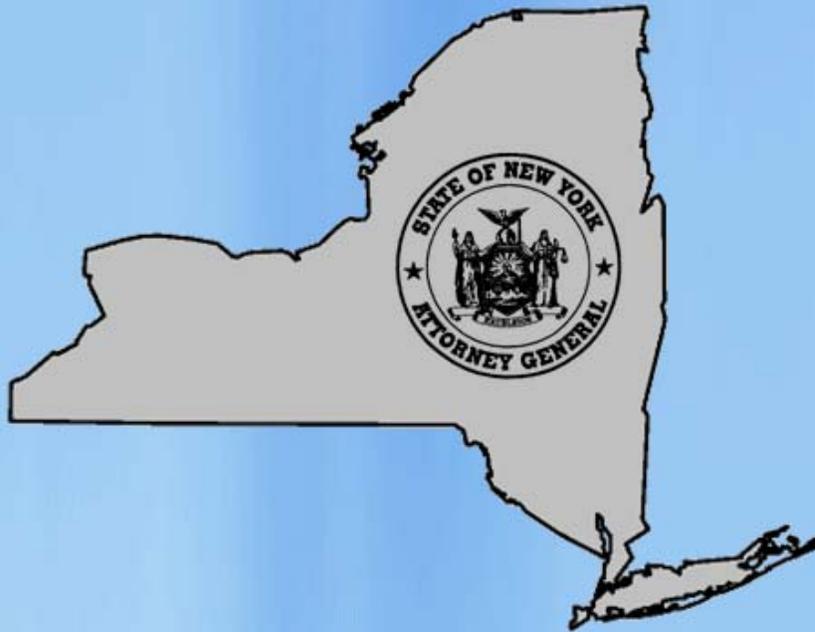


**Report to the Secretary
United States Department of Health and Human Services**

**New York State Office of the Attorney General
Medicaid Fraud Control Unit**

ANNUAL REPORT 2005



**Eliot Spitzer
New York State Attorney General**

**William J. Comiskey
Deputy Attorney General
Director, Medicaid Fraud Control Unit**

EXECUTIVE SUMMARY

This report constitutes the New York State Medicaid Fraud Control Unit's ("MFCU" or "the Unit") Annual Report to the Secretary of Health and Human Services, as required by 42 C.F.R. 1007.17. The report highlights the Unit's cases for January 1, 2005 to December 31, 2005, and it includes certain statistical information for both calendar year 2005 and federal fiscal year 2005 (which ended on September 30, 2005).

2005 HIGHLIGHTS

We were the first Unit to obtain criminal convictions based on evidence from undercover surveillance cameras monitoring nursing home care.

Our camera cases, which have been lauded by patient advocacy groups, revealed rampant neglect and fraud by caregivers and exposed systematic nursing home management failures. So far, they have led to 9 convictions and a lawsuit filed against a facility.

We set new records for Medicaid recoveries.

For federal fiscal year 2005, we reported to HHS-OIG more than \$219 million in judgments won and settlements negotiated – an amount which is more than two and a half times the previous national record for recoveries by a MFCU (set by the New York Unit in federal fiscal year 2004).

We secured the largest single state Medicaid recovery in history.

The Unit's \$76.5 million fraud settlement with *Staten Island University Hospital* was, to our knowledge, the largest Medicaid recovery ever achieved by any MFCU in a state case. The agreement also resulted in significant corporate reform and compliance terms.

We led a team of state Units and worked with the federal government to secure the largest national Medicaid settlement in history.

Under the leadership of an attorney from the New York MFCU, 40 states joined with the federal government to forge a national settlement with *Serono, Inc.*, which produced more than \$567 million for the nation, of which \$171 million represented restitution for losses sustained through New York's Medicaid program.

We led the nation in convictions and civil enforcement actions resolved.

In federal fiscal year 2005, we reported 122 convictions and 123 successful civil enforcement actions, leading the nation in each category.

CASES AND INVESTIGATIONS

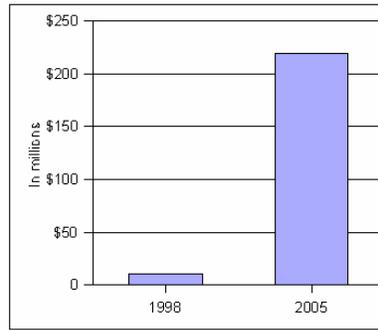
Our calendar year 2005 cases – many of which are described in this report – ran the gamut from prosecutions of individual patient abuse to sophisticated fraud by large institutions. Our cases included 35 convictions for crimes against patients, the second highest level in the history of the Unit. We accomplished this at the same time we obtained millions of dollars in recoveries in sophisticated fraud cases.

RECOVERIES

Because New York’s Medicaid budget has now climbed to approximately \$45 billion per year, New York’s Legislature has begun examining a variety of cost savings measures, including more potent anti-fraud legislation. In the course of its examination, it elicited data regarding MFCU’s recoveries. The data showed that, without significant changes in staff levels:

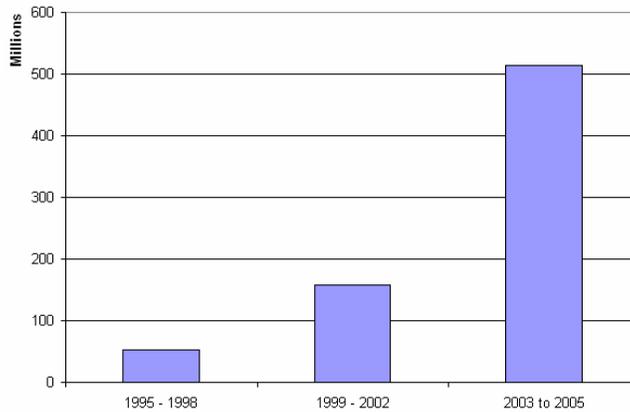
- Recoveries reported in federal fiscal year 2005 were more than 2000% higher than recoveries reported in federal fiscal year 1998 (the year before Attorney General Spitzer took office).

Year	Recoveries
1998	\$10,591,197
2005	\$219,092,375



- Last year’s performance reflects a significant continuing upward trend. Examining calendar year recoveries shows the following:

Term	Total Ordered Recoveries
1995 to 1998	\$53,073,936
1999 to 2002	\$158,062,720
2003 to 2005	\$514,188,454



OVERSIGHT OF THE UNIT

2005 also saw intense evaluation of New York's MFCU, by both the Office of the Inspector General ("OIG") of HHS, and the state Legislature. The OIG conducted an on-site review at the request of Congress, and the state Legislature held hearings on reducing fraud in the Medicaid program.

In the OIG's exit conference, the reviewers termed MFCU's work "fantastic" and made only minor suggestions for improvement. Among other things, the reviewers commented that we move our cases aggressively and quickly (often at a faster pace than federal cases) and that we prosecute patient abuse cases so well that the clear message in New York is that you are not going to "mess around" with senior citizens and get away with it.

In the Legislature's hearings and materials presented to it, we were repeatedly described as national leaders in the field, including by counsel to the National Association of Medicaid Fraud Control Units ("NAMFCU") ("to this day, the New York Unit remains the model that many states strive to emulate"), the director of Texas' MFCU ("[T]he New York Unit is one of the most effective Units in the nation. . . . [W]e modeled much of our restructuring on New York."), and the head of a patients' advocacy group ("We see MFCU, and its nursing home initiative, as an innovator in helping to stop systemic nursing home abuse and neglect.").

REFORMING NEW YORK STATE LAW

New York's Legislators are currently considering toughening state anti-fraud measures. As a result, they have begun debating reforms that the Attorney General has previously proposed for years, as well as an even stronger bill that we have recently proposed.

In particular, the Attorney General has proposed:

- 1) A False Claims Act to provide an incentive for whistleblowers to report Medicaid fraud to the authorities. Notably, the provisions of our proposed Act will allow New York to retain an additional 10% in Medicaid fraud recoveries based on federal legislation signed in January; and
- 2) A Martin Act for Healthcare, which would adopt the same prosecutorial tools to root out health care fraud that exist in New York to attack fraud in the financial industry. In particular, the proposal would create tougher health care fraud crimes and enhanced powers to subpoena witnesses and obtain documents.

As of the date of this writing, the legislature has enacted neither of these measures.

PROBLEMS AND RECOMMENDATIONS

We bring three items to your attention that we believe warrant change. First, we ask that you consider changing your standard on-site review report format to include the qualitative assessments of Unit performance made by OIG reviewers. This information can be extremely useful to states as they monitor the successes and failures of their own programs.

Second, we renew our request that you eliminate 42 CFR 10017.19(e)(2), which we believe places unwarranted restrictions on MFCU's ability to find and prosecute Medicaid Fraud. Good anti-fraud programs require more targeting, not less.

Third, we ask that OIG perform additional work to determine payment accuracy rates, both across the states and across different programs within Medicaid. In particular, it would be helpful to law enforcement to know what part of the 1.5% of payments that government audits have identified as being "improper" in New York is due to fraud rather than mistake, and what programs have higher rates of improper payments.

* * * * *

For 2006, we pledge to continue to do all that we can to hold accountable any provider who steals from the Medicaid program or mistreats patients. We are optimistic that given the keen interest of the Legislature and the appointment of New York's Medicaid Inspector General, the coming year offers tremendous potential to produce important changes to improve and reform the Medicaid system.



William J. Comiskey
Director
Medicaid Fraud Control Unit

2005 Annual Report

New York State Medicaid Fraud Control Unit

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SECTION I: 2005 CASE HIGHLIGHTS

Pursuant to federal law, we pursue three categories of cases:

- 1) cases involving the neglect and abuse of patients in federally funded health care and bed and board facilities;
- 2) cases involving fraudulent conduct by Medicaid providers and others involved with the provision of Medicaid services and by those who administer the Medicaid program; and
- 3) cases seeking the recovery of Medicaid overpayments identified in our investigation of fraud and patient abuse and neglect investigations.

A. PATIENT ABUSE AND NEGLECT

Under Attorney General Spitzer, the New York Unit has devoted substantial resources to the critical task of protecting vulnerable and infirm patient populations. Patient advocacy groups have consistently praised our work while the industry has scrambled to improve conditions.¹

In advancing the goal of patient protection, we have employed a three-prong approach: (1) bringing cases against nursing home owners for unlawfully failing to provide proper care; (2) informing the public about information crucial in choosing a nursing home, thus helping to prevent neglect in the first instance; and (3) bringing cases against individual caregivers for neglect or abuse of specific residents.

“The Office of Attorney General (OAG) continued to provide the strongest leadership in terms of protecting nursing home residents. The OAG’s Medicaid Fraud Control Unit actively investigated nursing home resident care and abuse, and these investigations resulted in real accountability of nursing home providers.”

LONG TERM CARE COMMUNITY COALITION REPORT CARD	
MEDICAID/MEDICARE	
Federal Government	D
NURSING HOME CARE	
Governor Pataki	D
New York State Department of Health	C-
New York State Justice	C+
New York State Assembly	F
Attorney General Eliot Spitzer	B-
ASSISTED LIVING	
NY Dept. of Health & State Office of Aging	A

The Long Term Community Care Coalition, 2005 Report Card for New York State.
<http://www.ltccc.org/documents/reportcard2.pdf> Reprinted with permission.

¹ One industry group, citing our cases, has talked to its membership about the “criminalization of quality of care deficiencies,” citing low staffing, pressure sores and repeat deficiencies in quality of care as “hot spots.” It warned that nursing homes should “Train, Train, Train” their staff. This is, in our opinion, a textbook example of deterrence and a clear indication that our cases are reducing instances of neglect.

1. THE NURSING HOME INITIATIVE: 2005

Our efforts to protect nursing home patients have extended far beyond the pursuit of individuals who abuse or neglect patients. Since 2000, the Unit has undertaken a Nursing Home Initiative, an investigative project which has examined corporate and executive responsibility for unacceptable nursing home conditions. To date, we have secured convictions against two nursing home owners and three nursing homes, sending one owner to state prison for up to 12 years. We have further secured civil settlements barring two nursing home owners from the nursing home industry and have recovered more than \$8 million in restitution for the Medicaid program. Equally important, our cases have led to corporate compliance agreements requiring the imposition of independent monitors to ensure the quality of future care.

In 2005, our Nursing Home Initiative took a new turn. Earlier investigations had involved labor-intensive efforts to reconstruct past events through the painstaking analysis of thousands of documents and medical records, coupled with hundreds of interviews and sworn testimony. Each case required years of effort from full teams of investigators, lawyers, and auditors.

Borrowing an investigative strategy often used in other types of investigations but never before used in a quality of care investigation in New York, in 2005 we decided to install hidden cameras in patient rooms.

With the permission of the family of a bedridden and comatose resident, the Unit installed a hidden camera in the room of a resident of the *Jennifer Matthew Nursing Home and Rehabilitation Center* (Jennifer Matthew) in Rochester. The evidence produced by this camera proved that nursing home staff repeatedly failed to deliver required care, and routinely lied in patient care records by falsely recording that care had been delivered. Significantly, the records of this one resident contained hundreds of false entries made by nearly 20% of the facility's staff. In December, the Unit arrested nine Jennifer Matthew employees. By the end of the year eight had pleaded guilty to criminal charges that they had endangered the resident and falsified his records.²

Industry sources report that our use of a covert camera sent shock waves through the health care industry,³ and health care facilities and workers have been publicly warned that acts of neglect may now be on tape. This has already led, we are told, to better care. We intend to continue to use this potent investigative tool.

In addition to our first nursing home camera case, 2005 saw the successful conclusion of the civil side of one of our most prominent and troubling Nursing Home Initiative prosecutions.

² Five additional employees of Jennifer Matthew have been arrested as of the writing of this report, one additional employee has pleaded guilty and a civil complaint against the nursing home and its owners has been filed.

³ Mulder, James T., Nursing Homes to Feature Webcams. Post Standard, February 10, 2006, Final ed.: D1.

As previously reported, the *Heritage Nursing Home* in Athens, Pennsylvania and its owner, *David Arnold*, were convicted in 2004 for stealing millions from the Medicaid program by billing for services that had not been provided and by billing both Pennsylvania and New York for other services. Even though Arnold was paid to deliver these services, hundreds of Heritage patients went years without dental services. Others were denied therapies to prevent contractures and problems with swallowing that developed into serious conditions, including aspiration pneumonia. Arnold was sentenced to 4 to 12 years in state prison.

In addition to the criminal case, the Unit sued Heritage and Arnold and sought treble damages. That lawsuit was successfully concluded in 2005 when Arnold was required to sell the nursing home to pay the New York Medicaid program \$4.2 million.

2. THE NURSING HOME STAFFING REPORT

In 2005, we also released a report on issues relating to nursing home staffing levels. Our Nursing Home Initiative cases had revealed a correlation in many instances between the levels of nurse staffing in nursing homes and the quality of care in those homes. As part of our investigations, we had gathered data on the reported levels of staffing in each of New York's nursing homes. We also examined academic and government literature relating to the adequacy of nursing home staffing and its impact on the quality of care. Finally, as part of our investigation of this aspect of the industry, we examined regulatory and statutory standards that had been established in other jurisdictions.

To assist consumers considering nursing home services, we published the information we had gathered in a report entitled: *Staffing Levels in New York's Nursing Home: Important Information for Making Choices*. That report is available on the Attorney General's website.

3. PATIENT ABUSE AND NEGLECT CASES

In calendar year 2005, we reviewed 1022 allegations of patient abuse or neglect. Many of these reviews required us to make on-site visits to ascertain whether the allegations presented a substantial probability of provable criminal conduct. Based on our initial assessment of the allegations, we opened criminal investigations in 56 cases and we secured convictions against 35 individuals. This represents the second highest number of neglect and abuse convictions since the Unit was formed in 1975.

Cases against those who abused nursing home residents included:

- *People v. Michael Edwards*, in which a licensed practical nurse was convicted after trial of First Degree Sexual Abuse and sentenced to three and one-half years in state prison for disrobing and fondling a 31-year-old female patient who was unable to speak, move or consent in any way.

- ***People v. Tina Simmons***, in which a certified nurse aide was convicted for slapping and roughly handling an 83-year-old patient.
- ***People v. Catherine Compo***, in which a certified nurse aide was convicted for jerking an 87-year-old Alzheimer's resident by the neck, slapping him in the face and causing him to fall, and for striking a second patient in the head.
- ***People v. Patricia Worwa, Shawn Garrett and Cynthia Adams***, in which a registered nurse and two nurse aides were convicted for illegally restraining two patients, including one 80-year-old patient suffering from dementia, Alzheimer's disease, Parkinson's disease, and diabetes, who was tied to his wheelchair with a bed sheet and left bound wearing only a tee shirt and briefs.

Cases against those who neglected residents and falsified their care records included:

- ***People v. Judi A. Soloway***, a licensed practical nurse was convicted for failing to test the blood glucose level of a thirty-two year old "brittle" diabetic patient and falsely recording a reading in the patient's medical chart that she made-up. She admitted falsifying the records of other patients that she failed to test as well.
- ***People v. Lorraine McFadden***, in which a licensed practical nurse was convicted after trial of falsifying the medical records of a patient by recording that the patient had received a required gastrostomy tube feeding when she had not.
- ***People v. Alicia Basso***, in which a licensed practical nurse was convicted for repeatedly failing to change a G-tube dressing on an elderly patient and for falsifying the patient's records

Cases against those who intentionally violated rules in the residents' care plans and attempted to cover-up the conduct included:

- ***People v. Quiana May***, in which a certified nurse aide was convicted and sentenced to 45 days in jail for failing to seek assistance for a 92-year-old woman after the aide broke the resident's arm while improperly transferring the patient from her wheelchair and later falsely claiming that she had followed proper procedures for the transfer.
- ***People v. Christine Wood***, in which a 94-year-old resident was injured during a fall when Wood, a certified nurse aide, conducted an improper transfer of the resident and then failed to report the fall. The resident was not treated until she was discovered an hour later by a nurse who found the resident bleeding and injured.

We also prosecuted caregivers who lied about their past convictions. For example, in *People v. Richard Winchester*, a certified nurse aide was convicted of felony falsification charges to resolve allegations that he had abused a 94-year-old resident and that he lied about his criminal history in his Nurse Aide Registry application. Winchester admitted that he falsely represented that he had no prior criminal convictions when he, in fact, had three prior convictions.

B. PROVIDER FRAUD AND THE RECOVERY OF MEDICAID OVERPAYMENTS

Pursuant to federal law, MFCUs are required to investigate and prosecute violations of all applicable state laws – civil and criminal – related to cases of fraud by those who provide Medicaid services. We are also required to pursue reimbursement of Medicaid overpayments that are identified in our fraud investigations. 2005 saw a number of investigations of sophisticated fraud come to fruition, and our cases reflected a mix of large institutions and small providers.

1. HOSPITALS, CLINICS AND DIAGNOSTIC AND TREATMENT CENTERS

Our investigations of care and services provided in New York’s hospitals, clinics and Diagnostic and Treatment Centers produced significant recoveries of Medicaid overpayments in 2005.

New York v. Staten Island University Hospital

In what is believed to be the largest state Medicaid fraud settlement in history, Staten Island University Hospital (“SIUH”), agreed to repay \$76.5 million to resolve allegations that the hospital fraudulently billed the Medicaid program for more services than the law allowed at 21 part-time clinics and that it submitted inaccurate cost report data that caused Medicaid to pay a wrongly inflated reimbursement rate for patient visits at more than 500 clinics over a three-year period.

SIUH did not contest the Unit’s allegations set forth in a detailed complaint filed in New York County. That complaint alleged that SIUH executives took advantage of a state regulation that allowed hospitals and other facilities to operate part-time clinics and to charge Medicaid enhanced rates for those services. The regulation, which had been enacted to encourage the delivery of services to remote and hard-to-service areas, limited the operation of the part-time clinics to 60 hours per month.

Even though SIUH had been repeatedly warned by its attorneys that the practice was illegal and that the hospital was in danger of becoming, in its attorneys’ words, a “scofflaw,” SIUH misled DOH and operated the part-time clinics well in excess of the 60-hour limitation and billed for all of the services rendered at the enhanced rate.

Not only did the settlement produce the largest recovery ever from a state provider, but the agreement resulted in corporate reform and enhanced compliance requirements. When the agreement was reached in May 2005, the hospital issued a statement which read, in pertinent part:

We deeply regret and are embarrassed by the misconduct carried out by former executives of the Hospital

We pledge to adhere to business and corporate governance reforms and practices that will be a national model for compliance and business ethics in the health care field. . . .

We recognize that the hospital bears great responsibility for conduct that resulted in the receipt of substantial amounts in state reimbursement to which were not entitled. We humbly pledge to work conscientiously to keep SIUH from ever again bringing such dishonor to the hospital.

Strong Memorial Hospital

Together with federal authorities, we conducted an audit of the Digestive Disease Unit at the University of Rochester's Strong Memorial Hospital ("Strong"). Strong agreed to pay \$492,507 after that audit revealed that Strong wrongly billed for endoscopic procedures provided by the former head of the digestive disease unit, when those services had in fact been provided by physician fellows without proper supervision. The audit further revealed that procedures had been performed in instances where the information in the patients' medical records did not demonstrate that the procedure was medically necessary.

New Dimensions in Living, Inc.

In December 2005, the Unit and the Department of Health entered into a settlement with New Dimensions in Living, Inc., ("New Dimensions"), a Public Health Law Article 28 Medicaid provider that had contractually agreed with numerous chapters of NYSARC, Inc. to provide services at part-time and extension clinic sites to developmentally disabled recipients. To settle allegations that New Dimensions had billed Medicaid for services that were not reimbursable, failed to follow applicable rules and regulations and violated state and federal anti-kickback laws and regulations, New Dimensions agreed to pay \$3.25 million in restitution to the Medicaid program. It additionally agreed to invest an additional \$1.4 million in two new dental clinics for developmentally disabled persons, a population whose dental needs were underserved in the upstate area.

Premier Healthcare and Young Adult Institute, Inc.

An audit of Premier Healthcare and Young Adult Institute, Inc. ("Premier"), an Article 28 Diagnostic and Treatment facility and a network of agencies serving the developmentally disabled, found that Premier had improperly billed for recipients living in Intermediate Care Facilities when those recipients were in fact hospitalized or otherwise temporarily placed in another facility. Following the audit, Premier agreed to repay Medicaid \$125,000.

Midwood Chayim Aruchim Dialysis Associates, Inc.

Midwood Chayim Aruchim Dialysis Associates, Inc., agreed to pay \$425,000 to settle audit findings that it operated and billed Medicaid for more chronic renal stations than it was authorized to operate, and that it billed Medicaid for delivering more Epogen to patients than it actually delivered.

2. HOME HEALTH CARE AGENCIES AND PROVIDERS

Each year, New York spends increasing amounts to deliver care to patients in their homes. In 2005, we investigated agencies involved in this aspect of the health care system as well as individual care givers who deliver the care.

An audit of a certified home health agency, *Americare Certified Special Services, Inc.*, (“Americare”) found that Americare had billed Medicaid for more hours of services than were needed, for hours not substantiated as medically necessary, and for services that should have been provided by the adult homes in which clients resided without additional charge to the Medicaid program. Americare agreed to pay \$7 million to the Medicaid Program. In addition, Americare instituted a corporate compliance program, appointed a compliance officer, and agreed to institute and maintain an improved records management system.

We also investigated individuals who provided home care. For example, *Burnadett Weir*, a licensed practical nurse, was convicted of Grand Larceny in the Third Degree and sentenced to jail. Weir had falsely certified that she had personally provided services to a severely mentally retarded seven-year-old child when, in fact, she had arranged for a variety of individuals, including unlicensed, unqualified, and unapproved individuals to provide those services.

Another case involving a home care provider revealed that *Jocelyne Louis-Charpentier* cheated Medicaid by falsely charging for home-care nursing services on days when she was actually working at a hospital or on days when she was out of the country. She also fraudulently billed Medicaid for providing in-home nursing services to children at times when those children were in school; for services rendered when her nursing license had been suspended; and for providing one-on-one nursing care when she was actually caring for two or three recipients simultaneously. Louis-Charpentier was convicted of Grand Larceny in the Third Degree and Offering a False Instrument in the First Degree. She was sentenced in November to two years’ incarceration for stealing nearly \$550,000 from the Medicaid program.

In yet another case involving an individual providing home care, *Shirleen Henry*, a licensed practical nurse, was caught billing Medicaid for health care services in a client’s home when, in fact, she had arranged for individuals who were not licensed health care workers to take care of the client. Henry was convicted of Grand Larceny in the Third Degree and was sentenced to five years’ probation and ordered to pay \$173,532 in restitution.

3. LONG-TERM HOME HEALTH CARE PROGRAMS

Since 2002, our Special Projects Unit has pursued a state-wide audit investigation examining Medicaid reimbursement to nursing homes and to their affiliated Long-Term Home Health Care Programs (“LTHHCPs”). As of the end of 2005, Special Projects had completed audits of 18 facilities and had recovered Medicaid overpayments of more than \$40 million.

Several audits were completed and settled in 2005:

<i>Childs Nursing Home Company</i>	\$1,211,723
<i>Isabella Geriatric Center</i>	\$1,142,528
<i>Morningside House Nursing Home</i>	\$1,103,239
<i>Hebrew Home for the Aged</i>	\$205,711

As part of this same investigative project, our Civil Enforcement Unit commenced a lawsuit against a 180 bed nursing home that also operated an LTHHCP. The complaint alleges that this LTHHCP received inflated hourly and per visit rates that improperly included payments for non-reimbursable costs, including expenditures for bad debts, advertising and marketing expenses, certain administrative and capital costs, and identified executive salary and benefit expenses. Altogether, the lawsuit seeks repayment of nearly \$1 million.

4. NURSING HOMES

In addition to our nursing home initiative cases described above, we also pursued financial investigations of nursing homes across the state in 2005. Several of those investigations concluded in 2005.

For example, we concluded our audit of *Terence Cardinal Cooke Health Care Center* (the “Center”). Based on our audit, the Center agreed to repay \$2.3 million to settle claims that it had billed Medicaid for services provided to Medicaid patients on dates after the patients had died. Our investigation ultimately revealed that the billings had resulted from errors – not fraud – that occurred following the Center’s implementation of a new computer billing system.

In a similar investigation, *Parker Jewish Nursing Home* agreed to repay \$704,000 for billing for services on dates after Medicaid recipients had died. These incorrect billings were also the result of insufficient internal controls and not fraud.

In contrast to these two investigations, which revealed overpayments but not fraud, our investigation of the *Park Avenue Extended Care Center* (“Park Avenue”) revealed that the nursing home had been victimized by the fraudulent conduct of its executives. *Brian Lawrence*, the former Director of Nursing and *Bryan Cassinera*, former Assistant Director of Nursing were convicted and sentenced to jail for stealing more than \$400,000 from the nursing home. Our investigation revealed that Lawrence and Cassinera caused the home to pay a company that they had separately set up for nursing services that had either not been provided or that had been provided by unqualified individuals.

5. SUBSTANCE ABUSE TREATMENT CENTERS

Substance abuse treatment centers are paid by Medicaid to provide treatment to those struggling with alcohol and drug addictions. Cases against those cheating these programs included:

A case against **Dr. James Betheaepstein**, owner of **Fresh Start Recovery, Inc.**, an Alcohol and Substance Abuse Program, revealed that Dr. Betheaepstein knowingly billed Medicaid for services that were not provided in accordance with the patients' treatment plans, were not properly supervised or, in some cases, were not provided at all. Both Dr. Betheaepstein and Fresh Start Recovery were convicted of felony larceny charges and were ordered to pay over \$100,000 in restitution.

In another case involving both fraud and compromised care, the **Human Service Centers, Inc.**, a licensed alcohol treatment clinic that operated a treatment program which specialized in treating patients who had immigrated from Russia and other countries which had been part of the former Soviet Union, was convicted of Grand Larceny in the First Degree for billing for alcohol service treatments that were not needed or that were not provided in accordance with governing regulations. **Daniel Panitz**, the owner of the facility, and **Yefim Melamed**, the director of its "Russian Program," were each convicted of Grand Larceny in the Second Degree for their participation in the fraud.

6. DENTISTS AND DENTAL SERVICES

Since 2001, the Unit has conducted an initiative examining dental fraud in the Medicaid program. To date, this investigative project has resulted in criminal charges against 50 defendants, 42 convictions (8 cases are pending) and ordered restitution totaling more than \$4.6 million. These cases are invariably difficult to investigate and often involve the examination of thousands of pages of medical records, expert testimony, interviews with numerous patients and other witnesses and, in some instances, the physical examination of patients to ascertain whether billed services were actually rendered. Some examples of our dental cases in 2005 are described below.

Dr. Joel Geller and his brother, **Howard Geller**, who served as the office manager for Triboro Dental Center, used the provider number of another dentist to fraudulently bill Medicaid for services that had been provided by a dentist who had been excluded from the Medicaid program. Both defendants were convicted of felony larceny charges and ordered to pay restitution.

In two other cases, **Dr. Dawer Nadi** was convicted of Offering a False Instrument in the First Degree, a Class E felony, for fraudulently billing Medicaid for dental services he never provided and Brooklyn dentist **Dr. Alexander Lebel** was convicted of falsifying records for submitting a document that falsely certified that he had provided a service when, in fact, he had not.

In addition, felony indictments are pending against two different practices in Brooklyn, each alleged to have stolen more than \$1 million.

7. PHARMACISTS AND PHARMACIES

In 2005, the Unit continued its aggressive pursuit of pharmacy fraud. We secured 12 convictions and over \$5.6 million in criminal restitution and we further completed several multi-million dollar civil cases, including one resulting in the recovery of \$5.7 million.

Our criminal prosecutions included **Narendra Patel**, the owner of Merrick Boulevard Pharmacy, who was sentenced in January 2005 to six months in jail and ordered to repay Medicaid \$750,000. Patel stole from taxpayers by fraudulently billing Medicaid for drugs that were never dispensed to patients or even kept in stock. He further paid customers cash for their prescriptions and then billed Medicaid, falsely claiming to have dispensed the drugs. During the investigation, Patel paid \$800 for prescriptions to an undercover agent who was posing as a Medicaid recipient. Patel later billed Medicaid \$5,000 as if the drugs listed in the prescriptions had been dispensed.

In another criminal case, **John Postiglione**, owner of Postiglione Pharmacy, was sentenced to a term of two to six years in prison for stealing more than \$700,000 from the Medicaid program and from the Village of Port Chester by billing for medications that were never dispensed. Once again, our investigation employed an undercover Unit investigator who posed as a Medicaid recipient and purchased drugs from Postiglione's pharmacy. When Postiglione billed for these drugs, he inflated the bill to add more than \$16,000 worth of medications that he never dispensed.

Maher Ishak, the owner of Woodbury Pharmacy, Inc., was convicted of Grand Larceny in the Third Degree, sentenced to jail, and ordered to repay Medicaid \$1.1 million for submitting hundreds of false reimbursement claims for medications which he never dispensed. In a similar case, **Kenneth Rizzo**, co-owner and supervising pharmacist of Option Care, was sentenced to a year in prison for fraudulently billing for more than \$1 million worth of infusion medicines and supplies that he falsely claimed had been provided to Medicaid recipients. Rizzo paid restitution of over \$1.2 million to the Medicaid program.

Our civil pharmacy investigations resulted in several significant recoveries in 2005. For example, **Parkview Health Services, Inc.**, agreed to pay over \$2 million to resolve allegations that it improperly over-supplied Medicaid recipients with more pharmaceuticals than they actually needed and that it also wrongly billed Medicaid for refilled prescriptions that lacked the supporting documentation required by law.

In another civil case, ten pharmacies, through their current parent company, **Omnicare, Inc.**, the nation's largest institutional pharmacy provider, agreed to repay Medicaid \$5.75 million to resolve allegations of numerous billing irregularities. These included instances where the pharmacies: filled prescriptions that lacked the signature of the prescribing physician; refilled telephone orders unsupported by written orders; and dispensed drugs in strengths that differed from the written orders, in quantities in excess of the quantity listed on the prescriptions, and without any written order.

Finally, in yet another civil pharmacy case, *Upstate Pharmacy Ltd.*, (“Upstate”) and pharmacists *Phillip Petoniak* and *Thaddeus Kuzniarek*, president and vice president, respectively, of the corporation, agreed to pay nearly \$1 million to settle allegations that Upstate fraudulently billed Medicaid for prescription drugs that were never dispensed and that it wrongly billed for refilled prescriptions that lacked supporting documentation.

8. PHYSICIANS

Although Medicaid claims by individual providers comprise only a small percentage of overall Medicaid claims, the Unit remains alert to fraud in this area. In addition, unlicensed or uncertified practitioners can and do pose a danger to Medicaid patients.

For example, *Dr. Roger J. Fares* was convicted of Unauthorized Practice of a Profession (Medicine) after he continued to practice medicine after his medical license had been suspended by the Department of Health.

The J Code Project

Since 2002, the Unit has conducted a statewide review of physician drug billings, commonly known as “J code” claims, for compliance with state pricing rules. Under New York law, to ensure that medical judgment is not affected by inappropriate financial influences, doctors are not permitted to make a profit on the drugs they dispense; they cannot bill Medicaid for more than their “actual” costs for dispensing the drug. Our investigations, however, have revealed numerous physicians who billed for far more than their actual costs.

To date, this investigative project has resulted in the recovery of nearly \$9 million from 29 providers, including hospitals, physician group practices, and individual physicians throughout New York State. In addition, as a result of this project and subsequent steps taken by DOH to ensure correct billings by physicians, annual J code billings to New York’s Medicaid program have dropped by more than 30%, resulting in annual savings to the Medicaid program of approximately \$7 million per year.

In one J code case, *New York Oncology Hematology, Inc.*, an Albany based physician group practice, agreed to pay more than \$1.2 million to settle a lawsuit alleging overcharging. The settlement represented a recovery of the full Medicaid overpayment with interest.

The Unit also obtained negotiated settlements in other “J Code” cases during 2005, including:

<i>New York Oncology and Hematology, PC</i>	\$1,223,719
<i>Mount Sinai School of Medicine of New York University</i>	\$1,042,847
<i>St. Vincent’s Hospital and Medical Center of NY</i>	\$639,399
<i>Westchester Oncology and Hematology Group, PC</i>	\$590,763
<i>Memorial Hospital for Cancer and Allied Diseases</i>	\$497,778
<i>Guthrie Clinic, Ltd</i>	\$268,256

<i>Our Lady of Mercy Hospital</i>	\$229,343
<i>North Shore Hematology/ Oncology Associates, PC</i>	\$206,800
<i>Zale Bernstein, MD</i>	\$170,000
<i>Catskill Regional Medical Center</i>	\$133,382
<i>David Sussman, MD</i>	\$81,774
<i>Orange Regional Medical Center</i>	\$79,679
<i>United Health Services Hospital</i>	\$72,728
<i>NYU Hospitals Center</i>	\$69,606
<i>Long Island College Hospital</i>	\$31,762

9. SOCIAL WORKERS

Nyack social worker *Allen Steven Levy* was sentenced in August to six months' imprisonment and five years' probation for stealing nearly \$275,000 from the Medicaid and Medicare programs by systematically presenting fraudulent claims to those programs for: sessions he did not provide; sessions that were required to be performed face-to-face that he, in fact, provided over the telephone; and sessions which he claimed occurred in New York City but which were actually performed in Rockland County, where lower reimbursement rates applied.

10. PHYSICAL THERAPISTS

Cosmas LeGrand was convicted of Grand Larceny in the Second Degree after being charged with defrauding government and private insurers of more than \$1.3 million by performing physical therapy services without a license. To obtain work as a physical therapist, LeGrand submitted forged documents purporting to show that he was licensed. He thereafter repeatedly submitted reports to his employer specifying services he performed as a "licensed" physical therapist.

Based on these false representations, Family Care was paid more than \$1.3 million by Medicaid, Medicare and other third-parties for the services LeGrand provided as a "licensed therapist."

11. NURSES

Our investigations of fraudulent conduct by nurses in 2005 produced convictions of nurses who engaged in identity theft, credentials fraud, and similar criminal conduct.

For example, *Tashiany Martin*, was convicted of Unauthorized Practice of a Profession, Identity Theft in the Second Degree, and Grand Larceny in the Fourth Degree after she obtained a nursing position at an upstate nursing home by assuming the name, identity and professional credentials of an actual nurse. She presented the nursing home with a forged Social Security card and New York State driver's license, as well as a copy of the genuine nurse's LPN license. Martin was sentenced to jail and ordered to pay restitution.

In a similar case, **Raye Gersonia**, of Canandaigua, posed as a registered nurse and provided nursing services to nursing home patients for nearly two years. In fact, Gersonia was not a nurse and had only been certified as a nurse aide. As part of her deception, Gersonia provided nursing home officials with altered documents, which falsely stated that she had been issued a Registered Professional Nurse license by the State of New York. Gersonia was convicted of Grand Larceny in the Second Degree and Unauthorized Practice of a Profession.

Finally, private duty nurse **Tammy Simizon** was convicted of Grand Larceny in the Fourth Degree and Unauthorized Practice of a Profession for billing Medicaid for nursing services after her nursing license had lapsed in 2003. To carry out her fraud, Simizon fraudulently altered her nursing registration certificate to make it appear that her nursing license was current.

12. DURABLE MEDICAL EQUIPMENT

Under New York's Medicaid rules, durable medical equipment ("DME"), provided to Medicaid patients must be new for Medicaid to pay for that equipment. In 2005, the Unit concluded a case against **Pediatric Services of America, Inc.** ("PSA"), a national DME provider. The Unit's investigation revealed situations in which the Medicaid Program paid PSA twice for the same equipment, and other instances where PSA was unable to furnish documentation required to prove that furnished equipment was new. PSA entered into an agreement to repay the Medicaid Program \$239,747.

13. TRANSPORTATION

We continued in 2005 to examine fraud in the delivery of transportation services in 2005.

In one case, the owner of a Westchester County transportation company stole more than \$400,000 from the Medicaid program by fraudulently billing for hundreds of rides that never took place, as well as for other rides that were not authorized by medical practitioners. **Meir Sassoon**, president of the Saswitz Corporation, was convicted of Grand Larceny in the Second Degree and multiple counts of Offering a False Instrument for Filing in the First Degree.

Similarly, **Emmett Carter**, owner of Carter's Taxi of Peekskill, was convicted of Grand Larceny in the Fourth Degree for stealing \$137,420 from Medicaid by billing for trips that had not occurred. In a related civil proceeding, our Civil Enforcement Unit obtained a court order to freeze the proceeds of the sale of real property owned by Carter.

14. GLOBAL SETTLEMENTS

The Unit participated in a number of significant multi-state "global" cases in 2005. These important cases are the result of a unique collaboration between the federal government and the states, which work through NAMFCU global case teams.

Not all states contribute resources to these national investigations. In contrast, the New York MFCU has consistently played a key role in these cases – as NAMFCU counsel Barbara Zelner has recently testified in hearings before our Assembly. For some cases we have served as lead counsel for the NAMFCU team on behalf of the states, with staff working on the case virtually full-time. In other cases, we provide logistical, administrative, investigative, and legal support to the NAMFCU teams and the federal government investigating the cases. We also serve on the NAMFCU Global Case Committee, which provides guidance and oversight to all the NAMFCU national cases. In all cases, we review the specific terms of the agreements that we enter on behalf of New York.

These global cases have been extraordinarily successful and have produced substantial recoveries for both the federal government and for the states. The cases are typically commenced as “qui tam” whistleblower lawsuits filed under seal under state and federal False Claims Acts, which provide for substantial monetary incentives for whistle blowers to come forward.⁴ As a result of these incentives, industry insiders have come forward to expose fraudulent conduct that government would likely not otherwise find. Many of the “global” cases have been brought against pharmaceutical manufacturers and involve “best price” allegations and allegations of “off-label” marketing of pharmaceuticals and other manipulation of pricing data.

Our global cases for calendar year 2005 include:

Serono, Inc. (December 2005)

Under the leadership of an attorney from the New York MFCU, 40 states joined with the federal government to forge a landmark national settlement with ***Serono, Inc.*** This settlement produced more than \$567 million for the nation, of which \$171 million represented restitution for losses sustained by New York’s Medicaid program.

This global case was reportedly the largest national Medicaid Fraud settlement in history, resolving allegations that Serono unlawfully boosted sales of the drug Serostim by paying kickbacks to doctors and pharmacies and by marketing the drug for purposes not approved by the federal Food and Drug Administration (“FDA”).

The Chief of New York’s Special Project’s Unit led the NAMFCU team that represented the states. In that role, the New York Unit participated in the investigation – issuing subpoenas, reviewing billing data and invoices, and conducting field interviews. In addition, as the leader of the NAMFCU settlement team, our Special Projects Chief conducted negotiations on behalf of the states, drafted the model state settlement agreement, and apportioned and delivered the settlement proceeds for all of the states.

⁴ Although the New York State Attorney General has proposed such a statute in New York, the legislature has repeatedly failed to enact it into law.

Schering-Plough Corporation (September 2005)

The Unit secured, as part of a national global settlement, a \$37.7 million recovery from ***Schering-Plough Corporation*** to settle allegations that Schering-Plough had misrepresented the “best price” it was paid for its drug Claritin and that it had fraudulently marketed that drug.

In addition to this Medicaid settlement, the New York Unit negotiated a separate \$1.8 million settlement with Schering-Plough to resolve allegations that New York’s EPIC and Home Relief programs had also been cheated by Schering-Plough’s best price misrepresentations. EPIC provides drug purchasing assistance to more than 320,000 qualifying senior citizens. The State’s Home Relief program provided a supplemental safety net to New York residents with financial needs who did not qualify for services under Medicaid.

Warner Lambert/Pfizer (March 2005)

A \$12.8 million recovery was secured from ***Warner/Lambert/Pfizer*** to settle allegations that ***Warner Lambert*** had marketed the drug Neurontin for unapproved uses. In a related case, the consumer frauds offices of all 50 states – led by New York and four others – recovered an additional \$38 million for educational programs, advertising campaigns, and investigative costs.

Astra-Zeneca (June 2005)

A \$4.9 million recovery was secured from ***Astra Zeneca*** to settle claims of improper pricing and marketing of its anti-cancer medication Zoladex.

SECTION II: PROBLEMS AND RECOMMENDATIONS

We have three recommendations for HHS and the OIG. First, as you know, the OIG recently concluded an on-site review of New York's MFCU, which reviewers termed our investigative techniques "fantastic." Current OIG report format does not allow for qualitative remarks to be reported. We recommend that the OIG consider amending the standard format for future reports, as qualitative assessments can be extremely useful.

Second, we renew our recommendation that HHS rescind its regulations that preclude MFCUs from routine targeting. We need more anti-fraud targeting, not less.

Third, we recommend that HHS commission additional studies to determine what portion of New York's "improper" Medicaid payments, which previous federal studies found to be approximately 1.5% of our payments, is attributable to intentional fraud, and which programs have the highest risks. This could greatly assist law enforcement in allocating resources.

The OIG Should Reexamine its On-Site Review Format

In the mid-1980s, the OIG adopted a set of benchmarks for measuring the effectiveness of MFCU units around the nation. In doing so, it rejected as yardsticks a set of ratios that had been proposed, both because they had been shown to be unreliable and because measuring prosecutors by numbers – rather than by whether they fairly administer justice – is ethically questionable.⁵

Yet, as currently constituted, the OIG standard report format does not routinely allow for the reviewing team to include positive or negative qualitative assessments relevant to the standards being measured. Instead, the reports read more like standard audit reports than of thoughtful assessments of an investigative program. For example, during our review and at our exit conference, the experienced investigators who reviewed our unit characterized our investigative methods as "fantastic," our mind set as "aggressive," and our supervision as superb. They noted that they had picked up investigative tips that they would use themselves, and that our cases often moved faster even than federal cases.

Although an assessment like this would certainly be useful to state officials who are evaluating whether state monies are being well spent, the standard report format does not include these judgments. Instead, the draft report we received focused on whether we had written rather than unwritten undercover guidelines and whether we received pre-approval by the OIG for what inspectors characterized as a de minimus loan of equipment (prorated to be worth about \$318) to the state Organized Crime Task Force. As a consequence, we recommend that in future years, you reevaluate the standard report

⁵ Cf., ABA Standards for Criminal Justice: Prosecution Function and Defense Function, § 3-3. 9 commentary, at 76 (3rd ed. 1993) ("a prosecutor should never allow the decision in a particular case to be influenced by a desire to inflate the success record of the office in obtaining convictions.").

format for on-site reviews to allow the assessors to include both positive and negative qualitative evaluations of the unit.

Similarly, the OIG should caution those who receive the data that HHS promulgates annually about the danger of judging units based on home-made ratios created by matching published recovery numbers to unit size, unit costs or state Medicaid spending. This was the type of approach the OIG rejected nearly two decades ago. Ratios such as these:

1. Incorrectly rank as low any state that has driven down its improper payment rate through prevention, deterrence, and incapacitation.⁶ Just the opposite is true: achieving a low improper payment rate is one sign of prosecutorial success.
2. Incorrectly rank as high any state with a large improper payment rate, and thus a large pool of unlawfully paid monies paid to a large pool of wrongdoers available for after-the-fact “recovery.”
3. Incorrectly rank as low a state that allocates significant resources to prosecuting patient abuse and neglect cases (which produce small financial recoveries) while rewarding a state that eschews patient abuse cases in favor of civil fraud cases (which bear the greatest likelihood of large financial recoveries).
4. Are statistically incapable of producing valid state comparisons because they do not control for strengths or weaknesses in each state’s enforcement laws (e.g., the existence of a state false claims act or weaknesses in a state’s penal statutes) and because they do not control for other structural differences between the states which impact unit costs or size.
5. Fail to recognize the effect of global cases on recoveries. Typically, the size of the global recovery is not based on whether the MFCU is hardworking, aggressive, effective, or whether they assisted in investigating or litigating the case, but on the amount of pharmaceutical product prescribed in the state.
6. Rely on data known to be inconsistent from state to state because of definitional uncertainties.

The restrictions imposed by 42 CFR 1007.19(e)(2) should be eliminated.

This office has previously requested that HHS eliminate the restrictions on case investigations set forth in 42 CFR 10017.19(e)(2). In our view, it is not good government

⁶ Federal investigators have defined “improper payments” to be “payments that should not have been made or were made in an incorrect amount (both overpayments and underpayments), and payments made on behalf of ineligible recipients.” See Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations Finance, Systems, and Budget Group, Payment Accuracy Measurement Project: Year 2 Final Report, at 1 (April 2004).

to forbid MFCU units from fully using existing computer capabilities at their disposal, and what the anti-fraud program needs is more targeting, not less. We renew our request.

HHS should do additional work to ascertain payment accuracy rates

One, but by no means the only, measure of success in an anti-fraud program is to measure the rate of inaccurate payments in a state. In other words, a low rate of “improper payments” is one sign that prevention, deterrence, and incapacitation are working.

A recent federally sponsored audit showed that New York has an improper payment rate of 1.5%, which contrasts favorably with rates as high as 18% elsewhere. See Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations Finance, Systems, and Budget Group, Payment Accuracy Measurement Project: Year 2 Final Report, at 6 (April 2004) [Hereinafter cited as “PAM study”]. At present, however, the improper payment rate is an imperfect measure of fraud, because it measures “both overpayments and underpayments.” Id. at 1. Fraud payments will be a subset of the “overpayment” category. Moreover, as regards MFCU efforts, the improper payment rate includes payments made on behalf of “ineligible recipients,” a type of fraud that Units may not pursue under federal law. Id.

No one has yet quantified what portion of New York’s improper payment rate of 1.5% is attributable to fraud (rather than mere error), or determined whether there is an additional category of fraud that the PAM study failed to capture altogether.⁷ To the contrary, even on a nationwide basis, the Government Accountability Office has written the New York State Senate, “We do not know how much fraud the Medicaid program . . . [W]e just do not know the answer.” Email from Leslie G. Aronovitz to Cathy Bern (Sept. 16, 2005).⁸

Better data on improper payments would assist in focusing investigative and prosecutorial resources. For example, the PAM studies show that different types of providers had different accuracy rates. Hospital services ranked among the highest accuracy rates, and individual practitioners and pharmacies ranked among the lowest. See PAM study at 6. And payment accuracy rates in managed care were higher than traditional fee for service programs. See id. at 8. A more accurate breakdown of the 1.5% would lead to better focused investigative resources.

⁷ This definition includes honest mistakes as well as fraud, and the report makes no attempt to differentiate between the two. Indeed, several years earlier, the GAO had written of the difficulty inherent in teasing these two apart. See Report to the Chairman of the House Committee on Energy and Commerce, Medicaid: State Efforts to Control Improper Payments Vary, at 8 (June 2001) (“An even more difficult portion of improper payments to identify are those attributable to intentional fraud.”).

⁸ Although the press has reported figures of fraud and waste as high as 10 to 40%, no study supporting this number has been produced. To the contrary, the GAO states that in response to recent press inquiries about the fraud rate, “when we are asked the question, we just have to explain that we do not have any idea about the percentage of fraud in the program.” Id.

SECTION III: SPECIAL INITIATIVES

The Unit undertook various special initiatives in 2005 to improve its performance, accountability and better serve New York State residents, including:

- √ The Unit streamlined the ability of members of the public to report Medicaid and insurance fraud and patient abuse by establishing both a new hotline (**866-NYS-FIGHT**) and an online complaint form available on the main page of the Attorney General's web site. (<http://www.ag.ny.gov/>)



- √ As described at page 8 above, as part of its ongoing Nursing Home Initiative, the Unit has investigated the relationship between facility staffing levels and the level of resident care. Utilizing OSCAR (CMS' Online Survey, Certification and Reporting), data and investigations, the Unit issued a report entitled, "*Staffing Levels in New York Nursing Homes: Important Information for Making Choices.*" This report is available on the Attorney General's web site.
- √ Unit staff provided in-service training to provider groups, nursing home workers, and patient advocacy groups. In addition, staff often spoke about our work to consumer and community groups. Educating the public about the law is an important part of our battle against provider fraud and patient abuse.

SECTION IV: LEGISLATIVE AND PROGRAMMATIC ISSUES AFFECTING PERFORMANCE

New York State has begun an intensive examination of its Medicaid anti-fraud efforts, which have included a special program review commissioned by the Governor and multiple hearings by the Legislature.

The Governor's review was conducted by Paul Shechtman (a former prosecutor and ex-Commissioner of New York's Division of Criminal Justice Services), who reported to the Governor at the end of 2005. Mr. Shechtman concluded that New York State could "significantly improve its efforts" in curbing Medicaid fraud and misspending, and delivered an extensive set of recommendations to the Governor.⁹ Chief among them was a major reorganization of the anti-fraud functions of New York's Department of Health ("DOH") and the creation of a Medicaid Inspector General ("MIG"). As a result of the recommendations, the Governor has proposed legislation to codify the office of the MIG, an office he created by Executive order, and to consolidate a number of now-disparate DOH functions under it. One goal of the restructuring is to increase the number and the quality of fraud referrals to MFCU.

In addition, we have again asked the New York State legislature to take action in areas where we have previously proposed legislation, including proposals to enact a state false claims act and to strengthen the state penal laws. In particular, we have asked the legislature for the same types of powers it has granted the Attorney General to combat securities fraud, tools which have proved particularly successful and have wrought significant reform. As of this printing, the Legislature has not done so.

⁹ Mr. Shechtman made no recommendations for change or reform within MFCU.

APPENDIX

UNIT PERFORMANCE STATISTICS

JUDGMENTS WON AND SETTLEMENTS NEGOTIATED GLOBAL AND NON-GLOBAL

FIGURE 1.

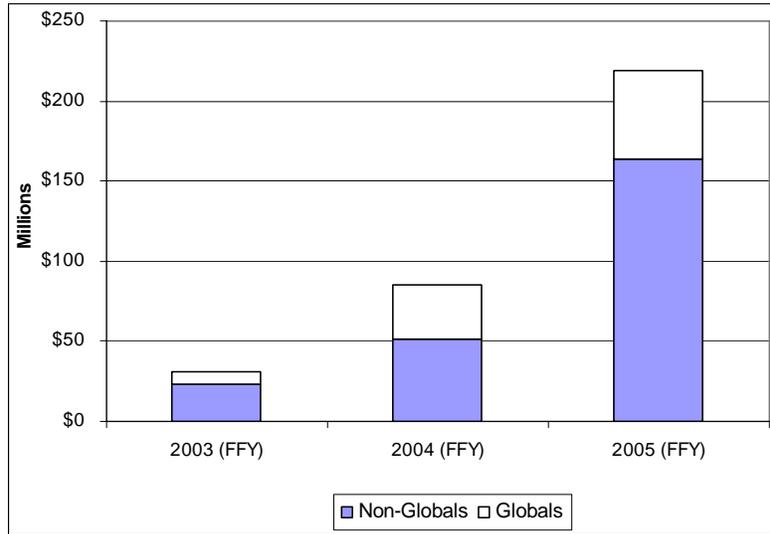


TABLE 1.

FFY	Non-Globals	Globals	Total
2005	\$163,482,916	\$55,609,459	\$219,092,375
2004	\$50,994,297	\$34,459,851	\$85,454,148
2003	\$23,691,210	\$7,422,686	\$31,113,896

Note to charts: The OIG has directed that we report: (1) All restitution ordered or agreed to in civil and criminal cases during the fiscal year (whether collected or not), including restitution for federal, state and local governmental entities and for private parties; (2) fines and penalties. These recoveries are reported to OIG in the following categories of the Quarterly Statistical Reports filed by the Unit with OIG:

- Criminal Receivables: Fines Ordered; Restitution Ordered; Other Restitution
- Civil & Administrative Receivables: Pre-filing Settlements

Recoveries reported do not include any sums collected during the fiscal year as a result of a judgment or agreement reported in a prior year.

The Unit has previously informed OIG that, using this definition, New York under-reported its recoveries by \$54,221,627 for federal fiscal years 2000 - 2004. OIG's published recovery data for those years is thus incorrect. During those years, New York did not include in its reported recoveries amounts attributable to restitution multipliers (treble damage awards) or to penalties. New York also did not report the full amount of civil settlements which called for structured payments over time, but only reported amounts as they were received under those settlements and it did not report recoveries to third-parties other than the Medicaid Program. Unless otherwise noted, the figures in this appendix reflect the corrected numbers.

Note: Figures 2 and 3 on this page reflect numbers as reported to OIG, without the corrections described on page A-1.

FIGURE 2.

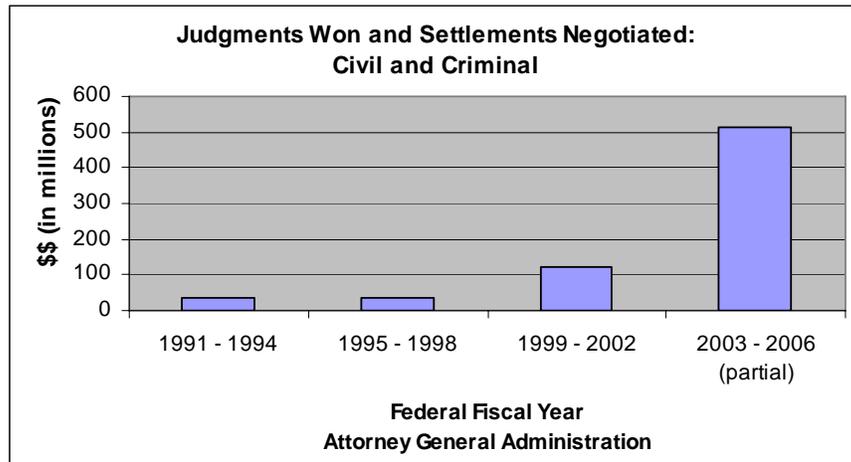


FIGURE 3.

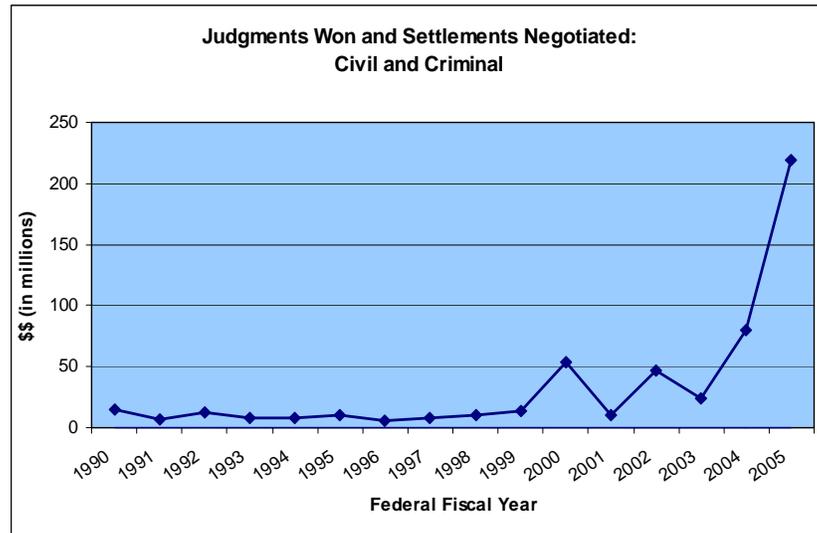
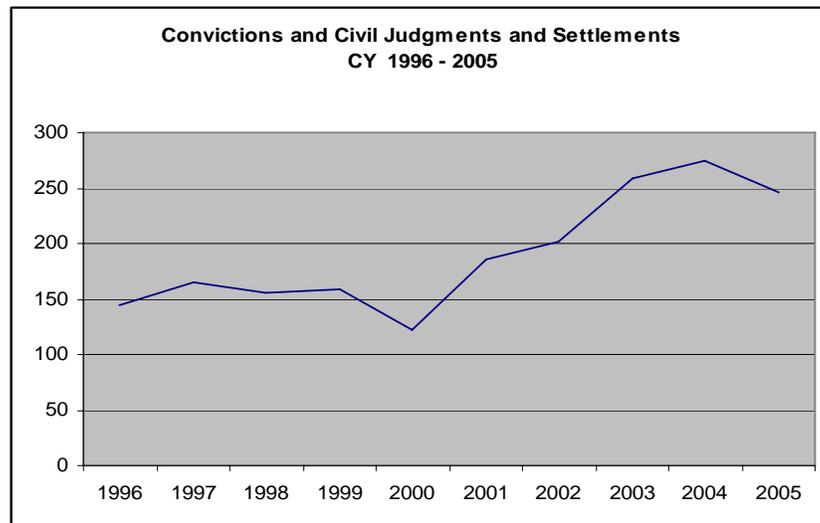


FIGURE 4.



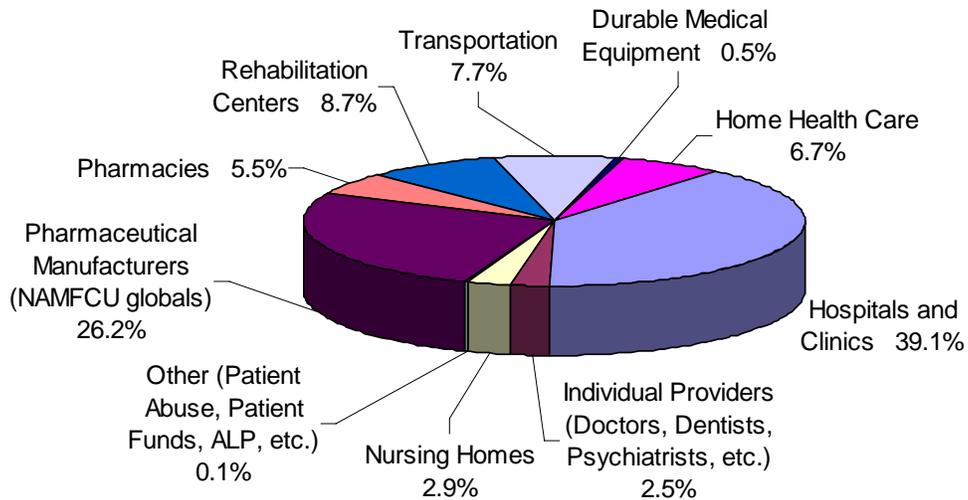
**JUDGMENTS WON AND SETTLEMENTS NEGOTIATED BY PROVIDER TYPE
FEDERAL FISCAL YEAR 2005**

TABLE 2.

Category	Amount
Hospitals and Clinics	\$85,707,097
Pharmaceutical Manufacturers (NAMFCU globals)	\$57,446,308
Rehabilitation Centers	\$19,133,553
Transportation	\$16,833,202
Home Health Care	\$14,626,572
Pharmacies	\$12,110,894
Nursing Homes	\$6,260,002
Individual Providers (Doctors, Dentists, Psychiatrists, etc.)	\$5,545,504
Durable Medical Equipment	\$1,165,614
Other (Patient Abuse, Patient Funds, ALP, etc.)	\$263,631
Total Recoveries FFY 2005:	\$219,092,376

FIGURE 5.

Federal Fiscal Year 2005



A) INVESTIGATION SUMMARY

TABLE 3.

QSR Code	Provider Type	Investigations Opened	Investigations Closed
4A-1	Institution – Nursing Facilities	18	38
4A-2	Institution – Hospitals	7	12
4A-3	Other Institutions (e.g., Adult Homes, ALP, ADHC)	0	2
4A-4	Facilities & Clinics – Substance Abuse Treatment Centers	4	8
4A-5	Facilities & Clinics – Free-standing Clinics	8	10
4A-6	Other Facilities	0	0
4A-7	Medical Doctors	16	15
4A-8	Dentists	20	20
4A-9	Chiropractors	0	0
4A-10	Podiatrists	1	1
4A-11	Ophthalmologists, Opticians, Optometrists	2	0
4A-12	Psychiatrists	8	5
4A-13	Other (e.g., Physical, Speech, Occupational Therapists)	2	4
4A-14	Pharmacy	28	40
4A-15	DME	4	8
4A-16	Lab	0	0
4A-17	Ambulance/ Transportation Services	12	8
4A-18	Home Health	35	30
4A-19	X-ray/ Imaging	0	0
4A-20	Psychologist	7	2
4A-21	Other (Other Healthcare-related workers, where no license or certification is required)	1	1
4A-22	Pre-paid Health	6	1
A	Total ‘A’ Fraud Investigations	179	205
B	Patient Abuse Investigations (Hospitals, Nursing Homes, Adult Homes, ALP, etc.)	53	74
C	Patient Funds Investigations	3	3
D	Total ‘D’ (Other) Fraud Investigations	4	4
Total – All Investigations:		239	286¹

¹ During the preparation of this report, we reviewed the classifications assigned to investigations opened and closed in 2005 and reclassified some of the cases previously reported to OIG in our quarterly reports. This table sets forth our revised classifications.

INVESTIGATION SUMMARY CONTINUED

TABLE 4.

Completed Investigations: Calendar Year 2005					
	Investigations Closed by Prosecution	Investigations Closed by Civil Action	Investigations Closed by Referral	Investigations Closed due to Insufficient Evidence	Total
<i>Fraud</i>	46	71	14	78	209
<i>Patient Abuse & Neglect</i>	32	1	2	39	74
<i>Patient Funds</i>	2	0	0	1	3
TOTAL COMPLETED INVESTIGATIONS:					286

B) CRIMINAL PROSECUTION SUMMARY

TABLE 5.

Criminal Prosecutions: Calendar Year 2005			
	Fraud	Patient Abuse, Neglect & Patient Funds	TOTAL
<i>a. Criminal prosecutions filed (by number of defendants)</i>	84	31	115
<i>b. Criminal prosecutions completed (by number of defendants)</i>	87	38	125
<i>Convictions</i>	85	35	120
<i>Acquittals</i>	0	1	1
<i>Dismissals</i>	2	2	4
TOTAL COMPLETED	87	38	125
<i>c. Conviction Rate</i>	97.7%	92.1%	96%

C) PATIENT ABUSE REFERRALS

TABLE 6.

Patient Abuse Summary Statistics: Calendar Year 2005	
Total Patient Abuse Complaints Received	1,022
Total Patient Abuse Investigations Opened ²	53
Total referrals to other state agencies	315

² The Unit also investigated 3 patient funds cases.

D) RECOVERY ACTIONS

TABLE 7.

Summary 2005 Recovery Actions (Calendar Year 2005)			
	Criminal	Civil	Total
Number of Recovery Actions Initiated by the Unit	61	126	187
Recoveries Reported to OIG	\$30,408,088	\$354,738,574	\$385,146,662
Recoveries Collected	\$12,035,885	\$261,497,809	\$273,533,694

The number of recovery actions referred to another agency: 0

E) RECOVERY ACTIONS INITIATED BY SINGLE STATE AGENCY

Actions initiated by DOH under its agreement with the Unit: 2
Overpayments collected by DOH under this agreement: \$139,000

F) PROJECTIONS

Although the amount of recoveries achieved by the Unit have historically fluctuated as a consequence of the timing of completed cases, we anticipate that our FFY 2006 recoveries, prosecutions, convictions and recovery actions will be similar to the results achieved in FFY 2005.

G) COSTS

TABLE 8.

Cost Type	Cost Incurred
Personal Services	\$21,202,889
Non-personal Services	\$9,534,365
Fringe Benefits	\$8,948,065
Total	\$39,685,319

NEW YORK STATE OFFICE OF THE ATTORNEY GENERAL
MEDICAID FRAUD CONTROL UNIT REGIONAL OFFICES

