State of Connecticut
Division of Criminal Justice

OFFICE OF
THE CHIEF STATE'S ATTORNEY

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December 23, 2019

Legislative Program Review and Investigations Committee
State Capitol
210 Capitol Avenue - Room 506
Hartford, Connecticut 06106-1591

RE: ANNUAL JOINT MEDICAID REPORT REQUIRED PURSUANT TO GENERAL STATUTES §17b-99b(a)

Dear Committee Members:

Attached is the report of the Medicaid Fraud Control Unit ("MFCU") in the Office of the Chief State's Attorney, pursuant to General Statutes §17b-99b(a), which provides that the Commissioner of Social Services, in coordination with the Chief State's Attorney and the Attorney General, shall submit a joint report on the state's efforts to prevent and control fraud, abuse and errors in the Medicaid payment system and to recover Medicaid overpayments. This report covers MFCU activity during the period July 1, 2018 through June 30, 2019.

Very truly yours,

CHRISTOPHER T. GODIALIS
Supervisory Assistant State's Attorney
Director – Medicaid Fraud Control Unit

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Annual General Assembly Medicaid Joint Report

Fiscal Year July 1, 2018 – June 30, 2019

The Connecticut Medicaid Fraud Control Unit ("MFCU") exists as a single identifiable entity of the state government within the Division of Criminal Justice, Office of the Chief State's Attorney. Pursuant to 42 United States Code §1007.11 (a), the MFCU is charged with conducting "a Statewide program for investigating and prosecuting (or referring for prosecution) violations of all applicable State laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, or the activities of providers of medical assistance under the state Medicaid plan."

The MFCU was first certified in 1978 by the Office of the Inspector General in the United States Department of Health and Human Services ("HHS"). The MFCU must satisfy annually twelve federal performance standards in order to retain its federal certification, which is a condition of Connecticut's eligibility for federal reimbursement of the state's Medicaid plan.

According to the federal performance standards, which take into account various factors including the amount of Connecticut's total Medicaid expenditures, the MFCU is authorized and expected to have sixteen full-time employees on staff. For the past three reporting periods, however, the Unit has struggled with significant understaffing that has varied between eight and eleven employees. In this reporting period, however, I am pleased to report that with the assistance of the State Auditors we have been fortunate to increase our staff to thirteen employees. The current staff includes the Director, two Assistant State's Attorneys, one Supervisory Police Inspector,

six Police Inspectors, two Forensic Fraud Examiners and a Secretary. HHS pays seventy-five percent of the cost of operating the MFCU. The Unit's annual recoveries, which can vary widely from year-to-year, always exceed the Unit's total operating costs.

During the one-year period covered by this report, the MFCU opened **42** new cases for investigation (by comparison, 42 last year), made **10** arrests (by comparison, 2 last year) and obtained **5** convictions (by comparison, 6 last year). As of June 30, 2019, the Unit had pending **87** pre-arrest (by comparison, 75 last year) and **10** post-arrest cases (by comparison, 7 last year).

The data required by Conn. Gen. Stat. §17b-99b(c) is presented in the documents attached hereto. Additionally, pursuant to Conn. Gen. Stat. §17b-99b(f) the MFCU provides the following information:

1. *Operational Protocols*

The MFCU utilizes a number of law-enforcement-confidential operational protocols, consistent with our federal performance standards, to ensure it conducts its investigations efficiently and effectively. It utilizes the tools at its disposal, which, unfortunately, still does not include state investigative subpoena authority, to obtain and evaluate information during the investigative process in order to reach an appropriate disposition in every matter.

Among these protocols are:

a) Intake and Assessment of Referrals and Complaints: The MFCU follows the protocol required by the federal performance standards to evaluate the referrals it receives from partner agencies and the complaints it receives from the general public and other sources. Among the factors considered in opening an investigation are whether the allegations bear indicia of reliability, the potential loss to the Medicaid program resulting from the alleged violation, and operational resource constraints. The MFCU's practice is to accept or reject a referral from the DSS within 45 days from receipt of the referral, although such decisions often are made in less time.

b) Investigative Plans: Each investigation is assigned to an attorney, a lead investigator and a forensic fraud examiner. There is an approved investigative plan, which is revisited and updated throughout the investigative process. If it is appropriate to do so, then an investigative plan may be developed and executed in coordination with other agencies that may also be investigating the same factual matter for different reasons (typically the Attorney General's Office and/or the U.S. Department of Health and Human Services Office of the Inspector General/Office of Investigations).

c) Status Meetings: Investigators meet with supervisors and others on a regular and as-needed basis to assess the progress of the investigation or to discuss important issues or strategic considerations.

2. *Projected Cost Savings*

The MFCU does not consider projected cost savings as part of its long range operational plans in criminal cases, other than to consider actual value of the loss as a factor in the decision whether to pursue a case.

3. *New Initiatives*

The MFCU is limited by federal law with respect to both how it may initiate investigations and what subject matter it may investigate. Primarily, we are authorized to pursue allegations of Medicaid fraud committed by providers who are brought to our attention through referral or complaint. We can also investigate a limited number of other matters involving facilities that receive Medicaid funding, regardless of whether the putative victim is a Medicaid recipient. We are currently prohibited by federal law from taking affirmative steps on our own to identify Medicaid fraud, although that rule is currently evolving and may change. For now, however, we rely on our partner agencies, principally the Department of Social Services Quality Assurance Unit, which does a truly outstanding job of identifying potential fraud and then referring it to us for investigation as required by federal law.

In this reporting period, the MFCU continued to participate in the

development and use of a unified state fraud reporting website which can be found at: www.fightfraudct.ct.gov.

The MFCU also continued to derive significant benefit from information and data provided by a third-party consultant contracted by the Office of Policy and Management and the DSS, specifically inasmuch as this resulted in both an increase in the number of potential fraud cases that were identified and an improvement in the amount and quality of information readily available to us for investigation and prosecution.

The MFCU Director is the chair of a committee which consists of the Directors of the Medicaid Fraud Control Units of six New England states. At our summer meeting in 2019, we continued planning for the implementation of operational data sharing among the regional MFCUs. This initiative is expected to help us identify fraudulent practices that rarely are limited by geographical boundaries.

Office of the Chief State's Attorney
State of Connecticut
Medicaid Fraud Control Unit
Annual General Assembly Medicaid Joint Report
Fiscal Year July 1, 2018 - June 30, 2019

Source Type	Count
Medicaid Agency - Other	18
Private Citizen	3
SUR/S - Medicaid Agency	21
Total Investigations Opened:	**42**

Nature of Allegations		Count
Facility Based, Inpatient/Residential - Developmental Disability		
False Claims	**Total**	**1**
Facility Based, Inpatient/Residential - Nursing Facilities		
Abuse / Neglect		1
False Claims		1
	Total	**2**
Facility Based, Outpatient &/or Day Services - Mental Health		
False Claims	**Total**	**1**
Physicians		
False Claims	**Total**	**2**
Licensed Practitioner - Clinical Social Worker		
Services Outside Scope of Practice		1
False Claims		1
	Total	**2**
Licensed Practitioner - Dentist		
False Claims	**Total**	**3**
Licensed Practitioner - Nurse Practitioner		
False Claims	**Total**	**1**
Licensed Practitioner - Other		
False Claims		3
Unqualified Practitioner		1
	Total	**4**
Licensed Practitioner - Psychologist		
False Claims	**Total**	**1**
Other Individual Providers - Personal Care Attendant		
False Claims	**Total**	**6**
Other Individual Providers - Optician		
False Claims	**Total**	**1**
Other Individual Providers - Other		
False Claims	**Total**	**1**
Medical Services - DME, Prosthetics, Orthotics & Supplies		
False Claims	**Total**	**2**
Medical Services - Lab (Clinical)		
Excessive/Not Medically Necessary Services		1
False Claims		2
	Total	**3**
Medical Services - Medical Device Manufacturer		

Defective Products		1
False Claims		1
Kickbacks		1
No FDA Approval		1
	Total	**4**
Medical Services - Pharmaceutical Manufacturer		
False Claims		1
Kickbacks		2
	Total	**3**
Medical Services - Pharmacy (Retail)		
False Claims		2
Unlawful Dispensing		1
Violated State and Federal Regulations		1
	Total	**4**
Medical Services - Transportation		
False Claims	**Total**	**1**
Medical Services - Other (Wound Management)		
Excessive and Unnecessary Services	**Total**	**1**
Total Count for all Provider Types:		**42**

Connecticut Medicaid Fraud Control Unit
Medicaid Joint Report FYE 6/30/2019
(c)(3) Length of Time Elapsed Between Case Opening and Closing

12/2/2019; 3:10 PM

Case Number	Case Name	Less Than One Month to Six Months (i)	Seven Months to Twelve Months (ii)	Thirteen Months to Twenty-four Months (iii)	Twenty-five Months or More (iv)
2014-00031	Sheik Ahmed, MD [E. Htfd Med Ctr]				iv
2014-00230	[Redacted]				iv
2015-00001	[Redacted]				iv
2015-00128	Amerisource Bergen [161]				iv
2015-00195	[Redacted]				iv
2015-00196	[Redacted]				iv
2015-00222	Arlene Werner				iv
2015-00229	Michelle Labrec				iv
2016-00024	Med Tech, LLC				iv
2016-00102	[Redacted]				iv
2016-00121	[Redacted]				iv
2016-00126	Walgreens et al, Insulin Pens, #16-04-01 [556]				iv
2016-00144	Davis Gp, LLC, aka Caring Family Solutions				iv
2016-00221	Abbott Laboratories #14-11-02 / #89 (Bergman)			iii	
2017-00081	[Redacted]			iii	
2017-00101	Patricia McAlinden			iii	
2017-00167	Healogics - 585		ii		
2018-00018	AstraZeneca-113		ii		
2018-00027	[Redacted]			iii	
2018-00038	Alere San Diego, Inc. #212 [13-12-01]	i			
2018-00122	[Redacted]	i			
2019-00034	[Redacted]	i			
2019-00035	CT Behavioral Hlth Assoc/Bassam Awwa MD	i			
2019-00059	CareFusion #458	i			
2019-00065	[Redacted]	i			
2019-00068	Bharat Patel	i			
Total:	26	7	2	4	13

Provider Type	Disposition Category	Count
Facility Based Inpatient - Nursing Facility	Insufficient Evidence	1
Facility Based Outpatient - Mental Health	Discretion of Prosecutor	1
Licensed Practitioner - Clinical Social Worker	Civil Action	2
Licensed Practitioner - Psychologist	Civil Action	1
Licensed Practitioner - Other (Behavioral Health Clinician)	Insufficient Evidence	1
Licensed Practitioner - Other (Behavioral Health Clinician)	Discretion of Prosecutor	1
Medical Services - DME, Prosthetics, Orthotics & Supplies	Civil Action	1
Medical Services - Lab (Clinical)	Discretion of Prosecutor	1
Medical Services - Medical Device Manufacturer	Civil Action	2
Medical Services - Pharmaceutical Manufacturer	Civil Action	2
Medical Services - Pharmacy (Institutional Wholesale)	Civil Action	1
Medical Services - Pharmacy (Retail)	Civil Action	1
Medical Services - Transportation	No Criminal Aspect	1
Other Individual Providers - Personal Care Attendant	Discretion of Prosecutor	2
Other Individual Providers - Personal Care Attendant	Insufficient Evidence	2
Physician - Family/Pediatrician/Internal Practice	Civil Action	2
Physician - Family/Pediatrician/Internal Practice	Discretion of Prosecutor	1
Physician - Family/Pediatrician/Internal Practice	Prosecution	1
Physician - Psychiatrist	Civil Action	1
Program Administration	Arrest by Local PD	1
	Total Cases Closed:	**26**

Action Type	Recovery Sought	Recovery Realized
Criminal Charges	2,811,571.85	314,953.85
Settlements	5,933,991.82	4,542,475.47
Judgments	91,551.00	30,500.00
Totals:	8,837,114.67	4,887,929.32

Reason Declined	Count
Discretion of the Prosecutor	2
Lack of Jurisdiction	5
No Criminal Aspect	4
Total, Declined Referrals / Complaints:	**11**

Outcome	Count
Arrests	10
Convictions	5

Arrest Status	Count
Pre-Arrest	87
Post Arrest	10
Pre & Post Arrest	97

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

JUL 17 2019

Christopher Godialis, Director
Medicaid Fraud Control Unit
Office of the Chief State's Attorney
300 Corporate Place
Rocky Hill, Connecticut 06067

Dear Mr. Godialis:

As part of the recertification process, we have reviewed the following documentation submitted by your office: (1) the Medicaid Fraud Control Unit (MFCU or Unit) Annual Report, (2) the Annual Statistical Report, and (3) the responses to the recertification questionnaire. In addition, we also reviewed the responses to the questionnaires received from the Office of Inspector General (OIG), Office of Investigations, Boston Regional Office and the Connecticut Department of Social Services.

Pursuant to 42 CFR § 1007.17, we have concluded that the Connecticut MFCU meets the Federal requirements for operation of a State Medicaid Fraud Control Unit. This recertification covers a 1-year period beginning August 15, 2019 and ending August 14, 2020. A reapplication for recertification should be submitted to OIG no later than June 15, 2020.

Should you have any questions or concerns regarding your Unit's recertification, please contact Jordan Clementi of my staff at (202) 836-1178.

Sincerely,

Richard Stern

Richard Stern
Director, Medicaid Fraud Policy
and Oversight Division