TELEPHONE
(860) 424-5053

TDD/TTY
1-800-842-4524

FAX
(860) 424-5057

E-MAIL
commis.dss@ct.gov

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

RODERICK L. BREMBY
Commissioner

January 8, 2015

Honorable John W. Fonfara, Senate Chair
Honorable Christie M. Carpino, House Chair
Honorable John A. Kissel, Senate Ranking Member
Honorable Mary M. Mushinsky, House Ranking Member
Legislative Program Review and Investigations Committee
State Capitol
210 Capitol Avenue Room 506
Hartford, CT 06106-1591

RE: PUBLIC ACT No. 13-293
AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING MEDICAD PROGRAM INTEGRITY

Dear Honorable Co-Chairs and Ranking Members of the Legislative Programs Review and Investigations Committee:

The attached joint report has been prepared by the Department of Social Services in coordination with the Office of the Chief State's Attorney and the Office of the Attorney General. The joint report represents the state's efforts to prevent and control fraud, abuse, and errors in the Medicaid payment system and to recover Medicaid overpayments. Included in this report is a final reconciled and unduplicated accounting of identified, ordered, collected and outstanding Medicaid recoveries for all sources. This report is for activity during the period July 1, 2013 through June 30, 2014.

Sincerely,

Roderick L. Bremby
Commissioner

RLB:JFM
Attachment

Cc: Kathleen Brennan, Deputy Commissioner
George Jepson, Attorney General
Kevin Kane, Chief State's Attorney
Krista Ostaszewski, Office of Public Affairs

Table of Contents

Connecticut Department of Social Services

Making a Difference

The Office of Quality Assurance ("QA") is responsible for ensuring the fiscal and programmatic integrity of all programs administered by the Connecticut Department of Social Services (Department), as well as all administrative functions of the Department. QA is committed to the belief that program integrity can be best achieved through the fair application of proactive, creative, and coordinated initiatives designed to both prevent and recover improper payments.

Organizationally, QA is located in the Department's Central Office. In addition, we have QA staff in our regional offices throughout the state. QA has four separate divisions, each with unique program integrity functions. The four divisions are: Audit, Resources & Recoveries, Quality Control, and Investigations.

The Audit Division

The Audit Division performs several audit related functions.

- Provider Audit Unit is responsible for conducting federally mandated audits of medical and health care providers that are paid through the various Medical Assistance Programs administered by the Department.
- Grants & Contracts Unit is responsible for reviewing federal and state single audit reports. The unit is also responsible for reviewing the financial reporting of various grants and contracts that the Department has with for- profit and non-profit agencies and municipalities.
- Internal Audits - These audits involve the review of administrative and programmatic functions within the Department as well as the electronic data processing systems used in their support.

- Grantee Audits – These audits involve the review of financial, administrative and programmatic functions of the Department's major grantees.
- Audits of the Department - The Audit Division is responsible for coordinating the Department's responses to all outside audit organizations reviews performed on the Department, including but not limited to, the State Auditors of Public Accounts and federal audit organizations.

The Resources & Recoveries Division

The Resources & Recoveries Division ensures that the Department is the payer of last resort for the cost of a client's medical care. This is accomplished through a variety of strategies including, 1) detecting, verifying, utilizing and recovering client third party payer resources; 2) establishing monetary recoveries realized from the sale of property and the release of liens against property held by the Department; 3) and establishing recoveries for miscellaneous Medicaid overpayments.

The Quality Control Division

As part of a national performance reporting system, the Department is required to conduct Quality Control (QC) reviews. QC reviews are conducted to determine the Department's compliance with federal and state program eligibility requirements for the Medicaid Program and the Supplemental Nutrition Assistance Program (SNAP).

The Investigations Division

The Investigations Division is charged with the responsibility of coordinating and conducting activities to prevent, detect and investigate fraud, waste, abuse and overpayments in the Medical Assistance Programs.

Client Fraud Unit

The Client Fraud Unit investigates alleged recipient fraud in various programs administered by the Department including, but not limited to, Supplemental Nutritional Assistance (SNAP), Connecticut Energy Assistance (CEAP) and Medicaid. In addition, although the administration of the Care4Kids program was transferred to the Office of Early Childhood, the Department's Client Fraud Unit continues to investigate fraud under this program. The Unit also performs data integrity matches with other federal agencies (i.e. Administration for Children and Families (ACF), U.S. Health and Human Services, U.S. Social Security Administration) to identify inappropriate payments made to recipients.

Provider Fraud Unit

The Investigation Unit has several functions including:

- Investigations of provider fraud, abuse and/or overpayments via data analytics and referrals from various sources including, but not limited to: fraud hotline, other state agencies, clients, law enforcement and medical providers.
- Fraud Referrals - The Department is required under federal regulations to refer matters of suspected Medicaid fraud and abuse to the Medicaid Fraud Control Unit of the Office of the Chief State's Attorney ("MFCU").
- Payment Suspension – The Affordable Care Act requires the suspension of payments to any Medicaid provider when there is pending an investigation of a "credible allegation of fraud".

Provider Enrollment Unit

Fraud prevention is also achieved by instituting provider disclosure requirements and verifying information received during the enrollment process. The Investigations Division is responsible for conducting screenings and background checks of newly and re-enrolled providers to determine their suitability for enrollment in the Connecticut Medical Assistance Programs.

Audit Division Statistics 07/01/13 – 06/30/14

Audits were conducted on 135 providers. Table 1.1 illustrates the number of audits conducted based on provider type.

Table 1.1	
Provider Type	Number of Audits
General Hospital-Outpatient	2
CT Home Care Program	59
Physician, MD - Group	5
Dentist	4
Dentist - Group	5
Community Clinic	1
Home Health Agency	13
Pharmacy	26
Medical Equipment Supplier	16
Hospice Agency	3
Medical Transportation	1
Total	135

A total of $16,669,987 in overpayments was identified. Table 1.2 identifies the amount of overpayments by provider type.

Table 1.2	
Provider Type	Amount of Overpayments Identified
General Hospital-Outpatient	$2,195,121
CT Home Care Program	$1,075,119
Physician, MD - Group	$67,441
Dentist	$847,310
Dentist - Group	$81,735
Community Clinic	$30,732
Home Health Agency	$3,456,224
Pharmacy	$7,552,795
Medical Equipment Supplier	$1,334,543
Hospice Agency	$28,966
Medical Transportation	-
Total	$16,669,987

A total of $8,115,481 in avoided costs was identified. Table 1.3 identifies the amount of avoided costs by provider type.

Table 1.3	
Provider Type	Amount of Avoided Costs Identified
General Hospital-Outpatient	$878,048
CT Home Care Program	$537,560
Physician, MD - Group	$33,721
Dentist	$423,655
Dentist - Group	$40,868
Community Clinic	$15,366
Home Health Agency	$1,728,112
Pharmacy	$3,776,398
Medical Equipment Supplier	$667,272
Hospice Agency	$14,483
Medical Transportation	-
Total	$8,115,481

A total of $16,086,964 in overpayments was recovered. Table 1.4 identifies the amount of overpayments recovered by provider type.

Table 1.4	
Provider Type	Amount of Overpayments Recovered
General Hospital-Outpatient	$1,709,201
CT Home Care Program	$999,138
Physician, MD - Group	$90,070
Dentist	$770,303
Dentist - Group	$116,873
Community Clinic	$ 14,906
Home Health Agency	3,378,781
Pharmacy	8,107,588
Medical Equipment Supplier	$871,138
Hospice Agency	$28,966
Medical Transportation	-
Total	$16,086,964

In addition to the above recoveries, the Audit Division recovered $6,700,000 through provider required self-reporting.

From the 135 (one hundred and thirty five) audits conducted (as identified in table 1.1), 3 (three) resulted in referrals to the Office of the Chief State's Attorney.

Investigation Division Statistics 07/01/13 – 06/30/14

Investigations Division – Provider

A total of 170 (one hundred and seventy) complaints were received. Table 1.5 identifies the number of complaints received for each source.

Table 1.5	
Source of complaint	Number of Complaints
Fraud Hotline	145
Other State Agencies	5
DSS Client	5
Program Integrity Email	3
Law Enforcement (HHS-OIG*, MFCU*, AG*, etc.)	3
DSS ASO* (ValueOptions, BeneCare, CHN*)	3
Internal-DSS Other Units	2
Program Integrity Mail Box	1
Medical Providers	1
DSS Fiscal Intermediary	1
Anonymous	1
Total	170

*HHS-OIG – Health and Human Service – Office of Inspector General
MFCU – Medicaid Fraud Control Unit
AG – Office of the Attorney General
ASO – Administrative Service Organization
CHN – Community Health Network

The Department does not track reasons for complaints.

A total of 33 (thirty three) investigations were opened. Table 1.6 identifies the number of investigations based on the source and further broken down by provider type.

Table 1.6		
Source	Provider Type	Number of Investigations
SURS*/Data Mining	DME	4
SURS/Data Mining	Physician Group	4
SURS/Data Mining	Physician	2
SURS/Data Mining	Hospital	2
SURS/Data Mining	Dentist	4
SURS/Data Mining	Dentist Group	2
RAC* Contractor	Physician	2
Other State Agencies	ABI* Waiver	1
Internal-DSS Other Units	MEDS	1
Complaint	ABI Waiver	1
Complaint	Behavioral Health Clinician	1
Complaint	CHCP*Performing Provider	1
Complaint	Dentist	1
Complaint	Dentist Group	2
Complaint	Physician	2
Anonymous	Dentist Group	1
HMS*	Behavioral Health Clinician	1
Other	Independent Laboratory	1
Total		33

*SURS - Surveillance and Utilization Review System
DME – Durable Medical Equipment
RAC - Recovery Audit Contractor
ABI – Acquire Brain Injury
CHCP - Connecticut Home Care Program
HMS – Health Management Systems

A total of 31 (thirty one) investigations were completed. Table 1.7 identifies the outcome of these investigations based on the source and further broken down by provider type.

Table 1.7			
Source	Provider Type	Outcome	Investigations Completed
SURS/Data Mining	DME	Integrity Review - With Findings	4
SURS/Data Mining	Physician Group	Integrity Review - With Findings	3
SURS/Data Mining	Hospital	Integrity Review - With Findings	2
SURS/Data Mining	Dentist	Integrity Review - With Findings	3
SURS/Data Mining	Dentist Group	Integrity Review - With Findings	2
SURS/Data Mining	Physician	Integrity Review-Referral to Law Enforcement	2
Complaint	Dentist	Integrity Review-With Findings	1
Complaint	Dentist Group	Integrity Review-Referral to Law Enforcement	1
Complaint	Physician	Integrity Review-Referral to Law Enforcement	2
Complaint	Behavioral Health Clinician	Integrity Review-Referral to Law Enforcement	1
Complaint	CHCP Performing Provider	Integrity Review-Referral to Law Enforcement	1
HMS	Physician	Integrity Review - With Findings	2
Anonymous	Dentist Group	Integrity Review - With Findings	1
HMS	Behavioral Health Clinician	Integrity Review-Referral to Law Enforcement	1
Internal-DSS Other Units	MEDS*	Integrity Review - With Findings	1
HMS Analytic Routine	Physician	Integrity Review - With Findings	1
Other	Independent Laboratory	Integrity Review-Referral to Law Enforcement	1
Other State Agencies	Physician Group	Integrity Review - No Material Findings	1
Other State Agencies	ABI Waiver	Integrity Review - With Findings	1
Total			31

* MEDS – Medical Equipment, Device and Supplies

A total of $1,198,037 in overpayments was identified due to investigations.

A total of $511,928 in overpayments was collected due to investigations.

Of the 33 (thirty three) investigations opened, 9 (nine) resulted in a referral to the Office of the Chief State's Attorney.

Table 1.8 identifies the length of time that elapsed from the opening to the closing of an investigation

Table 1.8	
Time Range	Investigations Completed
Less than one month to six months	21
Seven months to twelve months	2
Thirteen months to twenty four months	4
Twenty five months or more	4
Total	31

A total of 9 (nine) investigations resulted in a referral to another agency. Table 1.9 identifies the length of time that elapsed from the opening of an investigation to a referral to another agency.

Table 1.9	
Time Range	Investigations Resulting in a Referral
Less than one month to six months	3
Seven months to twelve months	2
Thirteen months to twenty four months	4
Twenty five months or more	0
Total	9

A total of 6 (six) investigations resulted in the suspension of Medicaid payments. Table 2.0 identifies the number of investigations that resulted in suspension of payment based on provider type.

Table 2.0	
Provider Type	Number of Payment Suspensions
Behavioral Health Clinician Group	1
Dental Groups	2
Physician-Individual	1
Independent Laboratory	1
Behavioral Health Clinician	1
Total	6

A total of 3 (three) investigations resulted in suspension/termination of provider enrollment from the Medicaid program. Table 2.1 identifies the number of investigations that resulted in suspension/termination of provider enrollments based on provider type.

Table 2.1	
Provider Type	Number of Suspension/Termination of Provider Enrollment
Dental Groups	2
CHCP Performing Provider	1
Total	3

The below information is supplemental to information required by Public Act No. 13-293.

Investigations Division – Client

Table 2.2 represents cost avoidance and recoveries from the Investigations Division - Client for SFY 2014.

Table 2.2	
	Amount of Avoided Costs and Recoveries
Cost Avoidance	$8,737,010
Actual Recoveries	$1,333,053
Total	$10,070,063

In SFY 2014, 44 (forty four) cases/arrest warrants were referred to State's Attorney's Office for criminal prosecution. Of those 44 (forty four) cases, 33 (thirty three) resulted in arrests.

Recovery Audit Contractor Statistics 07/01/13 – 06/30/14

Based on 20 (twenty) audits, $960,045 in overpayments and $480,023 in avoided costs were identified with a total of $736,755 in overpayments being recovered by HMS (recovery contractor). Table 2.3 identifies the amount of overpayments identified, the amount of avoided costs identified and the amount of overpayments recovered by provider.

Table 2.3				
Provider Type	Number of Audits	Amount of Overpayments Identified	Amount of Avoided Costs Identified	Amount of Overpayments Recovered
ABI - Acquired Brain Injury	6	$111,506	$55,753	$118,524
Dentist	6	$738,363	$369,182	$442,344
Dentist - Group	8	$110,176	$55,088	$175,887
Total	20	$960,045	$480,023	$736,755

Resources and Recovery Division Statistics 07/01/13 – 06/30/14

Table 2.4 identifies the total number of claims that were selected for billing to commercial health insurance and Medicare.

Table 2.4			
	SFY 2012	SFY 2013	SFY 2014
Commercial Insurance	1,235,986	3,270,854	2,035,520
Medicare	6,396	54,002	27,580
Total	1,242,382	3,324,856	2,063,100

Table 2.5 identifies the total amount billed for the claims referenced in table 2.4.

Table 2.5			
	SFY 2012	SFY 2013	SFY 2014
Commercial Insurance	$109,601,459	$252,790,738	$239,390,154
Medicare	$4,424,084	$9,612,011	$6,225,381
Total	$114,025,543	$262,402,750	$245,615,536

Table 2.6 identifies the number of claims where recovery occurred.

Table 2.6			
	SFY 2012	SFY 2013	SFY 2014
Commercial Insurance	273,005	230,486	223,520
Medicare	3,801	51,694	19,492
Total	276,806	282,180	243,012

Table 2.7 identifies the actual amount collected for the claims references in table 2.6.

Table 2.7			
	SFY 2012	SFY 2013	SFY 2014
Commercial Insurance	$22,607,847	$22,737,700	$23,810,525
Medicare	$3,267,786	$8,331,920	$4,774,145
Total	$25,875,633	$31,069,620	$28,584,670

Table 2.8 identifies the number and amount of Medicaid claims that were denied by commercial health insurance.

Table 2.8					
SFY 2012		SFY 2013		SFY 2014	
Claims	Dollars	Claims	Dollars	Claims	Dollars
590,685	$54,725,357	1,765,152	$142,756,462	1,307,794	$143,472,683

Reasons for commercial health insurance denial:

- **Client did not have coverage that was in effect at time of service**
- **Health care service is not covered**
- **Deductible/copay was not met**
- **Health insurance plans maximum benefit for service had been met**

Table 2.9 identifies the total number of files updated in the Department client eligibility records; as well as, a breakdown of commercial health insurance policies added, changed or deleted.

Table 2.9											
SFY 2012				SFY 2013				SFY 2014			
Additions	Changes	Deletions	Total	Additions	Changes	Deletions	Total	Additions	Changes	Deletions	Total
75,726	27,759	5,446	108,931	93,634	29,987	3,209	126,830	94,083	53,248	2,298	149,629

The estimated cost avoidance for third party liability is $449,388,287.

Performance Standard

Table 3.0 identifies the return on investment (ROI) by division. ROI was calculated as (Divisions Recoveries + Cost Avoidance)/Division Cost.

Table 3.0	
Division	Return on Investment
Audit Division	5.99
Investigations Division– Client	8.64
Investigations Division – Provider	0.95
Resources and Recovery Division	40.92

Projected Cost Savings

Audit Division

Table 3.1 represents the projected cost savings from the Audit Division for SFY 2015.

Table 3.1	
Description	Amount
Audit Recoupments	$20,000,000
Audit Cost Avoidance	$10,000,000
Self-Reporting	$6,700,000
Initiatives Recoveries/Cost Avoidance	$30,000,000
Total	$66,700,000

Investigations Division – Provider

Table 3.2 represents the projected cost savings from the Investigations Division - Provider for SFY 2015

Table 3.2	
Description	Amount
Payment Suspensions	$ 562,968
Recoupment Activities	$ 252,528
Global Settlements	$1,017,222
Total	$1,832,718

Investigations Division– Client

Table 3.3 represents the projected cost savings from the Investigations Division - Client for SFY 2015.

Table 3.3	
Description	Amount
Cost Avoidance	$11,778,342
Actual Recoveries	$1,230,744
Total	$13,009,086

Resources and Recovery Division

Table 3.4 represents the projected cost savings from the Resources and Recovery Division for SFY 2015.

Table 3.4	
Description	Amount
Third Party Liability	$484,891,132
Resources	$26,553,616
Central Processing	$4,860,044
Total	$516,304,792

New Initiatives to Prevent and Detect Overpayments

Audit Division

- The Audit Division is developing standard audit forms for each provider type. This would increase efficiency by reducing the amount of time for completing reports, keeping staff focus to what they need to do to complete the audits, and limit the time for reviewing the report and work papers by the supervisor and manager.
- The Audit Division is developing internal audit reports for cost avoidance and increase federal reimbursement based on audits of providers.
- The Audit Division is developing audit protocols.
- The Audit Division is developing a training program to assist providers in maintaining adequate records and bill for services provided.
- The Audit Division is developing a paperless audit process.

Investigations Division – Provider

Fraud Referrals

- The Investigation's Division has increased emphasis on fraud referrals to law enforcement via upgrading a staff person.

Integrity Reviews

- The Investigation's Division is conducting frequent peer to peer analysis on targeted provider types for potential review.

Medicaid Recovery Unit

- A total of 6 positions were added to the Investigations Division and titled the Medicaid Recovery Unit. These positions are responsible for investigation of fraudulent activities by providers enrolled in the Connecticut Medical Assistance Programs and will include analyzing, interpreting, and preparing computer generated data reports and performing field investigations.

Provider Enrollment

- The Investigation's Division has streamlined provider enrollment with a major emphasis on screening of high risk provider types.

Investigations Division– Client

- The Investigation's Division has allocated additional staff to address disqualified Supplemental Nutritional Assistance Program (SNAP) retailer trafficking referrals.
- The Investigation's Division is focusing on increase of number of arrest warrant affidavits processed; referral for prosecution and arrests.
- The Investigation's Division completed and distributed the Client Fraud Handbook guide as a training resource for consistent application of fraud investigation techniques.
- The Investigation's Division will continue emphasis on staff individualized training plans focusing on increased knowledge of the latest technological advances to combat fraud, waste and abuse.
- The Investigation's Division will continue to conduct quarterly statewide training/meetings.
- The Investigation's Division will continue to share statistical data and divisional updates monthly with statewide divisional staff.
- The Investigation's Division will continue to increase emphasis on answering and screening high percentage of Fraud Hotline complaints 'live' the same day they are called in.

Resources & Recoveries Division

Working in conjunction with Health Management Systems (HMS)

- The Division will expand its matching and verification with Medicare Parts A, B & D to minimize Medicaid payments for pharmacy, institutional and professional health care services.
- Expected savings will be approximately $4 million per year.

KEVIN T. KANE
CHIEF STATE'S ATTORNEY

State of Connecticut
Division of Criminal Justice

OFFICE OF
THE CHIEF STATE'S ATTORNEY

300 CORPORATE PLACE
ROCKY HILL, CONNECTICUT 06067
PHONE (860) 258-5800
FAX (860) 258-5858

December 22, 2014

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

RE: REPORT REQUIRED PURSUANT TO PUBLIC ACT NO. 13-293 AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING MEDICAID PROGRAM INTEGRITY

Dear Committee Members:

Attached is the report of the Medicaid Fraud Control Unit ("MFCU") pursuant to Public Act No. 13-293, 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, 2013 through June 30, 2014.

Very truly yours,

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

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

KEVIN T. KANE
CHIEF STATE'S ATTORNEY

State of Connecticut
Division of Criminal Justice

OFFICE OF
THE CHIEF STATE'S ATTORNEY

300 CORPORATE PLACE
ROCKY HILL, CONNECTICUT 06067
PHONE (860) 258-5800
FAX (860) 258-5858

Annual General Assembly Medicaid Joint Report

Fiscal Year July 1, 2013 – June 30, 2014

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 certification, which is a condition of Connecticut's eligibility for federal reimbursement of the state Medicaid plan.

The MFCU's current professional staff of thirteen consists of 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 typically exceed the operating costs many times over.

During the one year period covered by this report, the MFCU opened 37 new cases for investigation, made 9 arrests and obtained 15 convictions.

As of June 30, 2014, the Unit has pending 50 pre-arrest and 12 post-arrest cases.

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

1. *Operational Protocols*

The MFCU utilizes a number of law-enforcement-confidential operational protocols, consistent with federal performance standards, to ensure it conducts its investigations efficiently and effectively. It utilizes the tools at its disposal, which, unfortunately, does not include 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 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 within 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 process. If it is appropriate to do so, an investigative plan may be developed and executed in coordination with other agencies that may also be investigating the same matter (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, other than to consider actual value 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 effectively prohibited from taking affirmative steps on our own to identify Medicaid fraud. We rely on our partner agencies in that regard, principally the DSS, which is required by federal law to refer all suspected fraud to the MFCU.

Office of the Chief State's Attorney
State of Connecticut
Medicaid Fraud Control Unit
Annual General Assembly Medicaid Joint Report
Fiscal Year July 1, 2013 - June 30, 2014

Source Type	Count
HHS-OIG	2
Law Enforcement	2
Licensing Board	10
Medicaid Agency - Other	14
Private Citizen	3
SUR/S - Medicaid Agency	6
Total Investigations Opened:	**37**

Connecticut Medicaid Fraud Control Unit
Medicaid Joint Report - 6/30/2014
(c)(2) - General Nature of Allegations by Provider Type

12/5/2014; 2:33 PM

Nature of Allegations		Count
Provider Type: Nursing Home		
Abuse/Neglect		2
False Reporting		1
Quality of Care		6
	Total	9
Provider Type: Physician		
Excluded Provider Violation		1
False Claims		4
Not Medically Necessary		2
	Total	7
Provider Type: Nurse Practitioner		
Suspended License	Total	2
Provider Type: Personal Care Assistant		
Abuse/Neglect		1
False Claims		1
	Total	2
Provider Type: Home Health Agency		
Abuse/Neglect		1
Billed Medicaid Client		1
False Claims		1
Retaining Overpayments		1
	Total	4
Provider Type: Pharmacy Rx only		
Best Price		1
Kickbacks		1
	Total	2
Provider Type: Social Worker		
False Claims	Total	1
Provider Type: Medical Equipment Supplier		
False Claims		2
Off-Label Marketing/Unapproved by FDA		1
Not Medically Necessary		1
	Total	4
Provider Type: Pharmaceutical Manufacturer		
Kickbacks		2
Mislabeling		1
Off-Label Marketing/Unapproved by FDA		3
	Total	6
Total Count for all Provider Types:		37

Connecticut Medicaid Fraud Control Unit
Medicaid Joint Report - 6/30/2014
(c)(3) Length of Time Elapsed Between Case Opening and Closing

12/5/2014; 2:33 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)
MF200827	Joseph Ubaghs, LCSW				✓
MFG09009	Janssen Pharmaceuticals (Risperdal) #07-02-03				✓
MFG09014	Endo Pharmaceuticals, Inc (Lidoderm) #09-06-03				✓
MFG09015	Amgen, Inc [Amgen I & II-AWP] Aranesp) #09-01-01				✓
2010-00091	Dava Pharmaceutical, Inc. (Clarithromycin et alia) #10-04-01				✓
2010-00233	ISTA Pharmaceuticals Inc (Xibrom) #12-08-01				✓
2010-00265	[Redacted]				✓
2010-00269	[Redacted]				✓
2010-00279	Ranbaxy Laboratories #10-05-01				✓
2011-00136	[Redacted]				✓
2011-00301	[Redacted]				✓
2012-00055	Edwin Njoku, MD			✓	
2012-00144	[Redacted]			✓	
2012-00182	[Redacted]			✓	
2012-00184	[Redacted]			✓	
2012-00185	[Redacted]			✓	
2012-00192	Meridian Manor		✓		
2012-00193	[Redacted]			✓	
2012-00215	[Redacted]			✓	
2012-00240	[Redacted]			✓	
2013-00005	Sanofi US (Hyalgan) #12-11-02		✓		
2013-00028	Catherine A. Reardon		✓		
2013-00042	[Redacted]			✓	
2013-00065	[Redacted]		✓		
2013-00100	Novartis (Visudyne) #13-05-01		✓		
2013-00129	Wyeth (Rapamune) #12-01-01	✓			
2013-00197	[Redacted]	✓			
2013-00228	[Redacted]	✓			
2013-00229	[Redacted]	✓			
2013-00248	[Redacted]	✓			
2013-00260	[Redacted]	✓			
2013-00283	CareFusion Corp	✓			
2014-00003	[Redacted]	✓			
2014-00006	Genzyme Corporation	✓			

2014-00029	[Redacted]	✓			
2014-00034	[Redacted]	✓			
2014-00043	Omnicare - Aranesp #13-11-01	✓			
2014-00049	[Redacted]	✓			
2014-00070	[Redacted]	✓			
		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)
	Total Cases by Time Range :	14	5	9	11

Connecticut Medicaid Fraud Control Unit
Medicaid Joint Report - 6/30/2014
(c)(4) Final Disposition Category of Closed Cases by Provider Type

12/5/2014; 2:33 PM

Provider Type	Disposition Category	Count
Nursing Facility	Insufficient Evidence	14
Nursing Facility	Prosecution	1
Physician	Insufficient Evidence	2
Physician	Prosecution	1
Home Health Agency	Insufficient Evidence	5
Pharmacy	Civil Action	1
Counselor / Psychologist	Prosecution	2
Medical Equipment & Supplies	Civil Action	1
Pharmaceutical Manufacturer	Civil Action	10
Other Provders	Insufficient Evidence	2
Total Cases Closed:		39

Connecticut Medicaid Fraud Control Unit
Medicaid Joint Report - 6/30/2014
(c)(5) Monetary Recovery Sought and Realized

12/5/2014; 2:27 PM

Case Nbr	Case Name	OIG Prov Type	Date of Record	QSR (6-5) Qrty Rpt	Program	Crim/ Settlmt/ Judgmt	State Programs Sought	State Programs Collected	State Share Sought, Fed Pgms	Federal Share Sought, Fed Pgms	Aggregate Fed & State, Fed Pgms Before Int & Relator Fee	Relator Fee, Fed Pgms	Net State Share Sought, Fed Pgms	State Share Realized Before Interest, Fed Pgms	Interest, Fed Pgms	State Share Realized, with Interest, Fed Pgms	Federal Share, Fed Pgms	State Share Realized, w/ Int + Fed Share, Fed Pgms	Total Realized, Fed and State Pgms	Sought: State & Fed Pgms, After Int & Relator Fees	Comments
Recoveries Realized by Criminal Charges																					
MF200 559	Norma Yvette Johnson	4.19		12/31/2013	Medicaid	Crim								1,200.00	0.00	1,200.00	0.00	1,200.00	1,200.00	1,200.00	
MF200 820	Bertha Levine Tinsley (B Turner)	4.19		9/30/2013	Medicaid	Crim								150.00	0.00	150.00	0.00	150.00	150.00	150.00	
MF200 820	Bertha Levine Tinsley (B Turner)	4.19		12/31/2013	Medicaid	Crim								59.00	0.00	59.00	0.00	59.00	59.00	59.00	
MF200 820	Bertha Levine Tinsley (P Toby)	4.19		9/30/2013	Medicaid	Crim								300.00	0.00	300.00	0.00	300.00	300.00	300.00	
MF200 927	Kathleen Dunn	4.19	5/7/2014	6/30/2014	Medicaid	Crim								9,469.00	0.00	9,469.00	0.00	9,469.00	9,469.00	9,469.00	
MF200 946	Tomala Jones	4.26		9/30/2013	Medicaid	Crim								336.78	0.00	336.78	0.00	336.78	336.78	336.78	
MF200 946	Tomala Jones	4.26		12/31/2013	Medicaid	Crim								224.55	0.00	224.55	0.00	224.55	224.55	224.55	
2010-00116	Shari Shoes, LLC	4.15		9/30/2013	Medicaid	Crim								4,100.01	0.00	4,100.01	0.00	4,100.01	4,100.01	4,100.01	
2010-00116	Shari Shoes, LLC	4.15		12/31/2013	Medicaid	Crim								4,100.01	0.00	4,100.01	0.00	4,100.01	4,100.01	4,100.01	
2010-00116	Shari Shoes, LLC	4.15		3/31/2014	Medicaid	Crim								2,733.32	0.00	2,733.32	0.00	2,733.32	2,733.32	2,733.32	
2010-00116	Shari Shoes, LLC	4.15		6/30/2014	Medicaid	Crim								4,100.01	0.00	4,100.01	0.00	4,100.01	4,100.01	4,100.01	
2011-00072	Stevenn Daessner	4.19	2/19/2014	3/31/2014	Medicaid	Crim			6,000.00		6,000.00			6,000.00	0.00	6,000.00	0.00	6,000.00	6,000.00	6,000.00	
2012-00097	Alan Bradley (Deborah)	4.10	12/23/2013	12/31/2013	Medicaid	Crim			2,600.00		2,600.00			2,600.00	0.00	2,600.00	0.00	2,600.00	2,600.00	2,600.00	
2012-00097	Alan Bradley (Deborah)	4.10	2/3/2014	3/31/2014	Medicaid	Crim			500.00		500.00			500.00	0.00	500.00	0.00	500.00	500.00	500.00	
2012-00097	Alan Bradley (Deborah)	4.10	2/4/2014	3/31/2014	Medicaid	Crim			500.00		500.00			500.00	0.00	500.00	0.00	500.00	500.00	500.00	
2012-00097	Alan Bradley (Deborah)	4.10	3/12/2014	3/12/2014	Medicaid	Crim			500.00		500.00			500.00	0.00	500.00	0.00	500.00	500.00	500.00	
2012-00097	Alan Bradley (Deborah)	4.10	5/16/2014	6/30/2014	Medicaid	Crim			1,000.00		1,000.00			1,000.00	0.00	1,000.00	0.00	1,000.00	1,000.00	1,000.00	
2012-00192	Meridian Manor	4.33	8/28/2013	9/30/2013	Medicaid	Crim			140,171.47		140,171.47			0.00	0.00	0.00	0.00	0.00	0.00	0.00	

Case Nbr	Case Name	OIG Prov Type	Date of Record	QSR (6-5) Qtrly Rpt	Program	Crim/ Settlmt/ Judgmt	State Programs Sought	State Programs Collected	State Share Sought, Fed Pgms	Federal Share Sought, Fed Pgms	Aggregate Fed & State, Fed Pgms Before Int & Relator Fee	Relator Fee, Fed Pgms	Net State Share Sought, Fed Pgms	State Share Realized Before Interest, Fed Pgms	Interest, Fed Pgms	State Share Realized, with Interest, Fed Pgms	Federal Share, Fed Pgms	State Share Realized, w/ Int + Fed Share, Fed Pgms	Total Realized, Fed and State Pgms	Sought: State & Fed Pgms, After Int & Relator Fees	Comments
2012-00204	Cyril W. Pham - R. Luzietti MD [Eric Jimenez]	4.06	8/27/2013	9/30/2013	Medicaid	Crim			50.00		50.00			50.00	0.00	50.00	0.00	50.00	50.00	50.00	Fine
2012-00204	Cyril W. Pham - R. Luzietti MD [John C. Rosado]	4.06	7/24/2013	9/30/2013	Medicaid	Crim			25.00		25.00			25.00	0.00	25.00	0.00	25.00	25.00	25.00	Fine
2013-00028	Catherine A Reardon	4.10	10/16/2013	12/31/2013	Medicaid	Crim			3,499.12		3,499.12			3,499.12	0.00	3,499.12	0.00	3,499.12	3,499.12	3,499.12	
	Totals, Recoveries Realized by Criminal Charges:								154,845.59		154,845.59			41,446.80	0.00	41,446.80	0.00	41,446.80	41,446.80	41,446.80	
	Recoveries Realized by Judgments																				
MF2005589	Norma Yvette Johnson	4.19		3/31/2014		Judgmt			98,844.00		98,844.00			0.00	0.00	0.00	0.00	0.00	0.00	0.00	
	Totals, Recoveries Realized by Judgments:								98,844.00		98,844.00			0.00	0.00	0.00	0.00	0.00	0.00	0.00	
	Recoveries Realized by Settlements																				
MFG 09009	Janssen Pharmaceuticals (Risperdal) #07-02-03	4.14	9/10/2013	9/30/2013	Medicaid	Settlmt			9,659,729.28	9,838,384.35	19,498,113.63	1,532.58	9,658,196.70	9,658,196.70	158,675.94	9,816,872.64	9,838,384.35	19,655,256.99	19,655,256.99	19,655,256.99	
MFG 09009	Janssen Pharmaceuticals (Risperdal) #07-02-03	4.14	11/18/2013	12/31/2013	State Pgms	Settlmt	475,000.00	475,000.00											475,000.00	475,000.00	
MFG 09014	Endo Pharmaceuticals, Inc (Lidoderm) #09-06-03	4.14	2/18/2014	3/31/2014	Medicaid	Settlmt			533,404.72	546,680.76	1,080,085.48	0.00	533,404.72	533,404.72	7,429.77	540,834.49	546,680.76	1,087,515.25	1,087,515.25	1,087,515.25	
MFG 09014	Endo Pharmaceuticals, Inc (Lidoderm) #09-06-03	4.14	2/18/2014	3/31/2014	State Pgms - Outcome	Settlmt	79,973.67	79,973.67											79,973.67	79,973.67	
MFG 09015	Amgen, Inc I (Aranesp, Enbrel, Epogen et alia)	4.14	12/21/2012	9/30/2013	State Pgms - Rcpt/Collect	Settlmt		80,000.00											80,000.00	0.00	

Case Nbr	Case Name	OIG Prov Type	Date of Record	QSR (6-5) Qtrly Rpt	Program	Crim/ Settlmt/ Judgmt	State Programs Sought	State Programs Collected	State Share Sought, Fed Pgms	Federal Share Sought, Fed Pgms	Aggregate Fed & State, Fed Pgms Before Int & Relator Fee	Relator Fee, Fed Pgms	Net State Share Sought, Fed Pgms	State Share Realized Before Interest, Fed Pgms	Interest, Fed Pgms	State Share Realized, with Interest, Fed Pgms	Federal Share, Fed Pgms	State Share Realized, w/ Int + Fed Share, Fed Pgms	Total Realized, Fed and State Pgms	Sought: State & Fed Pgms, After Int & Relator Fees	Comments
2010-00091	Dava Pharmaceutical, Inc. (Clarithromycin et alia)	4.14	5/3/2013	9/30/2013	Medicaid - Rcpt/Collect	Settlmt								16,256.68	867.93	17,124.61	0.00	17,124.61	17,124.61	17,124.61	
2010-00233	ISTA Pharmaceuticals Inc (Xibrom) #12-08-01	4.14	7/16/2013	9/30/2013	Medicaid - Rcpt/Collect	Settlmt								7,086.93	54.01	7,140.94	7,926.19	15,067.13	15,067.13	15,067.13	
2010-00233	ISTA Pharmaceuticals Inc (Xibrom) #12-08-01	4.14	7/5/2013	9/30/2013	State Pgms - Rcpt/Collect	Settlmt		6,262.00											6,262.00	0.00	
2010-00279	Ranbaxy Laboratories	4.14	6/21/2013	9/30/2013	State Pgms - Rcpt/Collect	Settlmt		227,080.46											227,080.46	0.00	
2011-00073	WellCare	4.23	3/31/2014	3/31/2014	Medicaid - Rcpt/Collect	Settlmt								390,473.53	24,404.60	414,878.13	399,798.75	814,676.88	814,676.88	814,676.88	
2011-00287	KV Pharmaceutical Co. (Hyoscyamine & Nitroglycerin)	4.14	9/30/2013	9/30/2013	Medicaid - Rcpt/Collect	Settlmt			676.48	0.00	676.48	0.00	676.48	15,316.26	248.06	15,564.32	0.00	15,564.32	15,564.32	15,564.32	
2013-00005	Sanofi US (Hyalgan) #12-11-02	4.14	9/4/2013	9/30/2013	Medicaid - Rcpt/Collect	Settlmt			-6.12	6.12	0.00		-6.12	852.61	6.12	858.73	855.18	1,713.91	1,713.91	1,713.91	
2013-00037	Novartis Pharma Corp., ET AL., (Exjade & Myfortic) [BioScrip]	4.14	1/27/2014	3/31/2014	Medicaid - Outcome	Settlmt			55,644.36	55,534.34	111,178.70	6,691.57	48,952.79	9,790.55	137.09	9,927.64	55,534.34	65,461.98	65,461.98	65,461.98	
2013-00037	Novartis Pharma Corp., ET AL., (Exjade & Myfortic) [BioScrip]	4.14	2/13/2014	3/31/2014	State Pgms - Rcpt/Collect	Settlmt	2,839.69	2,839.69											2,839.69	2,839.69	

Connecticut Medicaid Fraud Control Unit
Medicaid Joint Report - 6/30/2014
(c)(5) Monetary Recovery Sought and Realized

Case Nbr	Case Name	OIG Prev Type	Date of Record	QSR (6-5) Qtrly Rpt	Program	Crim/ Settlmt/ Judgmt	State Programs Sought	State Programs Collected	State Share Sought, Fed Pgms	Federal Share Sought, Fed Pgms	Aggregate Fed & State, Fed Pgms Before Int & Relator Fee	Relator Fee, Fed Pgms	Net State Share Sought, Fed Pgms	State Share Realized Before Interest, Fed Pgms	Interest, Fed Pgms	State Share Realized, with Interest, Fed Pgms	Federal Share, Fed Pgms	State Share Realized, w/ Int + Fed Share, Fed Pgms	Total Realized, Fed and State Pgms	Sought: State & Fed Pgms, After Int & Relator Fees	Comments
2013-00100	Novartis (Vicudyne) #13-05-01	4.14	3/19/2014	3/31/2014	Medicaid - Outcome	Settlmt			4,440.43	4,534.99	8,975.42	0.00	4,440.43	4,440.43	0.00	4,440.43	4,534.99	8,975.42	8,975.42	8,975.42	
2013-00129	Wyeth (Rapamune) #12-01-01	4.14	8/5/2013	9/30/2013	Medicaid - Rcpt/Coll oct	Settlmt								297,520.69	2,772.29	300,292.98	347,648.15	647,941.13	647,941.13	647,941.13	
2013-00129	Wyeth (Rapamune) #12-01-01	4.14	8/5/2013	9/30/2013	State Pgms - Rcpt/Coll oct	Settlmt		127,778.02											127,778.02	0.00	
2013-00283	CareFusion Corporation	4.14	12/23/2013	12/31/2013	Medicaid - Outcome	Settlmt			76,859.90	58,573.32	135,433.22	5,286.94	71,572.96	71,572.96	620.04	72,193.00	58,573.32	130,766.32	130,766.32	130,766.32	
2014-00006	Genzyme Corp	4.15	1/9/2014	3/31/2014	Medicaid - Outcome	Settlmt			17,453.86	18,116.20	35,570.06	866.84	16,587.02	16,587.02	255.42	16,842.44	18,116.20	34,958.64	34,958.64	34,958.64	
2014-00043	Omnicare - Aranesp #13-11-01	4.13	2/24/2014	3/31/2014	Medicaid - Outcome	Settlmt			39,669.46	40,227.16	79,896.62	0.00	39,669.46	39,669.46	202.20	39,871.66	40,227.16	80,098.82	80,098.82	80,098.82	
2014-00043	Omnicare - Aranesp #13-11-01	4.13	2/24/2014	3/31/2014	State Pgms - Outcome	Settlmt	6,838.79	6,838.79											6,838.79	6,838.79	
2014-00080	Astellas Pharma US, Inc. (Mycamine)	4.14	5/2/2014	6/30/2014	Medicaid - Outcome	Settlmt			2,026.60	2,172.36	4,198.96	157.40	1,869.20						0.00	0.00	
	Totals, Recoveries Realized by Settlements:						$64,652.15	1,005,772.63	10,389,898.97	10,564,229.60	20,954,128.57	14,535.33	10,375,363.64	11,061,168.54	195,673.47	11,256,842.01	11,318,279.39	22,575,121.40	23,580,894.03	23,139,773.55	
	Totals, Recoveries Realized by Criminal Charges, Judgments & Settlements:						$64,652.15	1,005,772.63	10,643,588.56	10,564,229.60	21,207,818.16	14,535.33	10,375,363.64	11,102,615.34	195,673.47	11,298,288.81	11,318,279.39	22,616,568.20	23,622,340.83	23,181,220.35	

Connecticut Medcaid Fraud Control Unit
Medicaid Joint Report - 6/30/2014
(c)(6) Number of Referrals Declined and Reason

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Reason Declined	Count
Insufficient Evidence	2
Lack of Jurisdiction	7
No Criminal Aspect	4
No Damages	1
No Medicaid Aspect	6
Reguatory Matter	4
Total, Declined Referrals / Complaints:	**24**

Office of the Chief State's Attorney
State of Connecticut
Medicaid Fraud Control Unit
Annual General Assembly Medicaid Joint Report
Fiscal Year July 1, 2013 – June 30, 2014

UNIT CERTIFICATION AND PERFORMANCE STANDARDS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

AUG 14 2014

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

Dear Mr. Godialis: Chris —

As part of the recertification process, we have reviewed the following documentation submitted by your office: (1) the Medicaid Fraud Control Unit (MFCU) annual report, (2) the MFCU's quarterly statistical reports, and (3) the responses to the Office of Inspector General (OIG) recertification questionnaire submitted by the MFCU. In addition, we also reviewed the responses to the questionnaire submitted by Office of Inspector General (OIG), Office of Investigations, Boston Regional Office, and the Connecticut Department of Social Services.

Pursuant to 42 CFR § 1007.15, we have concluded that the Connecticut unit meets the Federal requirements for operation of a State MFCU. This recertification covers a 1 year period beginning August 15, 2014 and ends August 14, 2015. A reapplication for recertification should be submitted to OIG by June 15, 2015.

If you have any questions or concerns regarding your unit's recertification, please contact Thomas W. Brannon II at (202) 619-2547.

Sincerely,

Richard Stern

Richard Stern
Director, Medicaid Fraud Policy
Oversight Division

APPENDIX A

2012 Revised Performance Standards[27]

1. **A unit conforms with all applicable statutes, regulations, and policy directives, including:**
   a. Section 1903(q) of the Social Security Act, containing the basic requirements for operation of a MFCU;
   b. Regulations for operation of a MFCU contained in 42 CFR part 1007;
   c. Grant administration requirements at 45 CFR part 92 and Federal cost principles at 2 CFR part 225;
   d. OIG policy transmittals as maintained on the OIG Web site; and
   e. Terms and conditions of the notice of the grant award.
2. **A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.**
   a. The Unit employs the number of staff that is included in the Unit's budget estimate as approved by OIG.
   b. The Unit employs a total number of professional staff that is commensurate with the State's total Medicaid program expenditures and that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
   c. The Unit employs an appropriate mix and number of attorneys, auditors, investigators, and other professional staff that is both commensurate with the State's total Medicaid program expenditures and that allows the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
   d. The Unit employs a number of support staff in relation to its overall size that allows the Unit to operate effectively.
   e. To the extent that a Unit maintains multiple office locations, such locations are distributed throughout the State, and are adequately

[27] 77 Fed. Reg. 32645, June 1, 2012.

staffed, commensurate with the volume of case referrals and workload for each location.

3. **A Unit establishes written policies and procedures for its operations and ensures that staff are familiar with, and adhere to, policies and procedures.**

   a. The Unit has written guidelines or manuals that contain current policies and procedures, consistent with these performance standards, for the investigation and (for those Units with prosecutorial authority) prosecution of Medicaid fraud and patient abuse and neglect.

   b. The Unit adheres to current policies and procedures in its operations.

   c. Procedures include a process for referring cases, when appropriate, to Federal and State agencies. Referrals to State agencies, including the State Medicaid agency, should identify whether further investigation or other administrative action is warranted, such as the collection of overpayments or suspension of payments.

   d. Written guidelines and manuals are readily available to all Unit staff, either online or in hard copy.

   e. Policies and procedures address training standards for Unit employees.

4. **A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.**

   a. The Unit takes steps, such as the development of operational protocols, to ensure that the State Medicaid agency, managed care organizations, and other agencies refer to the Unit all suspected provider fraud cases. Consistent with 42 CFR 1007.9(g), the Unit provides timely written notice to the State Medicaid agency when referred cases are accepted or declined for investigation.

   b. The Unit provides periodic feedback to the State Medicaid agency and other referral sources on the adequacy of both the volume and quality of its referrals.

   c. The Unit provides timely information to the State Medicaid or other agency when the Medicaid or other agency requests information on the status of MFCU investigations, including when the Medicaid agency requests quarterly certification pursuant to 42 CFR 455.23(d)(3)(ii).

d. For those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases, the Unit takes steps, such as the development of operational protocols, to ensure that pertinent agencies refer such cases to the Unit, consistent with patient confidentiality and consent. Pertinent agencies vary by State but may include licensing and certification agencies, the State Long Term Care Ombudsman, and adult protective services offices.

e. The Unit provides timely information, when requested, to those agencies identified in (d) above regarding the status of referrals.

f. The Unit takes steps, through public outreach or other means, to encourage the public to refer cases to the Unit.

5. A Unit takes steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases.

a. Each stage of an investigation and prosecution is completed in an appropriate timeframe.

b. Supervisors approve the opening and closing of all investigations and review the progress of cases and take action as necessary to ensure that each stage of an investigation and prosecution is completed in an appropriate timeframe.

c. Delays to investigations and prosecutions are limited to situations imposed by resource constraints or other exigencies.

6. A Unit's case mix, as practicable, covers all significant provider types and includes a balance of fraud and, where appropriate, patient abuse and neglect cases.

a. The Unit seeks to have a mix of cases from all significant provider types in the State.

b. For those States that rely substantially on managed care entities for the provision of Medicaid services, the Unit includes a commensurate number of managed care cases in its mix of cases.

c. The Unit seeks to allocate resources among provider types based on levels of Medicaid expenditures or other risk factors. Special Unit initiatives may focus on specific provider types.

d. As part of its case mix, the Unit maintains a balance of fraud and patient abuse and neglect cases for those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases.

e. As part of its case mix, the Unit seeks to maintain, consistent with its legal authorities, a balance of criminal and civil fraud cases.

7. **A Unit maintains case files in an effective manner and develops a case management system that allows efficient access to case information and other performance data.**

   a. Reviews by supervisors are conducted periodically, consistent with MFCU policies and procedures, and are noted in the case file.

   b. Case files include all relevant facts and information and justify the opening and closing of the cases.

   c. Significant documents, such as charging documents and settlement agreements, are included in the file.

   d. Interview summaries are written promptly, as defined by the Unit's policies and procedures.

   e. The Unit has an information management system that manages and tracks case information from initiation to resolution.

   f. The Unit has an information management system that allows for the monitoring and reporting of case information, including the following:

      1. The number of cases opened and closed and the reason that cases are closed.

      2. The length of time taken to determine whether to open a case referred by the State Medicaid agency or other referring source.

      3. The number, age, and types of cases in the Unit's inventory/docket.

      4. The number of referrals received by the Unit and the number of referrals by the Unit to other agencies.

      5. The dollar amount of overpayments identified.

      6. The number of cases criminally prosecuted by the Unit or referred to others for prosecution, the number of individuals or entities charged, and the number of pending prosecutions.

      7. The number of criminal convictions and the number of civil judgments.

      8. The dollar amount of fines, penalties, and restitution ordered in a criminal case and the dollar amount of

recoveries and the types of relief obtained through civil judgments or prefiling settlements.

8. **A Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health care fraud.**

   a. The Unit communicates on a regular basis with OIG and other Federal agencies investigating or prosecuting health care fraud in the State.

   b. The Unit cooperates and, as appropriate, coordinates with OIG's Office of Investigations and other Federal agencies on cases being pursued jointly, cases involving the same suspects or allegations, and cases that have been referred to the Unit by OIG or another Federal agency.

   c. The Unit makes available, to the extent authorized by law and upon request by Federal investigators and prosecutors, all information in its possession concerning provider fraud or fraud in the administration of the Medicaid program.

   d. For cases that require the granting of "extended jurisdiction" to investigate Medicare or other Federal health care fraud, the Unit seeks permission from OIG or other relevant agencies under procedures as set by those agencies.

   e. For cases that have civil fraud potential, the Unit investigates and prosecutes such cases under State authority or refers such cases to OIG or the U.S. Department of Justice.

   f. The Unit transmits to OIG, for purposes of program exclusions under section 1128 of the Social Security Act, all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders.

   g. The Unit reports qualifying cases to the Healthcare Integrity & Protection Databank, the National Practitioner Data Bank, or successor data bases.

9. **A Unit makes statutory or programmatic recommendations, when warranted, to the State government.**

   a. The Unit, when warranted and appropriate, makes statutory recommendations to the State legislature to improve the operation of the Unit, including amendments to the enforcement provisions of the State code.

b. The Unit, when warranted and appropriate, makes other regulatory or administrative recommendations regarding program integrity issues to the State Medicaid agency and to other agencies responsible for Medicaid operations or funding. The Unit monitors actions taken by the State legislature and the State Medicaid or other agencies in response to recommendations.

10. **A Unit periodically reviews its MOU with the State Medicaid agency to ensure that it reflects current practice, policy, and legal requirements.**

a. The MFCU documents that it has reviewed the MOU at least every 5 years, and has renegotiated the MOU as necessary, to ensure that it reflects current practice, policy, and legal requirements.

b. The MOU meets current Federal legal requirements as contained in law or regulation, including 42 CFR 455.21, "Cooperation with State Medicaid fraud control units," and 42 CFR 455.23, "Suspension of payments in cases of fraud."

c. The MOU is consistent with current Federal and State policy, including any policies issued by OIG or the Centers for Medicare & Medicaid Services (CMS).

d. Consistent with Performance Standard 4, the MOU establishes a process to ensure the receipt of an adequate volume and quality of referrals to the Unit from the State Medicaid agency.

e. The MOU incorporates by reference the CMS Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit.

11. **A Unit exercises proper fiscal control over Unit resources.**

a. The Unit promptly submits to OIG its preliminary budget estimates, proposed budget, and Federal financial expenditure reports.

b. The Unit maintains an equipment inventory that is updated regularly to reflect all property under the Unit's control.

c. The Unit maintains an effective time and attendance system and personnel activity records.

d. The Unit applies generally accepted accounting principles in its control of Unit funding.

e. The Unit employs a financial system in compliance with the standards for financial management systems contained in 45 CFR 92.20.

12. A Unit conducts training that aids in the mission of the Unit.

a. The Unit maintains a training plan for each professional discipline that includes an annual minimum number of training hours and that is at least as stringent as required for professional certification.

b. The Unit ensures that professional staff comply with their training plans and maintain records of their staff's compliance.

c. Professional certifications are maintained for all staff, including those that fulfill continuing education requirements.

d. The Unit participates in MFCU related training, including training offered by OIG and other MFCUs, as such training is available and as funding permits.

e. The Unit participates in cross training with the fraud detection staff of the State Medicaid agency. As part of such training, Unit staff provide training on the elements of successful fraud referrals and receive training on the role and responsibilities of the State Medicaid agency.

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The Office of the Connecticut Attorney General ("CT OAG") has primary responsibility for enforcing the Connecticut False Claims Act, Conn. Gen. Stat. §17b-301a, *et seq.*, as amended by 2014 Conn. Public Acts #14-217, §§ 1-18, 257, (the "Act"), which provides, *inter alia*, a civil cause of action to recover treble damages incurred by certain Connecticut healthcare-related programs due to the submission of fraudulent and false claims. The CT OAG's Antitrust and Government Program Fraud Department has operational responsibility for the conduct of investigations and civil enforcement actions under the Act. The CT OAG's mission here is to protect Connecticut's health and human service programs from fraudulent, wasteful and abusive schemes.

The primary focus of the CT OAG's health care fraud efforts is to detect, investigate and civilly prosecute health care provider fraud that results in financial loss to the State of Connecticut's health and human services' programs, including the Connecticut Medical Assistance Program (of which Medicaid is a part). The CT OAG develops cases independently and in conjunction with other state and federal law enforcement and regulatory agencies. CT OAG staffing for these efforts includes Assistant Attorneys General, Forensic Fraud Examiners and Legal Investigators.

The data required by Conn. Gen. Stat. §17b-99(d) is presented in the attached report. In addition, in accordance with Conn. Gen. Stat. §17b-99(f) the CT OAG provides the following information:

1. Operational Protocols

The CT OAG utilizes a number of operational protocols to ensure it conducts its investigations efficiently and effectively, and utilizes the relevant tools at its disposal to obtain and assess probative information garnered through the investigation in order to reach the appropriate disposition in a given matter.

Among these protocols are:

a) Intake and assessment of agency referrals and complaints – the CT OAG follows a uniform approach in evaluating referrals it receives from federal and state agencies along with complaints from the public and other sources. Among the factors considered in opening an investigation are whether the allegations have indicia of reliability, the potential loss to the Medicaid program resulting from the alleged violation, and resource constraints. The CT OAG's practice is to accept or reject a referral from the DSS within forty-five (45) days from receipt of the referral, although such decisions are usually made within a shorter time period.

b) Development of investigative plans – At the beginning of each investigation assigned investigative staff will develop an investigative plan, which will be refined and updated as necessary. Where appropriate, investigative plans are developed in coordination with other agencies that may also be investigating the same matter (typically the Chief State's Attorney's Medicaid Fraud Control Unit and/or the U.S. Department of Health and Human Services Office of the Inspector General/Office of Investigations).

c) Appropriate use of compulsory process to obtain documents and/or testimony – Where necessary subpoenas duces tecum (documents) and subpoenas ad testificandum (testimony) are utilized to obtain relevant information and evidence, and determine whether (i) there is a violation, (ii) the matter should be closed, or (iii) an alternate disposition is appropriate.

d) Regular status meetings with investigative staff – investigative staff meet with the assigned AAGs and the Chief of the department 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 CT OAG does not incorporate projected cost savings or recoveries into its long range operational plans. Rather, as discussed above, specific investigations are pursued based upon the indicia of reliability of the allegations, the quality of the evidence developed, and if the investigation leads to a basis for believing that there is a false claims violation, the potential for recovery to the Medicaid program, along with resource constraints. Similarly, the amount of Medicaid spend may be a factor in identifying specific data mining initiatives to develop new avenues of investigation (see subsection 3(c), below).

3. New Initiatives

During the past fiscal year the CT OAG has embarked on a number of new initiatives to identify, investigate, civilly prosecute and recover Medicaid program funds lost due to fraud, waste and abuse. Many of these initiatives are developed and conducted jointly with various federal and state agencies. Others are developed unilaterally within the CT OAG.

Among the initiatives implemented and/or further developed during this fiscal year are:

a) Training – general and specialized training programs exist in the marketplace that will assist in enhancing the knowledge and skillset of the CT OAG's staff and better prepare the staff for its mission. Accordingly, the CT OAG is exploring options for additional training for its attorneys, forensic fraud examiners and investigators. Training programs that might be suitable for staff training are offered by, *e.g.*, the National Association of Medicaid Fraud Control Units, the U.S. Department of Justice's Medicaid Integrity Institute, and the National Health Care Anti-Fraud Association.

b) Liaison/coordination with private health care payors – the CT OAG is renewing an emphasis on strengthening its relationships with private payors and

establishing formal and informal procedures to share intelligence in an effort to identify additional referral and investigational leads.

c) Intelligence driven investigations – through its access to a third-party data analytic consultant contracted with the Office of Policy Management and the Department of Social Services, the CT OAG is placing greater emphasis on undertaking pro-active, intelligence driven investigations that utilize sophisticated data mining techniques and social network analysis. This new capability will assist the OAG and its partner agencies in identifying new health care sectors for analysis and possible investigation and/or potential specific fraudulent conduct for further investigation.

d) Unified state complaint website – the CT OAG is working with various state agencies to develop and launch a unified fraud reporting website to provide a "one stop" source to make it easier for the public to report fraud. The website's content will identify the types of fraudulent conduct or false claims that impact state programs (i.e., healthcare, tax, competition) and examples of the conduct that may be violations of law. The website will also enhance the public's ability to direct the complaint to the most appropriate agency.

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Medicaid Joint Report

Number of investigations opened by source type:

CT - DDS	1
CT - DPH	10
DSS	13
NAMFCU	22
Other	3
Private Citizen	1
Qui Tam Relator	66
US HHS-OIG	3

Total investigations opened: 119

General nature of allegations by provider type:

Provider type: All Other Providers - 98 — **Total:** 4

Nature of Allegations	Count
Diverting public assistance benefits	1
Overcharging	1
Quality of care	2

Provider type: Behavioral Health Clinician Group - 86 — **Total:** 3

Nature of Allegations	Count
Excessive services	1
Overcharging	2

Provider type: Behavioral Health Clinician- 33 — **Total:** 1

Nature of Allegations	Count
Services not rendered	1

Provider type: CT Home Care Program Performing Provider- 58 — **Total:** 1

Nature of Allegations	Count

Overcharging	1

Provider type: Dentist Group- 76 **Total:** 4

Nature of Allegations	Count
Services not medically necessary	3
Services not rendered	1

Provider type: Dentist- 27 **Total:** 1

Nature of Allegations	Count
Excessive services	1

Provider type: DME/Medical Supply Dealer- 25 **Total:** 2

Nature of Allegations	Count
Falsified records	1
Licensing non-compliance	1

Provider type: Extended Care Facility- 03 **Total:** 4

Nature of Allegations	Count
Quality of care	3
Upcoding	1

Provider type: General Hospital - 01 **Total:** 5

Nature of Allegations	Count
Quality of care	2
Safety/Quality Control	1
Services not medically necessary	2

Provider type: Home Health Agency- 05 **Total:** 4

Nature of Allegations	Count
Falsified records	1
Licensing non-compliance	1
Quality of care	2

Provider type: Laboratory- 28 **Total:** 5

Nature of Allegations	Count
Falsified records	1
Kickbacks	2
Services not medically necessary	2

Provider type: Managed Care Organization Federally Licensed Health Plan - 85 **Total:** 2

Nature of Allegations	Count
Kickbacks	1
Overcharging	1

Provider type: Pharmaceutical/ medical device company **Total:** 59

Nature of Allegations	Count
False reporting of price	5
Kickbacks	11

Medicaid rebate underpayment	1
Off-label marketing	22
Overcharging	2
Quality of care	1
Safety/Quality Control	11
Services not medically necessary	4
Upcoding	2

Provider type: Pharmacy- 24 **Total:** 12

Nature of Allegations	Count
Kickbacks	4
Most favored nation pricing	3
Overcharging	2
Retaining overpayments	2
Services not medically necessary	1

Provider type: Physician Group- 72 **Total:** 3

Nature of Allegations	Count
Overcharging	1
Retaining overpayments	1
Services not medically necessary	1

Provider type: Physician- 31 **Total:** 8

Nature of Allegations	Count
Excessive services	4
Excluded provider violation	1
Multiple billing	1
Overcharging	1
Upcoding	1

Provider type: Residential Care Home **Total:** 1

Nature of Allegations	Count
Quality of care	1

Length of investigation for each case closed during reporting period:

Matter Number	Matter Name	Less than one month to six months	Seven months to twelve months	Thirteen months to twenty-four months	Twenty-five or more months
422887	GENZYME (SEPRAFILM) GLOBAL			✓	
424608	PFIZER / WYETH (RAPAMUNE) GLOBAL			✓	
427756	CONFIDENTIAL MATTER AND/OR UNDER SEAL			✓	
427836	KMART GLOBAL				✓
427980	ENDO PHARMACEUTICALS (LIDODERM) GLOBAL				✓
428756	ATYPICAL ANTI-PSYCHOTICS (GLOBAL)				✓
429257	CONFIDENTIAL MATTER AND/OR UNDER SEAL			✓	
438774	CONFIDENTIAL MATTER AND/OR UNDER SEAL			✓	
439919	CAREFUSION GLOBAL			✓	
439920	SANOFI (HYALGAN) GLOBAL		✓		
447388	ISTA PHARMACEUTICALS (XIBROM) GLOBAL				✓
462375	CONFIDENTIAL MATTER AND/OR UNDER SEAL	✓			
463505	OMNICARE (ARANESP) GLOBAL	✓			
466375	CONFIDENTIAL MATTER AND/OR UNDER SEAL			✓	
466378	CONFIDENTIAL MATTER AND/OR UNDER SEAL		✓		
466379	MAXIM HEALTHCARE SERVICES	✓			
466380	CONFIDENTIAL MATTER AND/OR UNDER SEAL	✓			
466405	CONFIDENTIAL MATTER AND/OR UNDER SEAL		✓		
466406	CONFIDENTIAL MATTER AND/OR UNDER SEAL		✓		
466407	CONFIDENTIAL MATTER AND/OR UNDER SEAL	✓			
466408	CONFIDENTIAL MATTER AND/OR UNDER SEAL	✓			
468366	CONFIDENTIAL MATTER AND/OR UNDER SEAL	✓			
469831	CONFIDENTIAL MATTER AND/OR UNDER SEAL	✓			
900100	US ex rel Templin v. Pfizer, Inc.				✓
900104	US ex rel Kirk v. Carefusion Corporation				✓
900125	US ex rel Wiegman v. Novartis Pharmaceuticals				✓
900127	US ex rel Tun v. St Jude Medical, Inc.				✓
900128	US ex rel Worsfold v Pfizer, Inc.				✓
900136	US ex rel Barry v. Ortho-McNeil-Janssen Pharma				✓
900138	US ex rel O'Keefe v Pfizer, Inc.				✓

900148	US ex rel Pathology Comp. v Middlesex Hospital				✓
900165	US ex rel DJ Partnership v. Ista Pharmaceuticals				✓
900175	US ex rel Rahimi v. Walgreen Co.				✓
900194	US ex rel Wolfson v. Park Avenue Medical Assoc.				✓
900200	US ex rel Klotz v. Eli Lilly & Company (Strattera)				✓
900224	US ex rel Kirk v Carefusion Corporation				✓
900235	US ex rel Hamilton v. Sanofi SA			✓	
900240	US ex rel McEnroe v. Pfizer, Inc.			✓	
900242	US ex rel Marquis v. Omniguide, Inc.			✓	
900245	US ex rel Hammoud v. Walgreen Co.			✓	
900252	US ex rel Andreozzi v. Assurex Health, Inc.			✓	
900255	US ex rel Andreozzi v. Eli Lilly and Company			✓	
900257	US ex rel Critz v Prostrakan, Inc.			✓	
900262	Dava Pharmaceutical global settlement				✓
900266	US ex rel Hussain v Astellas			✓	
900272	US ex rel Giordano v. CSL Behring US			✓	
900287	US ex rel Furchak vl. Insys Therapeutics		✓		
900296	US ex rel Doe v Novartis Pharmaceuticals			✓	
900312	US ex rel Severn v. Avella Specialty Pharmacy		✓		
900336	US ex rel Nathan v. Takeda			✓	
900350	Wyeth/ Pfizer (Rapamune) Global Settlement			✓	
900361	Sanofi (Hyalgan) Global Settlement		✓		
900398	Omnicare (Aranesp) Global	✓			
900042	US ex rel Starr v. Janssen Pharmaceutical Products				✓
900053	US ex rel Murphy v. Actelion LTD				✓
900058	US ex rel Weathersby v. Endo Pharmaceuticals, Inc.				✓
900081	US ex rel Fuentes v. Genzyme Corporation				✓
AF1404276	CONFIDENTIAL MATTER AND/OR UNDER SEAL	✓			
AF1404245	CONFIDENTIAL MATTER AND/OR UNDER SEAL	✓			
		Less than one month to six months	Seven months to twelve months	Thirteen months to twenty-four months	Twenty-five or more months
	Total matters by time range:	**11**	**7**	**19**	**22**

Final Disposition by provider type:

Provider Type	Disposition	Count
All Other Providers - 98	No Action Required	5
	Referred to Another Agency	1

Provider Type	Disposition	Count
Extended Care Facility- 03	No Action Required	2
	Settlement Agreement	1

Provider Type	Disposition	Count
General Hospital - 01	No Action Required	1
	Referred to Another Agency	1

Provider Type	Disposition	Count
Home Health Agency- 05	No Action Required	2
	Referred to Another Agency	1

Provider Type	Disposition	Count
Pharmaceutical/ medical device company	Appeal-Dismissed	1
	Dismissed	1
	False Claims- withdrawn/dismissed by relator with prejudice	2
	False Claims- withdrawn/dismissed by relator without prejudice	13
	Settlement Agreement	22

Provider Type	Disposition	Count
Pharmacy- 24	False Claims- withdrawn/dismissed by relator without prejudice	4
	No Action Required	1
	Settlement Agreement	2

Provider Type	Disposition	Count
Physician Group- 72	False Claims- withdrawn/dismissed by relator without prejudice	1
	Settlement Agreement	1

Provider Type	Disposition	Count
Unknown - ##	No Action Required	1

Recoveries during report period:

AG Matter Number: 449145 - NOVARTIS (VISUDYNE) GLOBAL

Total Amount per Matter (449145): $8,975.42

Amount Type	Program	Received Date	Amount
Restitution	Medicaid - Federal Share	05/09/2014	$4,534.99
	Medicaid - State Share	05/09/2014	$4,440.43

AG Matter Number: 900042 - UNITED STATES OF AMERICA EX REL. VICTORIA STARR v. JANSSEN PHARMACEUTICAL PRODUCTS, LP

Total Amount per Matter (900042): $20,131,789.57

Amount Type	Program	Received Date	Amount
Restitution	Medicaid - Federal Share	12/09/2013	$9,838,384.35
	Medicaid - State Share	12/09/2013	$9,818,405.22
	State Program Recovery-DSS	11/18/2013	$475,000

AG Matter Number: 900058 - UNITED STATES OF AMERICA, EX REL. MAX H. WEATHERSBY, JR. v. ENDO PHARMACEUTICALS, INC., ENDO PHARMACEUTICALS HOLDINGS, INC., COVENTRY HEALTH CARE, INC., HEALTHSPRING, INC. and JAMES R. "RUSTY" HAILEY

Total Amount per Matter (900058): $1,167,488.92

Amount Type	Program	Received Date	Amount
Restitution	Medicaid - Federal Share	03/17/2014	$546,680.76
	Medicaid - State Share	03/17/2014	$540,834.49
	State Program Recovery-DSS	02/26/2014	$79,973.67

AG Matter Number: 900081 - UNITED STATES OF AMERICA, ex rel. JOSEPH FUENTES and CHRISTOPHER RUSSO v. GENZYME CORPORATION

Total Amount per Matter (900081): $35,825.48

Amount Type	Program	Received Date	Amount
Restitution	Medicaid - Federal Share	03/17/2014	$18,116.2
	Medicaid - State Share	03/17/2014	$17,709.28

AG Matter Number: 900104 - UNITED STATES OF AMERICA ex rel. CYNTHIA KIRK v. CAREFUSION CORPORATION and CARDINAL HEATLH, INC. (Carefusion I)

Total Amount per Matter (900104): $136,053.16

Amount Type	Program	Received Date	Amount
Restitution	Medicaid - Federal Share	01/27/2014	$58,573.32

	Medicaid - State Share	01/27/2014	$77,479.84

AG Matter Number: 900165 - UNITED STATES OF AMERICA, EX REL. DJ PARTNERSHIP, et al. v. ISTA PHARMACEUTICALS, INC.

Total Amount per Matter (900165): $21,714.49

Amount Type	Program	Received Date	Amount
Restitution	Medicaid - Federal Share	07/16/2013	$7,926.19
	Medicaid - State Share	07/16/2013	$7,526.3
	State Program Recovery-DSS	07/05/2013	$6,262

AG Matter Number: 900217 - UNITED STATES OF AMERICA ex rel. DAVID M. KESTER v. NOVARTIS PHARMACEUTICALS CORPORATION, ETC.

Total Amount per Matter (900217): $68,301.67

Amount Type	Program	Received Date	Amount
Restitution	Medicaid - Federal Share	04/23/2014	$55,534.34
	Medicaid - State Share	04/23/2014	$9,927.64
	State Program Recovery-DSS	02/18/2014	$2,839.69

AG Matter Number: 900237 - WellCare global settlement

Total Amount per Matter (900237): $414,878.13

Amount Type	Program	Received Date	Amount
Restitution	Medicaid - State Share	03/31/2014	$414,878.13

AG Matter Number: 900253 - KV Pharma global settlement

Total Amount per Matter (900253): $17,104.84

Amount Type	Program	Received Date	Amount
Restitution	Medicaid - State Share	12/12/2013	$1,220.73
	Medicaid - State Share	03/17/2014	$1,220.73
	Medicaid - State Share	09/25/2013	$13,122.86
	Medicaid - State Share	06/16/2014	$1,540.52

AG Matter Number: 900262 - Dava Pharmaceutical global settlement

Total Amount per Matter (900262): $16,799.34

Amount Type	Program	Received Date	Amount

Restitution	Medicaid - State Share	12/16/2013	$16,148.8
	Medicaid - State Share	08/07/2013	$325.27
	Medicaid - State Share	11/04/2013	$325.27

AG Matter Number: 900350 - Wyeth/ Pfizer (Rapamune) Global Settlement

Total Amount per Matter (900350): $775,719.15

Amount Type	Program	Received Date	Amount
Restitution	Medicaid - Federal Share	08/07/2013	$347,648.15
	Medicaid - State Share	08/07/2013	$300,292.98
	State Program Recovery-DSS	08/05/2013	$127,778.02

AG Matter Number: 900361 - Sanofi (Hyalgan) Global Settlement

Total Amount per Matter (900361): $1,713.91

Amount Type	Program	Received Date	Amount
Restitution	Medicaid - Federal Share	09/04/2013	$855.18
	Medicaid - State Share	09/14/2013	$858.73

AG Matter Number: 900398 - Omnicare (Aranesp) Global

Total Amount per Matter (900398): $86,937.61

Amount Type	Program	Received Date	Amount
Restitution	Medicaid - Federal Share	03/17/2014	$40,227.16
	Medicaid - State Share	03/17/2014	$39,871.66
	State Program Recovery-DSS	06/02/2014	$6,838.79

Recoveries Total from above report: $22,883,301.69

Recoveries Summary during Fiscal Year:

Program	Amount
Medicaid - Federal Share	$10,918,480.64
Medicaid - State Share	$11,266,128.88
State Program Recovery-DSS	$698,692.17
Total Recovery during fiscal year:	$22,883,301.69

State Recovery Summary:

Program	Amount
Medicaid - State Share	$11,261,688.45
Relator A	$-12,363.87
State Program Recovery-DSS	$698,692.17
Net State Recovery:	$11,948,016.75

Note: Net state recovery excluding federal share of Medicaid and deducting state relator shares reported above.

The number of referrals declined for cases closed during reporting period and reason:

Reason Declined	Count
Complaint withdrawn by relator	19
Insufficient damages	1
Insufficient evidence	2
Most appropriately handled by another agency	13

Total number of referral declined: 35