

State Attorneys General Powers and Responsibilities

Edited by
Emily Myers
National Association of Attorneys General

FOURTH EDITION
NATIONAL ASSOCIATION OF ATTORNEYS GENERAL

Courtesy Chapter

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*This book is dedicated to Attorneys General
and the men and women who work for them in the
56 jurisdictions. They continue to make an important
contribution to state government and the American legal
system. Without them, there would be no book to write.*

Courtesy Chapter

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This book is a collaborative effort, in which different authors with expertise in each substantive area contribute their time and talent. The principal authors are noted on each chapter, but we would like to thank them again here for their hard work and dedication. Many thanks to the following authors:

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CHAPTER 18

Medicaid Fraud

By Barbara Zelner, Executive Director, National Association of Medicaid Fraud Control Units

Medicaid provider fraud costs American taxpayers hundreds of millions of dollars annually and hinders the very integrity of the Medicaid program. State Medicaid Fraud Control Units (MFCUs), the majority of which are in state attorney general offices, have long been in the forefront of health care fraud enforcement. The MFCUs play a national leadership role in investigating and prosecuting health care fraud and resident abuse. The Units have been successful in serving as a deterrent to health care fraud, in identifying program savings, in removing incompetent practitioners from the health care system and in preventing physical and financial abuse of residents in health care facilities.

Medicaid, the federal/state entitlement program of Title IX of the Social Security Act, was established by Congress in 1965 to provide medical and health-related assistance to those who otherwise cannot afford to pay for their health care. These individuals and families include children, the aged, the blind and/or disabled and those who are eligible to receive federally assisted income maintenance payments. Medicaid should not be confused with Medicare, also enacted in 1965, which is financed by a combination of payroll taxes, beneficiary premium payments and general federal revenues. This program provides health insurance to those age 65 and over.

The Medicaid program is jointly funded by the states and the federal government but is administered by the states. Each state must designate an agency to implement and administer its Medicaid program, commonly referred to as the single state agency. To become a participant in the Medicaid program each state must meet certain federal standards, including the provision of selected minimum medical services but may use different methodologies to pay for those services. States have the option of choosing to provide additional health care services to qualified Medicaid recipients. Some states, for example, choose to

provide chiropractic and pediatric services as part of their Medicaid program, while others may opt to include payment for home health care or dental care. The majority of states now offer services through managed care organizations rather than on the traditional fee for service system. There is considerable variation among the states in the administration of their Medicaid program because each state, within broad federal guidelines, can establish its own eligibility standards, determine the type, amount, duration and scope of services. The amount of federal share also varies from 50 to 76 percent of the total program costs.

The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (HHS) is responsible for monitoring state Medicaid management.

OVERVIEW OF THE MFCU PROGRAM

History

Although Medicaid benefits vary from state to state, one common theme that has plagued the program from its beginning has been the skyrocketing costs to both state and federal budgets. The reasons include increasing enrollment, rising costs of medical care, the frequency with which the services are used, added services and our aging population.

From its inception in 1965, Medicaid operated with few controls against fraud and without any specific state or federal law enforcement agencies responsible for monitoring criminal activity within the program. By 1977, the Medicaid program had expanded significantly, costing federal and state governments \$19 billion a year.¹ Today, the Medicaid program has grown to \$574.2 billion.² The second largest program, in most state's budgets, after education, is the Medicaid program.³

Congressional investigations and hearings about the problem of health care fraud and abuse began in the early 1970s. The U.S. Senate Special Committee

1 U.S. Department of Health and Human Services, Office of Inspector General, State Medicaid Fraud Control Units, Annual Report, Fiscal Year 2003,5.

2 Kaiser Family Foundation, Total Medicaid Spending, FY 2016, www.kff.org.

3 Kaiser Commission on Medicaid and Uninsured, Moving Ahead Amid Fiscal Challenge: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Year 2011 and 2012, October 2011,11.

on Aging issued six reports between 1969 and 1982 focusing on the problems of both Medicare and Medicaid fraud. The U.S. House Aging Committee, the U.S. House Government Operations Committee, and the U.S. House Ways and Means Health Subcommittee on Investigations, all conducted hearings and called for measures to attack fraud, waste, and abuse in the Medicaid program. The U.S. General Accounting Office (GAO) also issued more than 100 reports on fraud, waste, and abuse in the Medicaid program between 1965 and 1982.⁴ In 1975, New York Governor Hugh L. Carey, with the support of attorney general Louis Lefkowitz, appointed a special prosecutor, Charles J. Hynes, in response to a massive scandal in the state's nursing home industry. The New York Office of Special State Prosecutor for Nursing Homes, Health and Social Services was the first full scale comprehensive effort in the country to tackle Medicaid fraud. Testifying before Congress in 1976, Mr. Hynes outlined a proposal to establish state fraud control units:

Established state prosecutors such as district attorneys are currently so overworked, understaffed, and underfinanced, that it would be wildly unrealistic to expect that they can cope with health care fraud. As I have explained, the schemes in operation are so complex, wide-ranging and sophisticated, they require a special staff of highly trained professionals working full time to even provide the ghost of a chance of coping with them.

Clearly, to combat health care fraud on an ongoing and effective basis, a special and separate investigative and prosecutorial framework is necessary.

The federal authorities could create a set of standards against which to measure a state application to participate. States meeting those standards could become eligible for federal funds.⁵

4 For a bibliography of major congressional documents on Medicare and Medicaid fraud and abuse, see Staff of Senate Special Comm. On Aging, 97th Cong., 1st Sess., Office of Inspector General, Department of Health and Human Services, *Efforts to Combat Fraud: Waste and Abuse* 65 (Comm. Print 1981).

5 *Medicare and Medicaid Frauds: 1976*, Hearing Before the Senate Special Comm. On Aging, Subcomm. On Long-Term Care, 94th Cong., 2d Sess. 776 (1976) (statement of Charles J. Hynes New York Deputy attorney general for Medicaid Fraud Control).

In 1977, Congress responded by enacting the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (P.L. 95-142). Their objective was “to strengthen the capability of the government to detect, prosecute, and punish fraudulent activities under the Medicare and Medicaid programs . . .” On October 25, 1977, President Jimmy Carter signed the legislation which provided each state with the opportunity and resources to establish a Medicaid Fraud Control Unit to investigate and prosecute provider fraud and resident abuse. Section 17 provided 90 percent federal funding to the states for three years to establish and operate a Medicaid Fraud Control Unit.

In 1978, the first Medicaid Fraud Control Units (MFCUs or Units) were federally certified and federal grant funds of \$9.1 million were awarded to 17 Units. In FY 2012, a total of almost \$202 million in federal funds was awarded to 50 MFCUs. In 1980, Congress demonstrated continued federal support for the MFCU program by providing for permanent federal funding for the Units beyond the initial three year period.⁶ New Units would continue to be funded at rate of 90 percent for a Unit’s first three years of operation. After that, a Unit would receive permanent federal funding at a rate of 75 percent.

All Units are now at the 75 percent matching rate. This funding formula allows the federal government to ensure that each Unit’s activities are devoted exclusively to investigating and prosecuting provider fraud, resident abuse and fraud in the administration of the Medicaid program. Federal financial participation for any one quarter may not exceed the higher of \$125,000 or 1/4 of one percent of the sums expended by the federal, state and local governments during the previous quarter in carrying out the state’s Medicaid program.

The MFCU program was voluntary until 1995. Federal law now requires each state to have a Medicaid Fraud Control Unit unless the state can demonstrate to the satisfaction of the Secretary of the U.S. Department of Health and Human Services that it has a minimum amount of fraud in its Medicaid program and Medicaid beneficiaries will be protected from abuse and neglect. Forty-nine states and the District of Columbia have a MFCU. North Dakota has been granted a waiver and does not have a MFCU.

Although the territories participate in the Medicaid program, they do not have MFCUs. However, the Consolidated Appropriation Act of 2017⁷ lifted the cap for Puerto Rico to allow it to establish a MFCU. The cap was lifted for the U.S. Virgin Islands by the Bipartisan Budget Act of 2018.

6 Omnibus Budget Reconciliation Act of 1980, P.L. 96-499.

7 P.L. No. 115-331, Division M, Title II, Section 202 (a).

Jurisdiction

The primary function of a MFCU is to conduct a statewide program for the investigation and prosecution of health care providers who defraud the Medicaid program. In addition, a MFCU reviews complaints of resident abuse or neglect in health care facilities that receive Medicaid funds. MFCUs may review complaints of the misappropriation of patient's private funds in these facilities. MFCUs are also charged with investigating fraud in the administration of the program and for providing for the collection or referral for collection to the single state agency and overpayments it identifies in carrying out its activities.

In 1999, the jurisdiction of the MFCUs was extended. MFCUs are now allowed, with the approval of the Inspector General of the relevant agency, to investigate fraud in any federally funded health care program such as Medicare or the Children's Health Insurance Program (CHIP) (Title XXI of the Social Security Act). This authority is limited to those cases that are primarily related to Medicaid.⁸

In addition, the MFCUs now have the option to investigate complaints of abuse or neglect of those residing in board and care facilities, regardless of the source of payment. Board and care facilities include residential settings where two or more unrelated adults reside and receive nursing care services provided by, or under the supervision of, either a R.N., L.P.N. or licensed nursing assistant, and/or a substantial amount of personal care services are provided that assist residents with the activities of daily living. Approval from the HHS Office of Inspector General (OIG) is not required for resident abuse investigations in board and care facilities.

Federal regulations prohibit the MFCUs from pursuing recipient fraud, unless there is a conspiracy with a provider and from engaging in routine computer screening activities that are the usual monitoring function of the Medicaid agency. Routine program monitoring activities include "data mining." The term data mining has been defined as, "the practice of electronically sorting claims through statistical models and intelligent technologies to uncover patterns and relationships contained within the Medicaid claims activity and history to identify aberrant utilization and billing practices that are potentially fraudulent."⁹ A MFCU cannot claim federal financial participation (FFP) for any data mining activities and must rely on referrals from the Medicaid agency.

⁸ The Ticket to Work and Work Incentives Improvement Act of 1999, P.L. 106-70.

⁹ Federal Register Vol. 76, No. 52, March 17, 2011 pp. 14638.

Civil Authority

The primary responsibility of the MFCUs is the investigation and prosecution or referral for prosecution of criminal violations related to the Medicaid program. However, in recent years, both state and federal prosecutions have increasingly relied on civil remedies to achieve a full resolution of health care fraud cases. In a federal guidance issued in 1999, the state MFCUs are encouraged to pursue civil remedies. MFCUs can now analyze all provider cases that are declined criminally for their civil potential. If no appropriate state law exists that allows the recovery for damages for both the state and federal share of Medicaid payments, meritorious civil cases may be referred to federal authorities. Those states that have enacted *qui tam* statutes have seen a dramatic increase in the number of civil complaints that are filed in their states.

Staffing

A Medicaid Fraud Control Unit is required to be a single, identifiable entity of state government and, as envisioned by the federal enabling legislation, is an integrated law enforcement unit comprised of attorneys, auditors and investigators. A Director, generally an Assistant Attorney General, manages the MFCU, although some MFCUs are managed by an investigator. This multidisciplinary approach, with the team directed by an attorney and operating out of one office, has been found to be the most successful approach to prosecuting Medicaid fraud cases. When Congress created the national MFCU program, it modeled the structure for the Units on the New York Special Prosecutor's Office. That Office created the attorney/auditor/investigator model, labeled the team concept, which recognized that neither local district attorneys nor state Medicaid agencies had the auditing or investigative resources to handle complex investigations of Medicaid fraud.

The professional staff of a Medicaid Fraud Control Unit must be employed by the MFCU for at least a year. This includes a full-time detail or assignment from another government agency if it is for a period of at least a year and is under the supervision of the MFCU.

The federal government has interpreted the "full-time" employment rule in several policy transmittals. OIG has emphasized that Congressional intent is clear, Unit staff, attorneys, investigators and auditors must work full-time in a MFCU in order to develop specialized expertise in investigating and prosecuting Medicaid fraud cases. All Medicaid Fraud Control Unit employees must work under the direction of the supervising personnel of the MFCU. If a professional employee works on a non-Medicaid related case or performs duties under

the direction of another state office, that individual is not considered a “full-time” employee and their personnel costs would not qualify for federal financial participation.

The regulations require that the staff of a Medicaid Fraud Control Unit include one or more attorneys experienced in investigating or prosecuting civil fraud or criminal cases, one or more experienced auditors capable of supervising the review of financial records and advising or assisting in the investigation of alleged fraud and a senior investigator with substantial experience in commercial or financial investigations who is capable of supervising and directing the MFCU’s investigative activities. A MFCU is also required to employ professional staff who are knowledgeable about the Medicaid program and the operation of health care providers, as well as sufficient administrative and support staff, who may be employed part-time, to carry out its duties and responsibilities.

MFCUs currently employ approximately 2,000 staff nationwide. MFCUs range in size from New York, the largest with a total staff of over 300, to Wyoming, the smallest with a total staff of four.

Location in State Government

When Congress created the Medicaid Fraud Control Units, it intended that state anti-fraud efforts be coordinated in one office and that agency have statewide prosecutorial authority, therefore allowing MFCU to prosecute their own cases. The legislative preference is for a MFCU to investigate and prosecute its own cases on a statewide basis. However, the law recognizes that not all states are able to do so. Approximately 14 of the 50 MFCUs do not prosecute their own cases, but refer them to either local or federal prosecutors. Forty-four of the 50 MFCUs are located in the office of the State attorney general and six are located in the other state agencies, such as the Bureau of Investigation or State Police.

Any of the three following alternatives is acceptable under the law for organizing and locating a Fraud Control Unit:

The entity (A) is a Unit of the office of the State attorney general or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations, (B) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Secretary, that (i) assure its referral of suspected criminal violations relating to the program under this subchapter to the appropriate authority or authorities in the State for prosecution and (ii) assure its assistance of, and coordination

with, such authority or authorities in such prosecutions, or (C) has a formal working relationship with the office of the State attorney general and has formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Secretary and which provide effective coordination of activities between the entity and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the program under this subchapter.¹⁰

RELATIONSHIP WITH MEDICAID AGENCY

To receive federal certification, a MFCU must be separate and distinct from the state Medicaid program or single state agency. According to the legislative history, MFCUs are housed outside the state health and welfare departments “because such Units were often too close to the providers and industries they had responsibility for regulating. Moreover, officials with responsibility for the operation of the program generally did not look kindly on investigations which disclosed fraud, waste and abuse in their programs.”¹¹

Federal regulations also prohibit any official from the Medicaid agency from having the authority to review or overrule activities of the Unit. Furthermore, the MFCU is prohibited from receiving funds from the Medicaid agency.

The Medicaid agency is required to enter into an agreement known as a Memorandum of Understanding (MOU) with the Unit. The Medicaid agency is required to promptly respond to requests from the MFCU to provide free copies of any records, information or computerized data that is kept by the agency and its contractors; and to initiate any available administrative or judicial action to recover improper payments to providers. Generally, an MOU should be updated every five years.

The state Medicaid agencies are required to maintain an automated claims processing and retrieval system, known as the Medicaid Management Information System (MMIS), a claims payment and information retrieval system. A vital part of MMIS is the Surveillance and Utilization Review Subsystem (SUR/S) that

10 42 U.S.C. § 1396 b(q).

11 STAFF OF HOUSE SELECT COMM. ON AGING, 97TH CONG., 2D SESS., *MEDICAID FRAUD: A CASE HISTORY IN THE FAILURE OF STATE ENFORCEMENT* 17 (Comm. Doc. 1982).

attempts to identify fraudulent and abusive providers, by reviewing aberrant patterns or practices.

Payment Suspension

Once the Medicaid agency verifies an allegation of fraud, it is required to refer the suspected fraud to the MFCU for further investigation.¹²

Federal regulations now require a state Medicaid agency to suspend payments to a provider after the agency determines that there is a credible allegation of fraud, unless the state has “good cause” not to suspend payments. A credible allegation of fraud is defined as an allegation that has been verified by the state from any source including the following: hotline complaints, data mining claims, provider audits, civil false claims acts, or a law enforcement investigation.

The regulations list the obligations of the Medicaid agency to the MFCU as well as list the good cause exceptions to the suspension.

As a result of this amendment, the federal regulation regarding the relationship between the MFCU and Medicaid agency was amended.¹³

RELATIONSHIP WITH THE HHS OFFICE OF INSPECTOR GENERAL

In 1976, Public Law 94-505 created an Office of Inspector General (OIG) within the then-Department of Health, Education and Welfare (HEW), now HHS. OIG is intended to be an independent and objective unit and was created with the specific responsibility to:

- (1) to conduct and supervise audits and investigations relating to programs and operations of the DHEW; (2) to provide leadership and coordination and recommend policies for activities designed to:
 - (A) promote economy and efficiency in the administration of; and
 - (B) prevent and detect fraud and abuse in such programs and operations; and (3) to provide a means for keeping the Secretary and the Congress fully and currently informed about problems and deficiencies relating to the administration of such programs and operations and necessity for and the progress of corrective action.¹⁴

¹² 42 CFR § 455.15 (a)(1).

¹³ 42 CFR § 1007.9 (e).

¹⁴ U.S. Department of Health and Human Services, Office of Inspector General, State Medicaid

The Health Care Financing Administration (HCFA), now CMS was responsible for the oversight and administrative responsibilities of the MFCU's activities as well as their annual certification. One year after the first MFCUs were certified in 1978, this responsibility was transferred from HCFA to OIG because the activities of the MFCUs were more closely related to OIG's investigative role.

OIG is also the agency within HHS that has been delegated the responsibility by the Department's Secretary for administering the state MFCU grant program. OIG uses 12 federal performance standards as guidelines, in addition to reports submitted by the MFCUs, and information from other state and federal agencies, to determine whether a Unit is performing effectively and efficiently. OIG has published a regulation that revises the performance standards which supersede those standards that were initially published in 1994.¹⁵ OIG also conducts regular on-site reviews as part of its oversight responsibility and issues a report detailing the findings of the on-site review. If OIG determines from the on-site reviews and various reports that a MFCU is deficient in not meeting one or more standard, it will provide technical assistance and recommendations for improvement. If OIG makes a determination that the Unit is not operating effectively, it may be designated as a high-risk grantee.

Reporting Requirements

In order to continue to receive federal grant funding, each MFCU must submit a re-application for certification. This report must be submitted to the Office of the Inspector General at least 60 days prior to the end of its current 12 month certification period. Regulations require that this report contain any changes in its organizational structure and location under state government; a statement from the state attorney general that the Unit has the authority to carry out its functions and responsibilities; a copy of the MOU with the appropriate state prosecuting agency if the Unit does not have statewide prosecutorial authority; a copy of the MOU with the Medicaid agency and a projected case load and proposed budget for the re-certification period.

In addition to the re-application for certification, a Unit must also submit an annual report at least 60 days prior to the expiration of the certification period. This report must contain the following information: the number of completed and closed cases categorized by type and provider; the number of cases finally resolved and their outcomes; the number of cases investigated but not prosecuted or referred for prosecution because of insufficient evidence; the number

Fraud Control Units, Annual Report, Fiscal Year 2002 (October 1, 2001 – September 30, 2002) p.2.

15 Federal Register Vol. 77, No. 106/June 12, 2012 pp 32645-32648.

of complaints received regarding abuse and neglect of patients in health care facilities; the number of such complaints investigated by the MFCU and the number referred to other state agencies; the number of recovery actions initiated by the MFCU; the number of recovery actions referred to another agency; the total amount of overpayments identified by the MFCU; and the total amount of overpayments actually collected by the MFCU; the number of recovery actions initiated by the Medicaid agency under its agreement with the MFCU; and the total amount of overpayments actually collected by the Medicaid agency; the costs incurred by the MFCU; and a narrative that evaluates the MFCU's performance and describes any specific problems it has and any other matters that may have impaired its effectiveness.

Exclusions

Health care providers paid by federal health-care programs, including Medicare or Medicaid, may be excluded from participation in these programs by the HHS Office of Inspector General (OIG). Often this sanction has a greater impact on the convicted provider than any other civil or criminal penalty because of its detrimental effect on a provider's financial status. OIG has both mandatory and discretionary authority to exclude unfit, unscrupulous or abusive health care practitioners for participating in federally-funded health care programs.

Those individuals or entities convicted of program-related crimes or patient abuse or neglect must be excluded from participation in government health care programs for a minimum of five years, although the period may be longer. Permissive exclusions, which are imposed for a minimum of three years, are for convictions for federal and state crimes relating to fraud, theft, embezzlement, financial abuse, interfering with a health care fraud investigation or for a revoked or suspended health care license. The states are required to report all qualifying cases to OIG for exclusion. Many federal exclusions are based upon MFCU actions that are reported to the Inspector General. Excluded providers and individuals are listed in several national databases.

PARTNERSHIPS WITH STATE AND FEDERAL AGENCIES

An important feature of the MFCU program is its cooperative relationships with various state and federal agencies to combat Medicaid provider fraud. Medicaid fraud is a crime under both state and federal statutes and may be prosecuted in state or federal courts. The MFCUs have routinely worked with agencies and

contractors that investigate and prosecute Medicare fraud and fraud in other federally funded health care programs, as well as with private insurers. Experience has demonstrated that a provider who defrauds one program may be defrauding other programs as well.

The MFCUs have developed cooperative relationships with the following state and federal agencies; HHS/OIG, the Federal Bureau of Investigation (FBI), the U.S. Postal Inspection Service, the Internal Revenue Service (IRS), the Drug Enforcement Administration (DEA), the Food and Drug Administration (FDA), the U.S. Department of Defense Criminal Investigative Service (DCIS), the U.S. Department of Justice (DOJ) and the U.S. Attorneys Offices, and state licensing and regulatory agencies. There are active state-federal health care fraud task forces and working groups in virtually every state in the country and MFCUs regularly participate in these task forces and working groups. Indeed, many MFCU attorneys are cross-designated as Special Assistant United States Attorneys (SAUSAs).

MEDICAID PROVIDER FRAUD SCHEMES

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 to conceal the resulting lack of care. The MFCUs have prosecuted psychiatrists who demanded sexual favors from their patients in exchange for prescription drugs, nursing home owners who stole money from residents, and even funeral directors who billed the estates of Medicaid recipients for funerals they did not perform.

The state Medicaid Fraud Control Units have identified serious fraud in numerous sectors of the health care industry, including, but not limited to, hospitals, home health care agencies, medical transportation, durable medical equipment companies, pharmacies, and medical clinics, and have prosecuted individual providers such as physicians, dentists, and mental health professionals.

The following are typical schemes that providers use to defraud the Medicaid program:

Billing for Services Not Provided—A provider bills for services not performed, such as blood tests or x-rays that were not taken, full denture plates when only partial ones are supplied, or a nursing home or hospital continues to bill for services rendered to a patient who is no longer at the facility either because of death or transfer.

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Double Billing—A provider bills both Medicaid and a private insurance company (or the recipient) for treatment, or two providers request payment on the same recipient for the same procedure on the same date.

Billing for Phantom Patient Visits—A provider falsely bills the Medicaid program for patient visits that never take place.

Billing for More Hours Than There Are in a Day—A psychiatrist inflates the amount of time he spent with his patients – billing for more than 24 hours of psychotherapy treatment in a day.

Falsifying Credentials—Misrepresenting the qualifications of a licensed provider in order to defraud Medicaid. For example, a physician who allows a non-physician to impersonate a licensed doctor who medically treats patients and prescribes drugs and then bills the Medicaid program.

Substitution of Generic Drugs—A pharmacy bills Medicaid for the cost of a brand-name prescription when, in fact, a generic substitute was supplied to the recipient at a substantially lower cost to the pharmacy.

Billing for Unnecessary Services or Tests—A provider falsifies the diagnosis and symptoms on recipient records and billings to obtain payments for unnecessary laboratory tests or equipment.

Billing for More Expensive Procedures Than Were Performed—A provider bills for a comprehensive procedure when only a limited one was administered or billing for expensive equipment and actually furnishing cheap substitutes.

Kickbacks—A nursing home owner or operator requires another provider, such as a laboratory, ambulance company, or a pharmacy, to pay the owner/operator a certain portion of the money received for rendering services to patients in the nursing home. This practice usually results in unnecessary services being performed to generate the additional income to pay the kickbacks.

False Cost Reports—A nursing home owner or operator includes personal expenses in its Medicaid claims.

RESIDENT ABUSE AND NEGLECT

When Congress created the MFCUs, it did so not only because of the evidence of massive fraud and chicanery in the Medicaid program, but also because of the horrendous tales of nursing home abuse and resident victimization. The MFCUs are the only law enforcement agencies in the country specifically charged with investigating and prosecuting abuse and neglect of residents in a nursing

home, other Medicaid-funded health care institutions and in board and care facilities.

Many MFCUs use their criminal and civil enforcement authority to enforce different types of resident abuse cases that underscore the insidious, hidden and often neglected concerns about the financial and physical safety of vulnerable, “at-risk” adults who can no longer care for themselves and who are disproportionately subject to abuse and debilitating injury. These cases include physical abuse, sexual abuse, corporate neglect, drug diversion that results in patient harm, misappropriation of patient funds, and homicide and manslaughter cases. In addition, the Units across the country have launched innovative programs that include training and public outreach programs to help prevent resident abuse. Other important activities 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.

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 or board and care homes is every bit as dangerous and harmful as intentional assaultive behaviors. Many states have prosecuted resident neglect cases of caregivers in facilities and sometimes owners who have failed to provide adequate care and treatment to residents, resulting in residents suffering from decubitus ulcers, dehydration and malnutrition.

Some states have utilized Medicaid fraud statutes to prosecute corporate owners of nursing homes. Others have reached civil settlements in lieu of prosecuting criminal charges against the facility, in cases where there is insufficient evidence or the MFCU concludes that shutting down the facility may not be in the best interest of all residents.

Reporting requirements play an important role in protecting residents from abuse and/or neglect. Most states that have statutes dealing with resident abuse include a mandatory reporting section. The statutes differ, however, as to who are considered mandated reporters. State statutes also differ regarding which agency the report goes to. Some states require the report to go to a state agency, such as a state Department of Health, while others require that the report be submitted to a law enforcement agency or to the MFCU. Investigating and prosecuting cases involving an alleged failure to report abuse in states where it is a criminal act is important because many victims are unable to protect their own interests. Moreover, some witnesses avoid getting involved for fear of repercussions from

the abuser, their associates, or at times, the facility itself. MFCUs and law enforcement may be the only voice some victims have.

An important step in preventing resident abuse in nursing homes is to prevent those 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.

The Medicaid Fraud Control Units based upon their unique and lengthy experience in investigating and prosecuting resident abuse and neglect—which all too often elude traditional methods of prosecution—have urged the strengthening of state and federal resident abuse laws and regulations. Statutes and regulations have long been in place to protect children and the mentally disabled and the MFCUs believe these same protections should be afforded to the sick and elderly who reside in nursing homes and/or board and care facilities. In 1988, the National Association of Medicaid Fraud Control Units (NAMFCU) in cooperation with the National Association of Attorneys General (NAAG), published “Guidelines and Commentary for Legislation to Prohibit Patient and Resident Abuse.” These Guidelines have been used by many states when drafting or amending resident abuse statutes.

In many states, resident abuse cases are either reported to local law enforcement or may be referred to local law enforcement for prosecution. Training of law enforcement to recognize and deal with resident abuse cases is essential and many MFCUs have developed and implemented such training programs. Others educate health care professionals, ombudsman and the public about recognizing and referring cases of resident abuse to the appropriate authorities.

NAMFCU GLOBAL INVESTIGATIONS AND SETTLEMENTS

For more than two decades, the National Association of Medicaid Fraud Control Units (NAMFCU) has served as the coordinating agency that represents the interests of its members in connection with multi-state/federal global investigations and cases.

Cooperative efforts between state and federal authorities have proven very effective in protecting federally funded healthcare programs from health care providers or vendors whose fraudulent activities harm these programs and cross state lines. These multi-state global cases are generally limited to Medicaid,

Medicare and other federally funded healthcare programs. They do not extend to any programs funded solely by state government.

The National Association of Medicaid Fraud Control Units encourages states to look beyond individual state perspectives with their participation in global settlements. These cases succeed only with the cooperation of all state MFCUs, whose goal is to protect not only the state's individual program but also the integrity of the entire Medicaid program. NAMFCU is an association of state law enforcement entities that has distinguished itself by working with all the states and the federal government to successfully negotiate numerous settlements that return money to the Medicaid program.

The federal government and defense attorneys recognize that settling with one state Medicaid program does not resolve Medicaid claims in other states. Most states, like the federal government, have the authority to exclude a convicted provider from their health care programs. Settlement of these cases would be more difficult if defense attorneys had to obtain separate settlement agreements from individual states and negotiate separate terms with each state.

State Medicaid Fraud Control Units (MFCUs) learn about a case when a *qui tam* complaint is served on a *qui tam* state, or when the United States Department of Justice (DOJ) or a United States Attorney's Office (USAO) requests NAMFCU's assistance. NAMFCU may also become aware of a case when defense counsel or some other source contacts NAMFCU and requests the assistance of the MFCUs. Once the request or recommendation has been analyzed and a determination is made that it is appropriate for the states to participate, the NAMFCU President appoints a team. Selection of team members may be based upon the involvement of one or more states in the investigation. Individual team member's abilities, training, experience and availability are also taken into consideration.

Working in cooperation with federal attorneys, each team initially engages the defendant by setting out some basic ground rules. These include the framework for negotiations, *e.g.* exclusion/non-exclusion, criminal pleas and/or civil settlements, and the payment of the team's expenses attributable to the negotiations. These expenses may include team travel expenses, mailing expenses, conference call costs and consultant expenses.

There are other crucial factors to consider in a settlement, such as the provider's ongoing viability, ability to pay, economic impact on the community where the provider is located or does business, and the effect that exclusion from Medicaid, Medicare and other state and federal health care payment programs will have on the ability of recipients to receive adequate and convenient medical care. Settlements may include additional components such as Corporate Integrity

Agreements (CIAs) which are negotiated by the Office of Counsel to the Inspector General (OCIG).

These negotiations are highly confidential. They are governed by federal and state law, grand jury secrecy requirements, *qui tam* seal provisions, various privileges and SEC regulations.

State recoveries generally are allocated based upon a state's actual damages. Often the participating states are asked to supply state-specific data regarding the defendant's billings. However, it is sometimes possible to calculate state losses from information supplied by other sources, such as the federal government or through discovery from the defendant. The NAMFCU team, in conjunction with the federal government, is tasked with negotiating the most advantageous settlement possible to cover damages and, when appropriate, interest and penalties. The federal government subsidizes each state's Medicaid program in differing amounts (Federal Medical Assistance Percentage-FMAP), and typically collects the federal share of the total Medicaid recovery.

A final, individualized set of settlement documents, including the state settlement agreement, a transmittal memorandum, a detailed accounting of the distribution of that state's funds, and a model press release are sent to each state. After participating states have agreed to the negotiated terms by executing and returning the settlement agreement, the settlement funds are distributed to each state.

EMERGING ISSUES

While the Medicaid Fraud Control Units have clearly demonstrated their success in investigating and prosecuting health care providers for four decades, they also have been very effective at adapting to the ever-changing nature of health care fraud schemes.

Data Mining

In 2013, the U.S. Department of Health and Human Services issued a final rule, "State Medicaid Fraud Control Units; Data Mining" (78 Fed. Reg. 290.55, Codified at 42 C.F.R. 1007-20 (a)) that amends a regulation that prohibited MFCUs from using federal financial participation (FFP) to data mine. Data Mining is defined as integrating fraud by screening and analyzing data. Data mining is allowed by the MFCUs if certain criteria are met and in order to

determine this an application must be submitted. These applications are reviewed by OIG, in consultation with the Center for Medicare and Medicaid Services.

In 2016, OIG issued a policy transmittal that outlines that process for submitting and reviewing a data mining application. Fifteen states have received approval for the data mining applications and five states have received renewal letters. The initial application is approved for three years. The MFCU may request renewal of its application for additional five year periods by submitting a written request to OIG.

Fraud in Medicaid Managed Care

In an attempt to control exploding Medicaid costs and to provide better access to care, most states have contracted with managed care entities (MCE) to provide low-cost, high-quality health care to more people. These entities provide comprehensive payment in return for a capitated payment for each enrolled recipient. Two-thirds of Medicaid enrollees now receive services through managed care arrangements.¹⁶

While many proponents of managed care believe that the very nature of the system prevents fraud, the experience of the Medicaid Fraud Control Units demonstrates otherwise. Rather, fraud simply takes different forms in response to the way the program is structured. In the traditional fee-for-service fraud, the health care provider is generally the one who commits the fraud. However, managed care fraud can be committed by a managed care organization (MCO), a contractor, a subcontractor, provider, state employee, or beneficiary. Managed care fraud includes the following: fraud in the procurement of the contract with the state Medicaid agency by the MCO; fraudulent subcontracts, falsification of financial solvency by the MCO, bribery, kickbacks, tax evasion, rebates, and other illegal economic arrangements, marketing and enrollment fraud, and fraud in the administration of the program.

Quality of care problems such as the underutilization of necessary services, falsification or misrepresentation of professional credentials and the use of unlicensed providers also may occur. Managed care fraud is more difficult to detect, investigate and prosecute than the traditional fee-for-service Medicaid provider fraud because of the complexity of the contractual agreements, the lack of referrals from the Medicaid agency and MCOs, and the lack of mandatory reporting requirements.

¹⁶ Kaiser Commission on Medicaid and the Uninsured, *Moving Ahead Amidst Fiscal Challenges*, p. 14.

The move by most states to shift its Medicaid population to a managed care model has presented a challenge to Medicaid fraud. To assist the states with this challenge, NAMFCU adopted *Model Criminal Enforcement Statutes for Managed Care* in 1996 and *Managed Care Civil Statutes* in 2000 to provide a framework to the states to address fraud in managed care. NAMFCU has established a Managed Care Working Group that is designed to conduct legal research, collect and compare state Medicaid managed care contacts and draft legislation and model contractual provisions to strengthen the ability of the MFCUs to pursue managed care fraud.

State Qui Tam Statutes

The federal False Claims Act (FCA) allows the government to prosecute those who submit false claims for payment to the government. This statute's *qui tam* provisions also allows private individuals, known as "whistleblowers" or "relators" to bring an action under the Act. The relator acts on behalf of the government and the information they provide to the government is intended to assist the government with its investigation. A relator must be an "original source" of the information and, if successful, may collect up to 30% of the recovery, but is generally guaranteed at least 15%. A *qui tam* complaint is filed under seal in federal district court and remains under seal for 60 days in order to allow the government sufficient time to conduct an adequate investigation in order to determine whether to intervene. This limit may be extended for good cause and is often extended numerous times.

The civil federal False Claims Act has been used very successfully by the federal government in pursuing health care fraud cases. An increasing number of states are enacting state false claims acts with *qui tam* provisions.

In 2006, only 15 states had statutes with *qui tam* provisions. Since the enactment of the Deficit Reduction Control Act (DRA), 31 states and the District of Columbia have enacted false claims statutes with *qui tam* provisions.

The DRA encourages states to enact *qui tam* statutes by providing a financial incentive to those states that meet four requirements. These four requirements include the following:

1. The law establishes liability to the state for false or fraudulent claims as described in the federal False Claims Act (FCA) with respect to Medicaid spending;

2. the law contains provisions that are at least as effective in rewarding and facilitating *qui tam* actions for false or fraudulent claims as those described in the FCA;
3. the law contains a requirement for filing an action under seal for 60 days with review by the State Attorney General;
4. the law contains a civil penalty that is not less than the amount of the civil penalty authorized under the federal False Claims Act.

Once HHS OIG, in consultation, with the U.S. DOJ determines that the state *qui tam* statute qualifies for an incentive under Section 1909 of the Social Security Act, the state is entitled to a ten percent increase in any Medicaid share recovered under the state law.

The federal False Claims Act has been amended by the Fraud Enforcement and Recovery Act of 2009 (FERA), the Patient Protection and Affordable Care Act (ACA), and the Dodd–Frank Wall Street Reform and Consumer Protection Act (the Dodd–Frank Act). These three acts, among other things, amended the bases for liability in the FCA and expanded certain rights of *qui tam* relators. In addition, in 2016, the civil penalties, authorized under the FCA, increased according to the Penalties Inflation Adjustment Improvement Act of 2015. As a result of the increase in civil penalties, OIG will review all previously reviewed state *qui tam* statutes to determine if they are compliant with Section 1909. A two year grace period will be provided during which time states that were previously determined to be compliant will continue to be deemed compliant and offered time to resubmit to OIG.

NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS

Founded in 1978, the National Association of Medicaid Fraud Control Units (NAMFCU) has played a pivotal role in providing the MFCUs with a national presence. Although membership is voluntary, all 50 federally certified MFCUs are members of the Association. NAMFCU was founded 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 about the MFCU program. Membership is limited to federally certified MFCUs. Each MFCU is represented by their Director.

One year after the signing of P.L. 95-142, the Medicare – Medicaid Anti – Fraud and Abuse Amendments, by President Jimmy Carter on October 25, 1977, 19 MFCU Directors met formally for the first time in Mt. Laurel, New Jersey at the inaugural National Training Conference for Medicaid Fraud Control.

These Directors met with key staff of the then – U.S. Department of Health, Education and Welfare (HEW) to discuss regulations, criteria for Unit certification and recertification and other matters of mutual concern. It was at this first meeting, due to a difference in opinion with HEW staff regarding reporting requirements of the Units and the need for investigative confidentiality, that the Unit Directors recognized the need to form a national association.

Formal organization of the National Association of Medicaid Fraud Control Units took place two months later, on December 2, 1978 at the National Conference on Fraud, Abuse and Error in Washington, D.C. The MFCU Directors from the 20 then certified states met to elect a President and to form an Executive Committee that would ensure that all states had equal representation. Charles (Joe) Hynes, New York State Deputy attorney general and Special Prosecutor for Nursing Homes, Health and Social Services was elected the first NAMFCU President.

The officers of the Association, the President and Vice President are elected annually by the Directors. The President, the principal spokesperson for NAMFCU, presides at all Association meetings, and appoints the chair and members of the various Committees and Working Groups. There are six regions of NAMFCU and each region elects a representative annually. These six regional representatives, the President, Vice President, the Director of the New York MFCU, and all past Presidents of NAMFCU are members of the NAMFCU Executive Committee. This Committee manages the Association. In addition, NAMFCU has several other Committees including the Resident Abuse, Training and Global Case Committees. The Association offers an extensive schedule of professional training programs for MFCU staff.

NAMFCU is staffed by an Executive Director, a Conference Coordinator, a Projects Manager, and an Association Assistant, and is housed at the National Association of Attorneys General in Washington, D.C. This unique Association has enabled the Units to deter some of the largest and most insidious health care provider frauds, recover program dollars, punish corrupt practitioners, and prosecute those who abuse or neglect nursing home residents.