violated the False Claims Act, the Unfair Trade Practices Act, and the Maine Pharmacy Act by switching patients from the prescribed Ranitidine tablets to unprescribed Ranitidine capsules. Omnicare paid $1,080,000 in fines, damages and costs to settle the case.

- The Vermont MFCU brought a three-count indictment against a defendant who fraudulently obtained control of nearly half a million dollars in Medicaid funds and embezzled approximately $139,000 from a non-profit agency that provided Medicaid waiver services to severely disabled children. The defendant was convicted of one count of Medicaid fraud, paid restitution in the amount of $89,105 and received a sentence of five to ten years.

- A Missouri speech therapist pleaded guilty to three counts of Health Care Payment Fraud and Abuse. He was sentenced to four years imprisonment, sentence suspended, and the court ordered restitution to the Missouri Medicaid program in the amount of $105,210.

- The owner and operator of a Delaware transportation company engaged in widespread overcharging of the Delaware Medicaid program for medical transportation. After a jury trial, the prosecution resulted in a conviction on five counts of Felony Health Care Fraud.

- A New Hampshire podiatry practice was convicted of Medicaid fraud after filing more than 80 fraudulent Medicaid claims to obtain reimbursement for orthotic foot devices and was ordered to pay restitution in the amount of $18,330. A parallel civil settlement with the company president resulted in the payment of $40,000 in civil penalties to the Medicaid program and the company's termination as a Medicaid provider.

- The South Dakota MFCU brought an action against non-licensed individuals who performed physical therapy on patients and then billed Medicaid, Medicare and private insurers for the services. Restitution to Medicaid was determined in the amount of $15,786 and an additional $15,018 was assessed as a civil penalty.

- The part owner and controller of an Intermediate Care Facility for individuals with mental retardation (ICF-MR) headquartered in North Carolina pleaded guilty to one count of Attempt to Obstruct a Criminal Investigation of a Health Care Offense (a federal crime) and was sentenced to three years probation, ordered to pay a $20,000 fine and to serve 100 hours of community service. He also entered into a civil settlement with the federal government and the state of North Carolina under which the company agreed to pay $102,972. The defendant part owner leased equipment from a contract services company and paid exorbitant rates for leasing equipment from the company without appropriate disclosures. He also attempted to obstruct the investigation by telling the straw owner to lie to investigators regarding specific business transactions between the two entities. As a result of the investigation, the assets of the contracting company were seized and forfeited, at a value of $727,251.37.

MFCU GLOBAL INVESTIGATIONS AND SETTLEMENTS

Interaction With Federal Agencies: One important feature of the MFCU oversight program is the effort to forge close and effective working relationships with state and federal agencies to combat fraud and abuse in the Medicaid programs of the various states. These cooperative efforts have grown out of the relationship between MFCUs and HHS-OIG, which has oversight over the MFCU program. Medicaid fraud is a crime under both state and federal statutes, may be prosecuted in either state or federal courts. Consequently, all MFCUs work closely with the Offices of the United States Attorneys in their respective states and with federal law enforcement agencies such as the U.S. Department of Justice, the FBI, HHS/OIG, the Internal Revenue Service and the U.S. Postal Service. There are active state-federal health care fraud task forces and working groups in virtually every state in the country, and the MFCUs regularly participate in these task forces and working groups.

Cooperative efforts between state and federal authorities have proven very effective in protecting the Medicaid and Medicare programs from health care providers or vendors who defraud

both programs and whose misconduct occurs in multiple states. Multi-state cases in which the MFCUs played a role have resulted in the return of almost a billion dollars to the Medicaid program. Defense attorneys recognize that settling an investigation brought by one state Medicaid program does not resolve Medicaid claims in other states, and that most states, like the federal government, have the authority to exclude a convicted provider from their health care programs. Accordingly, resolution of these cases would be difficult or impossible if the targets were required to negotiate separate terms and obtain separate settlement agreements from each state.

The federal False Claims Act (FCA) includes *qui tam* provisions which provide the authority and financial incentive to private individuals or "relators" to enforce the Act on behalf of the government. *Qui tam* relators, often called "whistleblowers," are generally current or former employees of target entities and are protected by the Act from retaliatory actions by their employers. A *qui tam* complaint is filed under seal in federal district court and remains under seal for at least 60 days (and often much longer) to allow the government to conduct a thorough investigation. In addition, fifteen states currently have false claims statutes with *qui tam* provisions, and an increasing number of relators are filing their cases with the states as well as the federal government. This development has fostered a significant increase in state/federal investigative partnerships.

The state Medicaid Fraud Control Units are generally notified about an ongoing investigation or case when the United States Department of Justice (DOJ) or a United States Attorney's Office (USAO), relator's counsel, defense attorney, or other source, contacts the National Association of Medicaid Fraud Control Units (NAMFCU) and requests the assistance of the MFCUs. NAMFCU obtains relevant information, such as the name of the parties, the subject of the conduct under investigation, and the type of criminal or civil violations suspected, then prepares a list of states affected by the suspected wrongdoing. The NAMFCU President then determines if it is appropriate for the states to participate and whether an investigative team should be appointed.

If the investigation reaches the settlement stage, the NAMFCU team will contact the defendant to set out basic ground rules, including the framework for negotiations (exclusion/ non-exclusion, criminal pleas and/or civil settlement, the payment of the team's expenses attributable to the negotiations, etc.). In joint federal-state cases, this process takes place in cooperation with federal attorneys assigned to the matter.

There are other crucial factors to consider in a settlement, such as the provider's ongoing economic viability, the effect on shareholders, potential employment impact on specific communities, and the effect that exclusion from Medicaid, Medicare and other state and federal health care payment programs will have upon the Medicaid beneficiaries' access to adequate and convenient medical care. Settlements may include additional issues such as incarceration of individual employees or officers, corporate reorganization and compliance or corporate integrity agreements ("CIAs"). The negotiations are highly confidential and often are governed by grand jury secrecy requirements, *qui tam* provisions, privilege issues and SEC statutes and regulations.

Under NAMFCU protocols, all state recoveries are allocated based upon a state's actual damages. The participating states usually are asked to supply state specific data regarding the defendant's billings, although it is sometimes possible to calculate state losses from information supplied by the federal government or through discovery from the defendant. The NAMFCU settlement team, in conjunction its partners in the federal government, is committed to negotiating for the best settlement possible for its member states, and will in appropriate circumstances seek penalties as well as damages.

Examples of recent federal/state global settlements follow:

ABBOTT LABORATORIES

Abbott Laboratories, a manufacturer of pharmaceutical and medical products, settled a $414 million case with the government for defrauding state Medicaid and federal Medicare programs through the marketing of its enteral feeding pumps and related supplies.

As part of the settlement agreement entered in federal court for the Southern District of Illinois, Abbott paid $364,816,174 in damages and penalties to the Medicare program and $49,638,575 to the Medicaid programs of the 50 states and the District of Columbia. C.G. Nutritionals, an Abbott subsidiary, also pleaded guilty to a federal charge of Obstruction of a Criminal Investigation of Health Care Offenses and paid a criminal fine of $200 million to the federal government.

The investigation showed that Abbott's Ross Products Division:

- Provided free enteral feeding pumps to nursing homes and DME suppliers in exchange for an agreement tat those buyers would purchase a specific number of pump sets;

- Told nursing homes and DME suppliers they could bill Medicare or Medicaid for pumps that had been supplied free of charge; and

- Paid improper financial incentives to DME suppliers and nursing homes to buy products from Ross.

ASTRAZENECA PHARMACEUTICALS LP

AstraZeneca Pharmaceuticals LP (Zeneca) agreed to pay $24 million to the state Medicaid programs for damages caused by Zeneca's marketing practices for its drug Zoladex, used for the treatment of prostate cancer. This agreement settled claims on behalf of all 50 states and the District of Columbia. The multi-state settlement was reached in conjunction with a federal settlement negotiated by the United States Attorney's Office in Delaware. Under the federal agreement, Zeneca

pleaded guilty to a charge of conspiracy to violate the Prescription Drug Marketing Act and entered a civil settlement to pay damages to Medicare and other federally funded health care programs.

Zeneca was accused of providing quantities of Zoladex to physicians and other providers free of charge, knowing and expecting that those free samples would be billed to the Medicaid and Medicare Programs, and of improperly giving physicians educational grants, consulting services, entertainment expenses and honoraria in exchange for orders of Zoladex. Most significantly for the states, Zeneca failed to include the free Zoladex in the calculation of its "best price" as required under the federal Medicaid drug rebate program, causing the state Medicaid programs to receive lower rebate amounts than were due.

As part of the agreement with the states, Zeneca will be required to report accurate pricing information to the state Medicaid programs for Zoladex and for other drug products marketed to physicians and clinics for in-office administration. Additionally, Zeneca will cooperate with the states in investigating individuals, including physicians, who have caused overcharges to the Medicaid programs by taking advantage of Zeneca's marketing schemes.

RITE AID

Thirty state Medicaid Programs recovered over $6.6 million dollars as a result of a settlement with Rite Aid Corporation. Rite Aid, a national retail pharmacy chain, agreed to pay a total of $7 million to the federal and state governments to settle allegations that the company dispensed partial or "short" prescriptions due to insufficient stock and returned unfilled medications to stock, but still received full payment from government health insurance programs (Medicaid, Tricare and the Federal Employee Health Benefit program).

The Rite Aide settlement includes a Corporate Integrity Agreement (CIA) that will be administered by the HHS/OIG. The CIA requires the company to modify its pharmacy billing operations to ensure future compliance with applicable laws and Medicare and Medicaid regulations.

SCHERING PLOUGH, INC.

Forty-nine states and the District of Columbia reached an agreement with pharmaceutical manufacturer Schering Plough, which paid $140.7 million to the state Medicaid Programs for damages and penalties from Schering's underpayment of Medicaid Drug Rebates on its blockbuster antihistamine drug, Claritin.

The federal Medicaid Drug Rebate statute requires all pharmaceutical manufacturers that supply products to Medicaid recipients to provide the Medicaid Programs the benefit of the "best price" available for their product. The manufacturers are obligated to file "best price" information with the Centers for Medicare and Medicaid Services ("CMS"); CMS then uses this information to calculate rebates for the state Medicaid Programs. The reported "best prices" reported by manufacturers must include discounts, rebates, payments and other incentives, but Schering failed

to notify the government of substantial concessions and incentives offered to certain HMO purchasers of Claritin. The result was that the states received millions less in rebates from Schering than would have been paid had "best price" been reported appropriately. Schering paid a total of $282.3 million to resolve its civil liability for this conduct.

PARKE-DAVIS/ WARNER-LAMBERT

The 2004 global federal and state settlement in this matter arose from a 1996 False Claims Act whistleblower case brought by David Franklin, a former medical liaison for Warner-Lambert. Franklin's lawsuit alleged that Warner-Lambert's Parke-Davis Division engaged in a scheme to promote the use of Neurontin for a wide variety of unapproved uses, including the treatment of psychiatric conditions, migraine headaches and attention deficit disorder. At the time, Neurontin had FDA approval only as an adjunct therapy for epilepsy. Federal law prohibits pharmaceutical companies from promoting their products for uses that have not received specific approval from the FDA. The total amount of the settlement to the state Medicaid programs nationwide (restitution and penalties) was $152 million.

The settlement was negotiated by the U.S. Attorney's Office in Boston, the National Association of Medicaid Fraud Control Units and a task force of representatives of the consumer protection divisions of the offices of the state Attorneys General. The resolution of the case required the manufacturer to pay restitution and penalties to the state Medicaid programs and to fund remedial programs designed to benefit consumers. In addition, Warner-Lambert, now a subsidiary of Pfizer, Inc., pleaded guilty by to a criminal violation of the Food, Drug and Cosmetic Act and paid a substantial criminal fine. Pfizer also agreed to the terms of a Corporate Integrity Agreement, under which its marketing practices will be subject to federal scrutiny for a period of three years.

SELECTED SIGNIFICANT RESIDENT ABUSE AND NEGLECT ENFORCEMENT EFFORTS BY THE STATE MEDICAID FRAUD CONTROL UNITS

Many MFCUs use their criminal and civil enforcement authority to investigate and prosecute the insidious and often hidden abuse of nursing home residents, including both financial exploitation and physical abuse of vulnerable and fragile senior citizens. Some of these cases involve allegations of sexual abuse, corporate neglect, drug diversion, misappropriation of patient trust funds, and have included prosecutions of caregivers for homicide and manslaughter. In addition, Units across the country have launched innovative training and public outreach programs to educate health care professionals and the public about the prevalence of elder abuse. Other important activities undertaken by the Units include legislative efforts to enhance and reform the laws that protect residents from these abuses and the referral of state criminal convictions, judgments and licensing actions to the HHS Office of the Inspector General so that individuals who are convicted of these

crimes may be excluded from working in any facility or program that receives Medicaid funding. Examples of these initiatives follow:

PHYSICAL ABUSE

It is difficult to conceive of a more vulnerable, less threatening group than residents of long-term care facilities, but too often they are the target of cruel and sometimes sadistic violence and mistreatment. Tragically, the perpetrators of physical abuse are usually those charged with the care and well-being of patients in long-term care facilities.

- A licensed practical nurse was arrested in Pennsylvania, and charged with one count of Neglect of a Care-Dependent Person, and four counts of Simple Assault. The LPN was observed striking patients to make them comply with her orders.

- A patient aide at an Intermediate Care Facility for individuals with mental retardation (ICF-MR) in Kentucky abused a 37-year-old male resident by striking him in the stomach with his fists. Upon his plea of guilty to the one misdemeanor count of abusing an adult, the defendant was sentenced to 12 months in the county jail. The defendant is also prohibited from ever seeking employment at any facility that cares for the physically or mentally infirm.

- A nursing home employee was charged with and convicted of patient abuse in a Montana facility after an investigation into the allegation that she had struck a resident with his own arms and stuck his urine soaked t-shirt in his mouth. She was fined, given a suspended jail sentence and excluded from the Medicaid program.

- The Vermont MFCU obtained the conviction of a nurse's aide after the aide struck an 81-year-old male resident of the nursing home, leaving a fist-shaped mark on the man's sternum. The defendant received a deferred sentence and was placed on probation for two years. As part of his probation, he is prohibited from being employed to give direct care to elderly and disabled adults. The resolution of the criminal case also triggered an administrative action by the federal Center for Medicare and Medicaid Services which will exclude him from employment in any Medicare or Medicaid funded position for a minimum of five years.

- A certified nursing assistant (CNA) in Washington State pleaded guilty to one count of Fourth Degree Assault. after she slapped a wheelchair bound 91-year-old suffering from dementia, neuropathy and leukemia. She was sentenced to 365 days in jail, with all but one day suspended, and a $5,000 fine suspended on condition of having no criminal law violations and attending anger management classes. The Washington State Department of Health revoked her certification to practice as a nursing assistant with no right to re-apply for at least five years.

- A nurse was convicted of one count of patient abuse at a Delaware long-term care facility after holding his hand over an elderly victim's mouth to quiet the victim.

- The Massachusetts MFCU obtained a 4 to 5 year committed state prison sentence against a CNA after a three week jury trial, proving that she abused five elderly Alzheimer patients including force-feeding one patient her own feces and slapping, kicking and spitting on other patients who lived at the nursing facility. The key to the success of the prosecution was convincing co-workers to come forward and testify after they had been intimidated by the defendant.

- Two nurse's aides in North Carolina pleaded guilty to simple assault after an investigation revealed that they dragged a nursing home resident through the halls of the facility because she resisted taking a scheduled bath. The resident suffered floor and carpet burns to her back as a result of the incident.

SEXUAL ABUSE

Sexual abuse of frail elders and people with disabilities is seldom discussed but occurs all too frequently. These individuals are easy prey for sexual predators because many of them sleep in unlocked rooms and regularly submit to physical contact in order to receive care.

- A nursing assistant in Minnesota was charged with four counts of criminal sexual conduct after he assaulted a nursing home resident, and was found guilty on two counts. He was sentenced to 33 months of incarceration and five years of supervised probation, and he must register as a sex offender and provide a DNA sample to the state.

- A New Hampshire neurologist at the state's psychiatric hospital pleaded guilty to charges involving the sexual assault of a patient. The MFCU successfully argued an issue of first impression under the governing sexual assault statute, which precluded health care providers from claiming the patient's alleged consent as a defense. Two of the assaults occurred while the defendant was treating the patient at the hospital. The defendant was sentenced to one year of incarceration, six months suspended, with a consecutive suspended state prison sentence, and was barred from seeking reinstatement of his medical license for four years.

- A residential treatment worker was convicted of the offenses of Sexual Abuse in the Third Degree and Wanton Neglect of a resident of a health care facility in Iowa and was sentenced to 12 years of imprisonment and fined. The female victim was unable to provide testimony because she suffered from profound mental retardation and lacked communication skills. The cornerstone of the prosecution was DNA-analysis evidence that was garnered from clothing of the defendant secured after the issuance

of a search warrant at his residence. This conviction has since been reviewed and affirmed by the Iowa Court of Appeals and the Iowa Supreme Court.

- A male registered nurse at a Tennessee mental health institute was suspected of engaging in sexual intercourse and other sexual acts with a female patient under his care. After an extensive investigation that raised many difficult issues, including the credibility of the victim and the fact that no other witnesses could be located, the R.N. was indicted. He was later convicted after a jury trial and sentenced to 30 days incarceration and two years supervised probation, sex offender treatment counseling, placement on the sex offender registry, 20 days public service, and loss of his nursing license.

PATIENT TRUST FUNDS

Federal regulations provide that the MFCUs may review complaints of the misappropriation of patients' private funds in nursing homes, and many of the Units investigate and prosecute these financial crimes.

- In Oklahoma, the administrator of the Grace Living Center was given a ten year suspended sentence and ordered to pay $32,590 in restitution for diverting the residents' funds for his own personal use.

- The office manager of a New Hampshire nursing home pleaded guilty to theft after stealing funds from more than 12 patient accounts. The defendant was sentenced to six months in jail, suspended, and was ordered to make restitution of more than $10,000.

- An owner/administrator of a residential care center in South Carolina transferred $61,508.16 of residents' funds into an operating account and used the funds for her own benefit. She was convicted and sentenced to a three year sentence and ordered to pay restitution.

- The financial manager of two nursing homes in Colorado was sentenced to ten years in the Department of Corrections and ordered to pay $672,240 in restitution. She had embezzled approximately $97,000 from one home and collected payments from the families of nursing home residents at the other.

- A business office assistant employed at two nursing homes in Richmond, Virginia embezzled funds from the patient trust accounts at both homes and was found guilty of two counts of embezzlement and one count of forgery. She was sentenced to a total of 30 years in prison with 25 years suspended and ordered to pay $15,279 in restitution.

- In the largest patient trust fund case in the history of the Texas MFCU, the former business manager of a Texas nursing facility pleaded guilty to diverting resident and facility funds. He issued 452 "petty cash" checks from the resident trust fund, totaling $368,367 for his own benefit. He was sentenced to ten years probation and ordered to serve 90 days in jail in addition to being ordered to make full restitution.

PATIENT NEGLECT

Those who accept the position of trust as caregivers to dependent, vulnerable adults should be held accountable for neglecting those in their charge. Failure to provide care and treatment to residents of nursing homes and board and care homes can be every bit as dangerous and harmful as intentional assaultive behavior. Many states have brought prosecutions against caregivers and sometimes against facility owners in cases where they have failed to provide adequate care and treatment to residents.

- The Kentucky MFCU led a three year joint agency investigation of a nursing home's practices and a catastrophic failure of care. The management corporation pleaded guilty in state court to criminal Medicaid Fraud and paid a total of $1.2 million dollars in fines and restitution to the Medicaid program. The owners also entered into an agreement with the federal and state government, and paid a total of $432,815 in civil monetary penalties and false claim liabilities.

- The Nebraska MFCU is planning to file both criminal and civil actions involving a case where a severely handicapped woman was allowed to develop third and fourth degree pressure ulcers while residing at a group home facility. The evidence shows that her medical needs far exceeded the licensure level of the facility and the management knew it. The Unit will be seeking to recover all Medicaid funds paid for this patient's care before and after the injuries, an amount in excess of $200,000.

- Four owners of a medical center in Florida were arrested and charged with patient neglect, after patients were denied needed medications, did not receive proper nutrition, failed to have access to staff and endured poor sanitary conditions. One resident with a history of severe mental illness was found to have left the facility and wandered into a busy intersection outside of the facility. The facility had received over $3.5 million dollars in Medicaid funds during its last year of operation, yet failed to pay its own employees for months at a time.

- The New York MFCU has created a Nursing Home Initiative, which examines corporate, institutional and executive liability for conditions leading to poor patient care and resident abuse. The Initiative has achieved several criminal convictions based upon unprecedented applications of New York's penal and public health laws. For example, two nursing homes agreed to repay $3 million to the Medicaid program after the MFCU concluded (1) that the nursing homes operated without sufficient

skilled nursing staff to deliver basic care to all of its residents; (2) that some residents did not receive the care that they were entitled to; and (3) that some of the homes' employees falsified records to show the delivery of care that had not been provided. In another case, a New York nursing home was held criminally liable for failing to provide adequate staff to care for residents. The nursing home corporation also admitted that its employees falsified business records to conceal that licensed practical nurses were unlawfully performing medical assessments. As a result, the corporation and its two owners agreed to divest themselves of their nursing home operations and were permanently enjoined from having any further involvement in the management, operation or ownership of any nursing home in New York State. In addition, the corporation was ordered to pay $1 million in restitution to the Medicaid program and $17,000 in fines.

- The Arkansas MFCU reached a settlement agreement with Beverly Enterprises, Inc., resulting from 42 separate investigations of resident mistreatment or neglect in several Beverly facilities in Arkansas. As a result of the investigations, Beverly agreed to pay the Arkansas Medicaid Program Trust Fund $1.3 million. In addition, Beverly agreed to pay $200,000 to the University of Arkansas Medical Sciences Center on Aging for research to improve the quality of care for nursing home residents in Arkansas.

- A nursing home in Illinois was closed by federal and state regulators because of deficient patient care, including unsafe, dangerous, hazardous and unsanitary nursing facility conditions. In addition, the nursing home paid $594,500 because the Illinois Medicaid program had reimbursed the home for services that were not provided.

- A Massachusetts nursing home owner paid $660,000 to Medicaid for failing to provide adequate nursing staff levels to meet the basic health and safety needs of residents. The MFCU used medical experts to determine that nursing staff levels were too low resulting in high rates of medication errors, inadequate supervision to prevent accidents, substandard nutrition levels and high incidence of skin sores in hundreds of patients.

INVOLUNTARY MANSLAUGHTER/ HOMICIDE

On occasion, the MFCUs prosecute caregivers at nursing homes and group homes for negligent homicide, involuntary manslaughter and homicide.

- The Louisiana MFCU brought charges against a nurse and a nursing assistant at a nursing home for negligent homicide. The nurse was responsible for the care of a resident who was found dead from suffocation after her tracheotomy tube was dislodged.

- The Maryland MFCU convicted a caregiver at a group home for the developmentally disabled of two counts of involuntary manslaughter and one count of reckless endangerment. He was sentenced to five years of incarceration with 15 months to be served. The defendant failed to monitor electric stove burners, and two residents died of smoke inhalation when the facility caught fire.

- The Arkansas Unit investigated a homicide at a nursing home after two certified nursing assistants (CNAs) beat a resident to death with a set of brass knuckles. One CNA pleaded guilty and was sentenced to 30 years in prison and the other is awaiting trial on Capital Felony Murder charges.

FAILURE TO REPORT

Reporting requirements play an important role in protecting residents from abuse and/or neglect and most states statutes dealing with patient abuse include a mandatory reporting section. The statutes differ, however, as to who is considered a mandated reporter and which agency receives the report. The enforcement of these reporting requirements is vital because many victims are unable to speak coherently, and witnesses may fear retaliation from the abuser, their associates, or the facility itself.

- An employee of a Missouri nursing home assaulted a facility resident by striking him in the head, and the resident died as a result of the injuries. The employee later pleaded guilty to elder abuse in the first degree and was sentenced to 15 years in the Missouri Department of Corrections. The president of the management company and the facility administrator knowingly failed to immediately report this incident of abuse as required. A jury found the president, the company (through the president), and the nursing home guilty of failure to report elder abuse. The court sentenced the president to one year imprisonment in the county jail and payment of a fine of $1,000, and sentenced the management company and the nursing home administrator to pay a fine of $5,000 each.

- An administrator of a skilled nursing facility in California failed to report an incident of suspected dependent adult abuse and was sentenced to six months in jail, placed on three years of probation and ordered to complete 500 hours of community service. Following an appeal to the California Court of Appeals, Fourth District, the three-judge panel unanimously issued a ruling that will have an impact on all future failure-to-report cases. The court ruled that: (a) a purely objective standard applies to a "reasonable suspicion," which triggers a duty to report elder and dependent adult abuse; (b) a violation of the state's mandated reporting law is a strict liability offense, and does not require a finding of criminal negligence; and (c) a nursing home administrator has a duty to report abuse upon receipt of a victim's direct or indirect report of abuse, and once elder and dependent abuse is suspected, the designated

outside agency, not the mandated reporter, has the responsibility to investigate and determine whether abuse actually occurred.

CRIMINAL BACKGROUND CHECKS

An important step in preventing resident abuse in nursing homes is to stop individuals with a criminal background from working in the facility. While many states require a nursing home to check an applicant's record prior to hiring, in too many instances this requirement is not enforced. Many individuals employed as caregivers in nursing homes have been convicted of a crime or even a series of crimes.

- A nursing assistant in Washington State pleaded guilty to one count of Forgery and was sentenced to 12 months probation, and was ordered to pay $500 to the Crime Victim's Compensation Fund, $200 in attorney fees and $110 in court costs. The defendant had applied for employment as a nursing assistant at a long-term care facility in Washington State and completed a Criminal Conviction Background Check as part of the application process. Her application falsely stated that she was employable in all medical facilities, and that her prior criminal conviction had been for a non-reportable juvenile offense.

DRUG DIVERSION IN NURSING HOMES

One of the most common types of neglect occurs when the professional caregiver fails to follow a plan of care or fails to provide medication pursuant to a physician's orders.

- An employee of a nursing facility in Iowa pleaded guilty to three counts of Obtaining a Prescription Drug by Fraud. She admitted to taking three Duragestic Patches, a Schedule II narcotic, from residents in her care and was sentenced to be imprisoned for a period of up to ten years for the three counts and ordered to pay restitution.

- The Vermont Unit obtained multiple convictions in a jury trial involving a registered nurse who diverted morphine from a terminally ill nursing home resident's CADD pump, and also used a syringe to remove the narcotic fentanyl from the patches administered placed on nursing home residents. The nurse was caught on a surveillance camera placed in the facility by Unit investigators. In addition to charges of abuse, the jury found the nurse guilty of illegally possessing and consuming the narcotics, and she was sentenced to three years imprisonment on a four to ten year sentence on drug and elder abuse charges. In addition to jail time, the sentence provides for a variety of special conditions of probation after she completes her term of incarceration, restricting her employment and access to regulated narcotics and alcohol and requiring her to continue treatment and to submit to monitoring by her probation officer. In accord with the plea agreement, she was required to reimburse Vermont's Medicaid program $1,000 for the value of the drugs

she diverted and to make a $5,000 donation in lieu of fines to the Victim's Compensation Fund. She also agreed to be interviewed by staff of the Vermont Attorney General's Office for an educational videotape on drug addiction for health care workers.

- A registered nurse in Oregon was convicted of criminal mistreatment in the First Degree. Oregon MFCU investigators received information that she had been fired from a long-term care facility for "documentation errors" in the patient records. Narcotic records at the facility indicated that she was checking out large quantities of Vicodin without making corresponding entries in the patient records that the medication was actually administered. Further investigation revealed a pattern by the nurse of taking the maximum doses of Vicodin from six patients on a daily basis when the drug had been prescribed on a PRN (as needed) basis. During a six month period, the nurse (whose duties did not include administering medications) received 1,931 pills to be dispensed to residents, while only 23 pills had actually been administered to patients. Under Oregon's Criminal Mistreatment law, a caretaker can be charged with a felony if she steals – regardless of amount – from an elder or dependent person in her care. The case was prosecuted without the testimony of any of the victims, who were not in a condition that would allow them to testify.

- A Director of Nursing was investigated by the Indiana Medicaid Fraud Control Unit for diverting residents' controlled substances and for falsely obtaining other drugs through her position at the long term care facility. She pleaded to four counts of Medicaid fraud and four counts of forgery and was sentenced to four years suspended, four years probation, 18 months home detention and restitution.

- A registered nurse employed at a nursing home in Maine drained the liquid morphine prescribed for an 85-year-old woman suffering from coronary problems and replaced it with saline and tampered with the patient's morphine pills. This case was prosecuted in federal court and the nurse was sentenced to 71 months in federal prison and three years probation.

LEGISLATION

The Medicaid Fraud Control Units, based upon their unique and lengthy experience in investigating and prosecuting resident abuse and neglect, have long urged the strengthening of state and federal resident abuse laws and regulations. Statutes and regulations have been in place to protect children and the mentally disabled, and the MFCUs believe these same protections should be afforded the sick and elderly who reside in nursing homes and board and care facilities.

- The New Hampshire MFCU played a lead role in successfully advocating for a newly established criminal neglect law that protects the elderly, people with disabilities and impaired adults. The purpose of the legislation is to fill a gap in the existing statutes

governing assault crimes. The law provides for the first time a definition of "caregiver" and imposes a duty of care on those who meet that definition. Under the statute, neglect occurs when a caregiver fails to perform the functions expected of a person with the responsibilities set forth in the statute.

- In New York, state officials implemented regulations that now require non-licensed direct care nursing home and home care staff to undergo criminal background checks. The regulations require all agencies employing non-licensed employees who provide direct care to patients in nursing homes or through a home health care agency to conduct a Federal Bureau of Investigation (FBI) criminal background check on such applicants. The FBI checks are capable of providing criminal histories of prospective employees and would include information from all 50 states and the District of Columbia.

- The South Carolina MFCU suggested legislation requiring criminal record checks be made a condition of employment for nursing home staff. The state legislature passed the proposal and criminal background checks are now required for direct caregivers.

- Over the past several years, the Vermont Medicaid Fraud and Residential Abuse Unit has been spearheading an effort to pass legislation to enhance the criminal penalties for crimes against vulnerable adults. This year, "An Act relating to Criminal Abuse, Neglect, and Exploitation of Vulnerable Adults" was passed by the House and Senate and will become law. The purpose of the law is to move criminal abuse, neglect, and exploitation of Vulnerable Adults from the adult protective services civil/administrative statute into the criminal statutes. Most importantly, the bill provides for penalty enhancements for these crimes based on the seriousness of the injury and/or the monetary value of the exploitation. In current law, crimes against vulnerable adults in Vermont are only misdemeanors. Once the new law takes effect, law enforcement will be able to charge felonies in cases of serious abuse, neglect and exploitation of this highly vulnerable population.

- The Massachusetts Legislature passed a bill that increases criminal penalties for elder abuse and holds nursing home owners, operators and supervisors accountable for allowing patterns of abuse and neglect to occur in their nursing home facilities. Drafted by the Attorney General's MFCU, the law establishes the crime of indecent assault and battery upon an elder or person with a disability and assault and battery against an elder or disabled person, both containing enhanced penalties. The law also allows a civil case to be brought against a caregiver or supervisor who permits another to abuse, mistreat or neglect an elder or disabled person.

TRAINING

In many states, resident abuse cases are either reported directly to local law enforcement or may be referred to local authorities for prosecution. Training of law enforcement personnel to recognize and deal with resident abuse cases is an essential part of the MFCUs' mission, and many Units have developed and implemented such training and outreach programs. Others educate health care professionals, ombudsmen and the public to recognize and refer cases of resident abuse to the appropriate authorities.

- Under the Delaware MFCU's continuing statewide patient abuse training initiative, which began in 1998, MFCU investigators provide in-service training to each new Delaware Police Officer, as well as veteran Police Officers, nursing home and other long-term caregivers, senior citizen groups, Citizen Police Academy attendees, senior victim advocates and paramedics.

- The Hawaii MFCU continues its efforts to train, educate and network with front line responders, such as the Adult Protective Services (APS) of the Department of Human Services. APS is required to send all of its intakes and complaints to the MFCU. As a result, the MFCU is able to expeditiously review, investigate and prosecute all complaints and reports, many of which went unreported to any law enforcement agency prior to this agreement.

- A two year abuse and neglect awareness project of the Tennessee MFCU, the Tennessee Department of Health and Human Services' Adult Protective Service (APS) and the Tennessee Commission on Aging and Disability culminated with the public release of a video entitled "Unheard Cries." The video has been distributed to law enforcement and health care oversight agencies throughout the state and nation, together with informational brochures and posters.

- The Illinois MFCU provides on-site training regarding resident abuse and neglect to any facility or organization upon request.

- The Louisiana MFCU formed the Louisiana Patient Abuse and Neglect Action Committee (LAPANAC) as a means of partnering with other state and federal agencies and the health care community in an effort to heighten awareness and increase reporting of elder abuse.

- The Maryland MFCU has conducted sessions to train all Baltimore City Police Officers on issues relating to the investigation of abuse and neglect of vulnerable adults, with each session consisting of a presentation by an attorney and an experienced investigator. In addition, the Unit has held several Town Hall meetings to provide information to caregivers and others on patient abuse issues.

- The Montana MFCU is proactive in presenting training sessions to various provider and elder groups and continually presents training to nursing home staff regarding patient abuse. The Unit also makes presentations on patient abuse issues to other groups such as the aging council, volunteer ombudsmen and the AARP.
- Members of the Nevada MFCU are designing a curriculum on resident abuse and neglect for the University of Nevada.

- The Attorney General of Ohio convened an Elder Abuse Task Force comprised of various state, county and municipal organizations, which met monthly for one year to develop recommendations to improve the state's response to the growing issue of elder abuse. The task force recommended initiatives in the areas of policy, coordination and visibility, and its final recommendations were posted on the Attorney General's web site and presented to the Governor by the Attorney General in February 2005.

- The South Dakota MFCU helped to prepare a Senior Handbook on resident abuse issues, which was published by the Attorney General's office. In addition, the Unit provides instruction on resident abuse at the state law enforcement training center.

- The Pennsylvania MFCU conducts training sessions on the state's Neglect of Care-Dependent Persons statute and participates in a Medical-Legal Board about Elder Abuse and Neglect to identify and address cases of patient neglect around the state.

- The Rhode Island MFCU has presented numerous in-service trainings in nursing facilities throughout the state.

- The Utah Unit conducts monthly multi-disciplinary team meetings for organizations that work with vulnerable adult populations, and many of the cases discussed in these meetings are investigated by the Unit.

- The Washington State MFCU trains law enforcement personnel to recognize criminal mistreatment and resident abuse and to improve their response to such crimes. The Unit provides materials and conducts training regularly for the Basic Law Enforcement Academy and the Washington State Patrol Academy, provides a vulnerable adult training video to all Washington State law enforcement agencies for in-service training, and maintains and updates a network of contacts of all individuals in state law enforcement entities responsible for handling vulnerable adult and resident abuse allegations.

CONCLUSION

In closing, I want to emphasize that the Medicaid Fraud Control Units continue to play a national leadership role in detecting and prosecuting health care fraud and resident abuse. The Units have been successful in serving as a deterrent to health care fraud identifying program savings, removing incompetent practitioners from the health care system, and preventing physical and financial abuse of residents in health care facilities.

Thank you again for giving me the opportunity to testify today.