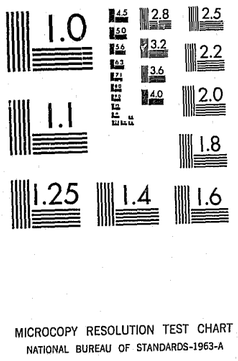

ANNUAL REPORT ··1978··

Charles J. Hynes
Deputy Attorney General

FOURTH ANNUAL REPORT

TO
Hugh L. Carey, Governor
Robert Abrams, Attorney General
The Legislature of the State of New York
The People of the State of New York

FROM
Charles J. Hynes
Deputy Attorney General
for Medicaid Fraud Control

MAY 10, 1979

PROLOGUE

From August of 1974 through the early days of 1975, New Yorkers were barraged daily with horror stories of squalid conditions in nursing homes across the State - stories of sub-standard food, stories of our elderly forced to lay in their own excrement while their bedsores festered unattended. While these stories shocked and disgusted us, what equally outraged us were reports of a wholesale rape of the State and Federal treasuries by thieves who ran so many of these homes and into whose care we had committed our helpless elderly. We heard stories of trips abroad, mink coats, summer homes and swimming pools - all financed by Medicaid dollars.

And, we were further outraged to discover that this scandal was nothing new. Thirteen years earlier in New York City the same thing had occurred and worse. Many of the same people we read about in 1974 were uncovered in 1961. We learned that in 1961 no one was prosecuted. That restitution was limited to 10-20 cents on the dollar. And, incredible as it may seem, these thieves were permitted to remain in business.

In response to these reports and charges, on the 10th day of his new Administration in 1975, Governor Hugh L. Carey created a Moreland Commission under the direction of a distinguished lawyer, the former President of Brandeis University, Morris B. Abram, and appointed an independent Special Prosecutor who would thoroughly investigate these and other charges, and prosecute all those engaged in nursing home crime. The Attorney General agreed and I was appointed Special Prosecutor.

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APPOINTMENT & JURISDICTION

On January 10, 1975 this office was established with my appointment as Deputy Attorney General for Nursing Homes, Health and Social Services in New York State. At that time, we began to investigate Medicaid fraud, patient abuse and official misconduct in the operations of residential health care facilities.* These included nursing homes for patients requiring continuous nursing care, and health related facilities (HRFs), designed to care for patients who require on-going medical supervision, but do not require full-time nursing supervision.

In 1976, the Legislature restricted this office in the non-profit area to investigations of direct allegations of criminality until our investigations of proprietary long term care facilities were completed. This restriction was based upon evidence which suggested that fraud was pervasive in the profit-making nursing home industry. Similar information was not available with respect to non-profit facilities.

* Statewide, as of September 6, 1978 there were 528 nursing homes with 66,000 beds -- 275 proprietary nursing homes, 214 voluntary nursing homes and 39 public nursing homes. There were 241 health related facilities with 26,000 beds -- 98 are proprietary, 116 are voluntary and 27 are public.

This office pursuant to Section 63 (3) and 63 (8) of the Executive Law, was empowered to conduct criminal and civil investigations into all aspects of these industries. This authority has been the subject of much substantial protracted litigation throughout the State and in federal courts. (Discussion of that litigation appears elsewhere in this report.)

The jurisdiction of this office was expanded on June 28, 1976 to include the investigation of Private Proprietary Homes for Adults, commonly known as adult homes. These are residential facilities -- not health care facilities -- and they are not funded by Medicaid.* Technically, adult home residents themselves pay the homes for the services they receive, but, in fact, about 70 percent of the residents finance their stay through the taxpayer financed Supplemental Security Income (SSI) Program.

Beginning September 1, 1977, a Civil Recovery Division was established in our office to prepare, file and prosecute civil law suits against nursing home operators for the return of Medicaid funds to which they are not entitled. Prior to the establishment of this new unit, my office had the capacity to obtain restitution only in connection with criminal cases.

* Statewide, there are currently 411 Private Proprietary Homes for Adults with 24,653 beds.

On September 30, 1977, upon the signing of an understanding between New York State and the U.S. Department of Health, Education and Welfare, this office was authorized and given the resources to investigate and prosecute fraud and abuse in hospitals serving New York's Medicare and Medicaid patients.

As of August 3, 1978, Governor Hugh L. Carey authorized the certification of this office as the Medicaid Fraud Control Unit for New York State by the U.S. Department of Health, Education and Welfare, under Section 17 of PL 95-142. This designation has enabled us to investigate the provision and financing of ambulatory care delivery services -- that is, doctors, pharmacists, clinical laboratories, Medicaid mills and the like -- statewide.

Upon my installation and in a time of financial crisis, the new administration and the New York State Legislature made a major commitment to this investigation by assuring from the outset that substantial resources would be made available to this office to conduct effective investigations and meaningful prosecutions. During the last four years, government has continued this support.

Today, this office is budgeted at $13,692,000* enabling a staff of more than 500 -- including some 400 professional attorneys, auditors and investigators -- to work together effectively out of seven regional offices in key areas throughout the State. As a result, this office is now the largest statewide operation in the nation dedicated to the investigation and prosecution of white collar crime.

* $10,692,000 state funded fiscal year ending 3/31/79.
$6,000,000 2 year federal hospital contract ending 10/31/79.
Most of state funds are 90% reimbursed under Section 17 of PL 95-142. The reimbursement covers all state-funded agency activities with the exception of part of the adult homes investigation.

INTRODUCTION

The Medicaid Program was enacted in 1965.* Its aim was to provide medical assistance to certain needy and low income people. The first full year** of the program's operation cost New York State $606,667,818.*** Some 13 years later, New York's expenditures for this program have quadrupled to $3.2 billion.****

The mushrooming of Medicaid costs is not a phenomenon unique to New York. Throughout the nation, the Medicaid program has grown from what was once a minor Government health insurance plan to aid the needy into a massive program that costs the taxpayers of this country $16.3 billion.**** Undoubtedly, most of the medical providers -- the hospitals, the nursing homes and the doctors -- who send their bills to Medicaid are honest. But there are others, the unscrupulous who have set out to bilk Medicaid.

* On May 1, 1966 the Medicaid program came into being in New York State

** 1967 was the first full year of operation for the program in New York State

*** A survey of the Medicaid Program in N.Y.C. and N.Y.S. December 1975 by Program Planner, Inc.

**** Fiscal year 1977

Such figures are more than alarming. They suggest that the Medicaid program has failed -- not in its ideals but in its execution. Some of the reasons for its failure can be found in New York's experience. Our office has been investigating Medicaid fraud for the past four years. Initially, we were charged with investigating nursing homes. In 1977 this jurisdiction was expanded to include hospitals. And, in 1978 through the passage of federal legislation * we were designated as New York State's Medicaid Fraud Control Unit. This legislation has given us the opportunity to investigate ambulatory care as well. As a result, we are now responsible for investigating all aspects of Medicaid provider fraud.

To date,** this office has indicted 184 individuals for Medicaid fraud and related crimes. And, out of 122 completed cases, there are 103 convictions, 10 acquittals and 9 dismissals. Moreover, we have recovered over $6 million in taxpayer dollars through criminal prosecutions and identified $64 million more in Medicaid overstatements.

The following report highlights our work in the investigation of provider fraud in nursing homes, hospitals and ambulatory care services; our patient abuse activities and our various other responsibilities.

* See Appointment & Jurisdiction Section
** As of May 10, 1979.

NURSING HOMES

Today, the investigation of the past financial dealings of New York's profit making long-term care facilities is nearing completion. The results of the past four years of investigations are at once shocking and encouraging. Shocking, in that they reveal New York's profit-making nursing home operators submitted over $63 million worth of inflated claims for Medicaid reimbursement between 1969 and 1975 which cost the taxpayers of this State $42.6 million. (Approximately five cents of every Medicaid nursing home dollar subsidized fraud.) Further, nearly one quarter of these homes have been involved in Medicaid fraud and related crimes. Encouraging in that New York has led the nation in initiating a successful program of identification and recovery of these lost monies.

The results are part of a Section 63 (8) report, "Analysis of New York's Profit-Making Long Term Care Facilities", issued by this Office to the Governor, the Legislature and the People of this State in December of 1978. That report summarizes an in-depth audit of 343 of New York's profit-making long-term care facilities. These audit findings total $63,136,249 in overstated expense claims which resulted in a loss to the State of $42,600,000 in Medicaid overpayments. Of this amount, $31.2

million is in the process of being recovered. ($7 million has already been returned). The process of collecting the remaining $11.4 million will begin upon completion of investigative work. These findings are the results of four years of intensive investigation of New York's proprietary nursing homes.

Illustration I* summarizes these recapture proceedings for the $31.2 million. As the illustration shows, this office is responsible for the collection of $28.5 million of the $31.2 million available for recapture. The balance, $2.7 million, has been forwarded to the Department of Health for collection by that agency.

When we began four years ago, the preliminary results of our nursing home investigations had established that the misuse of public funds had spread far beyond a few highly publicized individuals. Every facility investigated in our first year had submitted inflated Medicaid claims. To clean up this industry, only a full scale investigation commensurate with the size of the problem could provide the public with a meaningful guarantee that fraud would be ended. This would entail an audit of all cost claims submitted by industry participants between 1969 and 1975, with whatever backup investigation necessary.

* See Appendix A

Such a review, at its conclusion, it was hoped, would leave a nursing home industry where there would be no reimbursement rates inflated by overstatement of past costs, to compromise the State's revitalized health care program. It would also leave the State with a cadre of investigative personnel who, trained in industry practice and familiar with the usages of fraud, could successfully conduct an ongoing fraud prevention program.

To the people of this State, this proposal meant even more. New York State would be given an opportunity to meaningfully address the problems of rising health care costs. The ramifications of these findings would be far reaching in determining the actual costs of health care.

This proposal also promised considerable relief to New York's long suffering taxpayers. Millions of tax dollars lost in Medicaid overpayments would be identified for public recovery.

A major reason for our success has been this office's use of the "team concept" of investigation -- attorneys, auditors and investigators working together in one agency.

In this setup, the auditor is the first line of offense. It is his job to peruse the subpoenaed books and records of the particular nursing home operator or other health care provider and to carve out items which appear suspicious. The investigator then takes these leads and contacts appropriate

witnesses, especially those vendors who do business with nursing home operators. These two specialists, the auditor and investigator, are supervised throughout by a lawyer who closely screens the evidence acquired with a clear understanding that, ultimately, the investigation can lead to the court room and beyond - to the appellate courts for review.

This past year alone, my staff has conducted 16,324 witness interviews; issued and served 2,359 subpoenas.

If no more than usual audit techniques had been used, fraudulent practices would have remained concealed. Many expenses in the cost reimbursement statements would have been accepted as reasonable and properly classified. Field checking identified concealed vendor kickbacks, phony billings, undisclosed related companies, inflated rental agreements among related parties, and transferral expenses from one facility to another facility with a higher rate.

Such fraud audits are far more productive in terms of prosecution than are standard business practice audits. Their objective, fraud detection and prosecution, demands particular fraud audit programs and procedures. Normal auditing practice is not primarily oriented to identifying fraud. A fraudulent item disguised by proper entry and false documentation would normally escape detection.

The results of such investigations have been startling. We have found sweeping applications for reimbursement of nursing home expenses claimed to be patient care related, which really were part of a predominantly three-pronged system to defraud Medicaid, involving personal luxury fraud, kickbacks and pyramiding.

1. Personal Luxury Fraud

This all-time favorite kind of fraud has enabled health care providers to write off purely personal expenditures (disguised as patient related costs) with taxpayer dollars. Among the most outrageous personal expenses illicitly reimbursed with public money have been salaries for personal maids, vacations, luxury apartments, wedding receptions, and expensive artwork. In short, almost every personal luxury imaginable has been submitted for Medicaid reimbursement under the guise of care related expenses.

Illustrative of just such fraud is the prosecution and conviction of a New York City nursing home operator. During the review of his particular home, the auditors found invoices for 400 paintings valued at $60,000, lithographs with an average worth of $150. The auditor was told that these were to brighten up the environment for the residents of the homes owned by the operator. Our investigators interviewed health inspectors who had been to all four homes and who told them there was nothing resembling the described lithographs in the homes but rather there were a few cheap cardboard scenes hung in various locations. The investigators took note of the fact that the address of the vendor was in an area where very expensive shops were located. At first, the vendor was uncooperative. He, as well as his books and records, were then subpoenaed. His attorney quickly understood that unless he could prove he had purchased 400 paintings, it would be difficult

to prove that he had sold 400 paintings to the nursing home operator. The vendor finally admitted he had sold several paintings, including a Renoir, to the nursing home operator for $60,000, and he made invoices out for many cheaper paintings and addressed them to the nursing home.

A substantial number of indictments and convictions sadly reflect this personal luxury type of Medicaid fraud.

2. Kickbacks

An equally pervasive type of fraud has been unlawful kickbacks. Such fraud entails the secret return by a vendor of a portion of monies received, usually pursuant to a conspiratorial agreement, to the nursing home operator.

The objective of the kickback scheme, as it is with personal luxury fraud, is the diversion of Medicaid monies away from patient care and into the pockets of corrupt nursing home operators.*

Our kickback investigations commenced in May of 1975 with the recording by undercover agents of a series of corrupt conversations with the top 30 suppliers of typical nursing home goods and services in the New York Metropolitan area. During the majority of these confidentially recorded discussions, suppliers proposed a variety of business arrangements based on kickbacks ranging from 5% to 33-1/3% of gross monthly billings. These schemes generally fell into three

* See Appendix B for diagram on how the kickback system works.

categories:

One -- "Inflated Billing:" Here, a vendor arranges to remit to the nursing home official invoices reporting prices exceeding the true prices of goods sold. The operator pays the falsely inflated bill, receives a secret cash kickback from the supplier in the amount of the inflation, and thereafter, submits the inflated bills for eventual reimbursement by Medicaid.

Two -- "Phony Billing:" Here, the supplier remits to the nursing home operator invoices for deliveries never actually made. The operator pays the bogus invoice, thereafter submitting it for Medicaid reimbursement, while the supplier has returned to the operator, in cash, the total sums of the bogus invoice.

Three -- "Phony Items:" Here, the supplier adds to invoices for items actually delivered charges for additional items never actually delivered. Again, the same payoff system fraudulently charges Medicaid and rewards the operator.

An added wrinkle puts nursing home operators in a position to receive large sums of so-called "front money." Here, the operator receives substantial so-called "loans" from suppliers in return for signing long-term supplier contracts. The loans are repaid automatically, with the

supplier submitting and the operator regularly approving fraudulently inflated invoices. As usual, Medicaid reimburses the operator in the inflated amounts of patient-related expenditures, thereby financing the lump sum of "front money."

In November 1976, the first Grand Jury indictments of 26 individuals were returned, arising out of this kickback investigation. And, in March 1977, a second series of indictments charged another 16 nursing home officials with accepting unlawful kickbacks from their commercial suppliers.

There have been many successes arising out of our kickback investigations. The convictions in August 1978 of Neil Ellman and Benjamin Gelbtuch are illustrative of this. They were employed as Administrator and Assistant Administrator, respectively, of the New San Souci Nursing Home which is owned by their father-in-law (who is presently awaiting trial on charges of larceny and fraud). They are the first to be convicted after trial for Medicaid fraud arising out of our vendor undercover operation. Previously, numerous defendants were convicted of perjury for lying to the Grand Jury and for Wilful Violation of the Public Health Laws in connection with the receipt of illegal kickbacks brought to light through this project.

These prosecutions have disclosed fraudulent kickbacks varying in magnitude from a low of $400 over a two-month period, to a high of $335,000 over a six-year span, involving among others, suppliers of meat, laundry, groceries, linens and pharmaceuticals. "Phony Billing," "Inflated Billing," and "Phony Items" were integral parts of the kickback schemes.

To date,* this phase of our inquiry has brought about the indictment of 52 individuals of which 41 have been convicted. There have been no dismissals or acquittals.

The potential scope of kickback-based fraud could reach truly astounding proportions where the span of kickbacks range from 5% to 33-1/3% of gross billings for food, linens and housekeeping supplies. In the Metropolitan New York area alone, in 1977, Medicaid records confirm spending in excess of $60 million in this category.

Unfortunately, the penalty for convicted defendants involved in unlawful kickback schemes is limited to punishment of up to one year in jail since the charge is presently only a misdemeanor. The deterrence and elimination of such fraud will depend, in part, upon elevating the penalty for such conduct to the felony status it now carries under Federal law. My staff has prepared legislation to that effect, which was not passed by the 1977 and 1978 Legislatures. Hopefully,

* As of May 10, 1979.

the 1979 Legislature will see fit to enact this essential legislation, without which no meaningful deterrent will exist.

3. Pyramiding

The third major type of fraud is what this office has termed "pyramiding." Since government will reimburse nursing home operators for actual costs incurred in arms length transactions, operators go to incredible lengths to mask their financial interests in the companies with which they deal. For example, an operator will receive a higher rate if he leases the facility from an independent real estate holding company than he would if he owned it himself and was paying a mortgage. Often rent far exceeds the average market scale, and the landlord company is in reality secretly owned by the nursing home operator through a so-called dummy corporation.

HOSPITALS

The Hospital Division was established on September 30, 1977 through a 2 year, 100% funded contract from the U.S. Department of Health, Education and Welfare (Health Care Financing Administration). This Division has authority to investigate and prosecute fraud and abuse in the operation of hospitals serving New York's Medicare and Medicaid patients.

The HEW contract also requires this Division to review hospital costs, develop a model investigative and prosecutorial manual for conducting hospital inquiries nationwide, and similarly, design an audit program to test the validity of hospital provider costs.

At present the statewide staff is organized into three regional offices: New York City, Long Island and and Pearl River. To date, the statewide staff consists of 111 persons: 15 lawyers, 42 auditors, 30 investigators, and 24 support personnel.

Investigations of a number of hospitals have been commenced, and the audit phase of many have been substantially completed. In addition, the division has examined the books and records of dozens of vendors. More than 100 cases have been opened, involving more

than 2500 interviews and the serving of approximately 360 subpoenas. Several grand jury investigations are underway.

In March 1978, the first hospital indictment was announced. The principal owner and the administrator of Smithtown General Hospital were charged with accepting more than $600,000 in illegal kickbacks from suppliers of goods and services to the hospital. The administrator of the hospital was also indicted for the theft of $1,200,000 from the hospital by misappropriating income generated by the hospital's outpatient department and laboratory and the employee's cafeteria; in addition, the administrator was charged with tax evasion. In August 1978, the principal owner of Smithtown General Hospital pleaded guilty to a felony grand larceny count of the indictment and agreed to make restitution in the amount of $1,250,000 (for findings in nursing home and hospital facilities), and to relinquish all New York State health facility licenses. The trial of the administrator should begin in early 1979. In September and December the indictments of two other hospital officials were announced. Both cases involved accepting of illegal kickbacks from vendors to the hospitals, and falsifying hospital records.*

* As of May 1, 1979, a total of 28 individuals have been indicted by the Hospital Division. And the two completed cases have both resulted in convictions.

Unlike the nursing home industry, the delivery of health care by hospitals is largely on a non-profit basis, with a major emphasis on the education of interns and residents. It is also a highly technical field. Legislative decisions have been made with far-reaching impact on the delivery of service, financing and reimbursement, and each aspect of hospitals delivery of care systems have had to be analyzed in terms of these complex and interacting factors.

In order to investigate any single item, it has been necessary to understand each issue in terms of legislation, regulatory structure, administrative memoranda, local initiative, coverage and eligibility, fees and reimbursement, hospital/individual provider relationships, hospital/departmental relationships, and the relationship of the hospital to other forms of care and delivery of service.

As a result, the Hospital Division has been required to gather research, analytic materials and reports. They have had to establish liaisons with a wide variety of professionals from federal, state and local governments, universities, hospital associations, health reform groups, as well as organizations and individuals involved with delivery and financing of services, legislative change, facility operation, and consumer health care issues. Without such activities, the complex nature of the hospital administrative

CORRECTION

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and service structures, its financing mechanisms, and its reimbursement policies could not be thoroughly understood. Moreover, fraud and abuse could not be identified and prosecuted successfully.

As in the nursing home investigation, numerous challenges to the Division's jurisdiction and its grand jury subpoena power have been made. These challenges have been met and none has had adverse effects on the progress of this investigation.

Substantial progress is being made through our hospital investigation. Our findings will make a meaningful contribution to understanding the high cost of hospital care. Moreover, we are confident that they will give us the information needed to contain these costs without damaging the quality of care given to the patient.

AMBULATORY CARE

On August 3, 1978, our office was certified as the Medicaid Fraud Control Unit of New York State by the U.S. Department of Health, Education and Welfare. This certification is a result of H.R. 3, Section 17 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142), which were signed into law by President Carter on October 25, 1977.

This legislation gives each state in the union the opportunity to establish a program of long-term control of fraud in health care by setting up a Medicaid Fraud Control unit. It is designed to improve the capacity of state and federal governments, to detect, prosecute, punish, and discourage fraud and abuse by providers participating in the Medicare and Medicaid programs. The success of New York, particularly our investigations, provided the example and incentive for this new program which it is believed, will finally control Medicaid fraud. As Congress said of this office at the time the bill was enacted:

> "The Committee was particularly impressed with the organization and operation of the New York Special Prosecutor's Office, and believes it constitutes a model for anti-fraud efforts in other states..."*

* Committee on Finance--U.S. Senate Medicare-Medicaid Anti-Fraud and Abuse Amendments, September 26, 1977, pg. 35.

This federal anti-fraud program established by Section 17 has three key elements. First, it sets out a specific design for a program to control Medicaid fraud. The design is based on the organization of this office and the investigative techniques we pioneered. Second, it requires this kind of investigative presence throughout the Medicaid system. Third, states who meet the federal standards, receive federal reimbursements of 90 per cent of their costs for a period of three years. As a result of our certification, New York State's expenditure for this comprehensive investigation has been reduced to about $2.6 million for the last fiscal year.

And, we now have the opportunity to undertake a much-needed investigation into the provision and financing of ambulatory care delivery services - that is, doctors, dentists, psychiatrists, Medicaid mills, clinical laboratories, pharmacies, and the like - throughout the state.

This legislation requires us not only to identify, prosecute and punish those who defraud Medicaid, and insure that punishment of wrongdoers will deter others; but to establish a procedure for returning promptly to our states money reimbursed fraudulently. It also enables us to use the results of our investigations in fact-finding

reports and analyses of the changes needed to meaningfully penalize unnecessary spending and poor patient treatment. Such work will hopefully lead to systems by which Medicaid can be administered simply, efficiently and fairly. This work will build on our investigations of fraud and abuse to provide essential information for the design of our future health care system.

PATIENT ABUSE

The Patient Abuse Unit has continued to work for the improvement of patient care in health facilities. As we have noted in prior annual reports, our efforts in this regard are fraught with difficulties. However, in the last year, improvement in care has become more evident.

A significant development has been the passage of the Patient Abuse Reporting Statute*, which mandates that professionals in residential health facilities report instances of patient abuse, mistreatment or neglect. Although the law became effective on September 1, 1977, it was not implemented until April 1, 1978 because of delays in promulgating regulations interpreting the statute. Under the law, initial reports are made to the Patient Advocate's Office of the State Department of Health. Pursuant to a Memorandum of Understanding between that agency and this office, all such reports are then referred to the Patient Abuse Unit, with those complaints within our jurisdiction accepted as active cases. The number of complaints received in this manner has

* Public Health Law § 2803-D

caused a corresponding increase in the workload of the Unit. In 1978 we investigated 279 cases, 114 of those opened from reports under the new statute. This involved more than 1,000 interviews, an increase of more than 180% from the previous year. The Unit has expanded to include three attorneys and six investigators in the New York City Office, with one attorney in each of the regional offices responsible for patient abuse cases.

In order to familiarize administrators, operators, and other interested persons with the statute, our office has assisted the State Department of Health with its training sessions held throughout the state. Following each session, the number of reports of patient abuse from professionals in that region has increased. Although the Patient Abuse Reporting Statute has produced encouraging results, certain deficiencies remain in the language of the statute. One is that the law does not include the reporting of patient abuse in hospitals. This is of concern to this office, since during the last year, we have undertaken an investigation of hospitals. An amended

version of this statute is being introduced in the 1979 Legislature. If it is passed, I anticipate an increase in reports of patient abuse in hospitals, similar to the increase in nursing home complaints which arose when this Reporting statute became effective.

We also have expanded our liaison with other groups involved with the care of the elderly. Our meetings with providers have resulted in an increased number of abuse complaints from administrators. We have addressed training sessions sponsored by the New York State Office of the Aging Ombudsmen Program, which places volunteers in nursing homes to assist patients with their non-medical problems. These volunteers are alerted as to what they can do to recognize and prevent abuses they may encounter in the facilities. We have shared our experiences with representatives of Michigan, Missouri, and New Jersey, who are interested in establishing programs to detect and prevent patient abuse. Various community groups have reported cases to us and have been invaluable in assisting us in improving the care of the elderly.

The Patient Abuse Unit, in conjunction with the Department of Health and the Department of Social Services, has continued its program of unannounced inspections of residential health care facilities and private proprietary homes for adults. These inspections, which include night visits, are scheduled on a regular basis with fifteen facilities surveyed on each round. The focus of each round is a different aspect of the facilities' operations, such as fire safety, sanitation or staffing. Although the law requires that the survey team from the Department of Social Services or the Department of Health be admitted, the facility has a constitutional right to deny entry to the Office of the Special Prosecutor. When this right is exercised, our team leaves the premises and awaits the findings of the department. During 1978 we visited 32 nursing homes and adult homes.

We still maintain a policy of completely investigating all complaints within our jurisdiction. Violations of the State Code are referred to the Department of Health for administrative action,

while instances of professional misconduct are referred to the State Department of Education. However, as we have indicated in earlier reports, the lower rate of prosecution and conviction in this area is due in large part to the problems of dealing with geriatric patients who are often senile or unable to identify an assailant or unaware of being abused. In 1978, two cases brought to trial by the Unit resulted in acquittals, due in part, to the failure of the geriatric witnesses to provide convincing testimony against the alleged assailants. Another case in upstate New York was dismissed before trial as a matter of law, although it was alleged that a nurse's aide had put excrement in the mouth of a patient. This case was appealed successfully and the indictment was reinstated.

In the next year, we will be making further recommendations to the Legislature to correct problems discovered during our investigation. As our expertise has grown and our presence become more widely known, we are convinced that we have become an effective watchdog on behalf of institutionalized patients in New York State.

SPECIAL INQUIRIES

Any thorough investigation involving government's licensing of a multitude of entrepeneurs who share in the receipt of millions of tax dollars must include the question of whether influence-peddling played some role in deciding to license or not to license. The Special Inquiries Section is responsible for such investigations.

This section undertakes research and investigation into selected allegations including those relating to alleged actions of government officials, labor officials, banking executives, etc., insofar as they relate to health care industries.

These cases, where they exist, are among the most difficult to prove. And, the majority of our investigations in this area have shown an absence of criminal behavior on the part of public officials. However, there is a serious potential for irreparable damage to the reputations of public officials through such inquiries. So, we have gone to extreme lengths to assure the confidentiality of such sensitive inquiries, including the fact of the appearance of prominent witnesses in my offices and before grand juries throughout the state.

In January 1978, the Broome County Court released a grand jury report which dealt with (1) the failure of the County to prevent certain nursing homes from receiving reimbursement for Medicaid and Medicare for the same services, (2) the unauthorized and preferential treatment of certain nursing homes

so that they received cash advances while other nursing homes did not and (3) the failure of the Broome County Department of Social Services to inform the District Attorney about double-billing by a nursing home, after officials in the Department were aware of this double billing.

Based upon these findings, the Grand Jury recommended that all reimbursement claims submitted by nursing homes to Broome County be audited and paid in accordance with uniform standard auditing and accounting procedures; all reimbursement claims be paid strictly in accordance with existing law; every Broome County Department or Agency head must immediately inform the Office of Comptroller and District Attorney of any matter relative to evidence of larcenies or other improprieties with respect to County funds.

Under the authority of Section 63 (8) of the Executive Law and Executive Order No. 4 dated February 7, 1975*, this Section issued a report in May 1978, concerning its investigation of Broome County's Willow Point Nursing Home and Health Related Facility. This report traced our year-long, non-criminal investigation into the lease, construction and sale of this 342-bed, publicly operated facility to Broome County by private entrepreneurs. This purchase resulted in the diversion of almost $3 million away from the care of the elderly and into the pockets of those entrepreneurs. Our inquiry into

* This authority empowers our office to inquire into "the management, control, operation or funding of any nursing home, care center, health facility, or related entity located in the State of New York".

the Willow Point complex revealed malfeasance on the part of State and local officials. That malfeasance manifested itself in a number of ways:

1. A secret agreement in violation of State and local law, at public expense;
2. Business dealings by public officials which, though technically at arms length, appear to evidence a total lack of concern for the rights of the taxpayer;
3. Inflated construction, lease and sale costs having no true relation to patient care;
4. Conduct by local and high echelon State officials in dereliction of duty and disregard of law resulting in a Medicaid dollar loss of at least $2,187,590.

The most unfortunate but natural consequence of the entire Willow Point affair is that millions of Medicaid dollars were given away as private profit and put beyond the reach of the State's elderly infirm, for whom such monies were always intended. Based upon the information gathered during this investigation, a civil lawsuit has been commenced by this office for damages against many of those who were involved in this matter.

One of the most difficult aspects of these investigations is that use of political influence is often not a crime. Based upon the information gathered by the Moreland Commission, and our investigations, various legislators have represented nursing

homes and health related facilities before the State Health Department, or other State agencies. Unfortunately, there are no statutes which prohibit such practices.

The Moreland Commission recommended in 1975, that Section 73 of the Public Officers Law be amended so as to prohibit a Legislator from appearing before a State agency on behalf of a client (a person who paid $100, or more, during the preceding two years). The Moreland proposal, however, would not prohibit a legislator's law firm from appearing before such agencies. The Moreland proposal would also require legislators to disclose any interst which they had in any entity subject to the regulation of the Department of Health, Board of Social Welfare and Mental Hygiene. It would do so by amending Section 73 of the Public Officers Law so as to include these agencies as regulatory agencies.

While we support the Moreland proposals, which have yet to be enacted into law, we think they should be strengthened by:

1. DISCLOSURE OF INTEREST IN FIRMS REPRESENTING NURSING HOMES

   As noted, the Moreland proposal would allow a legislator's law firm to appear before the Health Department and the legislator would be allowed to share in the fee. But, this fact would not be disclosed to the public. We think this should be disclosed to the public, and that Section 73 of the

Public Officers Law should be amended so as to require legislators to disclose all interest in firms which appear before regulatory agencies, even though the firms, themselves, are not subject to regulation by such agencies. (The Moreland proposal only requires disclosure of interests in firms subject to regulation.)

2. CONFLICTS OF INTEREST BY STATE EMPLOYEES

   Section 74 of the Public Officers Law states that no employee should have a financial interest "which is in substantial conflict with the proper discharge of his duties in the public interest." (subdivision 2). This is a very general statute, and no criminal penalties attach to its violation. We think that Section 73 of the Public Officers Law should be amended so as to prohibit any employee of a regulatory agency from having any interest, direct or indirect, in any entity subject to regulation by such agency, or in any entity whose ownership is associated with the entity subject to regulation.

In addition, Section 73 should be amended to require disclosure by an employee of a regulatory agency of any financial interest in any entity subject to regulation by that employee's agency which is held by, or accrues to, the employee's spouse or unemancipated children under the age of eighteen.

Such interest would not only include equity interest, but loans, other financial dealing, and employment. Under this proposal, the employee of the regulatory agency would be prohibited from receiving anything from any entity subject to that regulatory agency and members of his household, including his spouse, would be required to disclose what interest, if any, they had in such regulated entities.

ADULT HOMES

1978 was an important year for our Adult Homes Division. It was able to begin the audit of the books and records of a number of homes. As we indicated in previous annual reports, this investigation had been stymied in its audit effort because of non-compliance with our subpoenas.

In April, 1978 the Court of Appeals ruled in the case of Moskowitz v. Hynes, that this office had authority under Section 63 (8) of the Executive Law to conduct an inquiry into conditions in the adult home industry. Although there had been some production of books and records prior to this decision, it paved the way for production of documents on a larger scale.

As a result during 1978 the Division was able to complete 22 audits of adult homes' records, analyzing the daily cost of resident care and individual resident accounts. These reports* will be released to the Governor, the Commissioner of Social Services, to members of the Legislature and to the people of this State. They provide an overview of

* As of May 10, 1978 these reports were released.

the financial demands of maintaining a decent level of care for residents of the State's adult homes.

In addition the Division is preparing a further Section 63 (8) report to supplement the interim report that was forwarded to you in April, 1977.* This report discusses the results of our audits and discusses continuing problems involving the placement and care of adult home residents. It is a comprehensive document providing the Governor, and the public at large, a broad description of adult home finances and residential care. Among the topics covered are the results and conclusions derived from the cost analysis reports, a demonstration of the inability of adult homes to provide for the mental health needs of the approximately 6,000 deinstitutionalized mental patients now residing in adult homes, the effect of legislation concerning adult homes (particularly the transferring of jurisdiction over these facilities from the Board of Social Welfare to the Department of Social Services), and the medical problems of residents. Research and investigation for the report involved

* As Of May 10, 1978 this report was released.

some 75 interviews state-wide with State, county and local officials as well as with representatives of various community organizations.

In 1978 this Division participated in an investigation in Kings County which led to the issuance of a Grand Jury Report recommending legislative and administrative changes. The Grand Jury had examined the deaths of 11 adult home residents who had either lived in facilities in Kings County or had been discharged by institutions in Kings County to adult homes in other counties. The Grand Jury found that the physical and mental health of many of these persons had deteriorated to shocking levels while they were residing at adult homes, and it recommended new laws and regulations to deal with the problems it uncovered.

With respect to criminal cases,* this Division obtained the conviction in Monroe County of a former employee of the Board of Social Welfare who was indicted for obtaining unlawful gratuities from an adult home operator. However, a former operator of an adult home in Brooklyn, who was indicted for giving unlawful gratuities to two state employees, was acquitted after a jury trial.

* As of May 10, 1979, seven individuals have been indicted by the Adult Homes Division. And out of 4 completed cases, there have been three convictions and one acquittal.

In Kings County, a Grand Jury has indicted a bookkeeper of an adult home for allegedly forging public benefit checks that were sent to the residents of the home. In Suffolk County, a Grand Jury has indicted a man involved with an employee of an adult home for allegedly committing perjury during the course of an investigation concerning various adult homes in that county.

Several difficulties have been presented in the investigation and prosecution of criminal conduct relating to financial transactions at adult homes. Foremost among these is that control and management of adult homes in general rests in individuals (rather than corporations) or in partnerships of family-related or other closely-knit groups. As such, the owners, operators, and employees of these facilities are not amenable to aiding in our investigation of possible criminality.

Again, unlike the Medicaid reimbursement plan applying to nursing homes, the adult home financial arrangement calls for support payments (by government, pension, or private sources) made to the resident,

who in turn pays the facility. The concomitant absence of documentation, particularly that provided by the facility, poses additional evidentiary problems to establishing criminal charges.

Further, the nature of the population involved -- some 6,000 deinstitutionalized former mental patients together with a large number of elderly people -- makes inherently difficult the detection and proof of criminal conduct (including resident abuse) to which these residents are witnesses. Indeed, often these residents are the unknowing victims of the apparent larceny of their funds.

Finally, the non-ambulatory character of the adult home population raises obstacles to effective investigation. Since most residents rarely leave the home, inquiries concerning a target home may require on-premises interviews, which are rarely conducive to gathering information relative to criminality on the part of the operators or employees of the home. Even where the home is cooperative, the physical impracticalities of transporting residents to our office

calls for manpower-consuming interviews in the field by investigators and, at times, attorneys. In the first five months of the current fiscal year, some 567 interviews were conducted by the investigators for the New York City region alone, most of these in the field.

During 1978 the Division continued to work on legislation that was designed to increase the protection of adult home residents. The staff participated in the drafting of three bills which were passed by the Legislature: The first increases the power of a court to deal with physical conditions that threaten the health and safety of persons living in adult homes; the second provides a criminal penalty for misappropriation of personal allowance funds held by the adult home operators; and the third requires a more comprehensive statement by a physician who certifies that an adult home resident is suitable for domiciliary care.

During 1979 this Division will continue to audit the books and records of adult homes. They will continue to prosecute criminal violations of law wherever possible. And, as a result of the agency's

designation as New York's Medicaid Fraud Control Unit, the Adult Home Investigation has added to its functions the investigation of Medicaid fraud committed by providers to adult homes -- physicians, pharmacists, dentists, ambulette services, and suppliers of various health-related devices. This latter, investigative activity, of course, will be eligible for 90 per cent federal reimbursement pursuant to Section 17 of PL 95-142.*

* See Appointment & Jurisdiction section for further information.

CIVIL RECOVERY

The Civil Recovery Division has been in existence for just over a year and a half. It was established to secure speedy recovery of Medicaid overpayments because administrative procedures were of such long duration that there was a danger that the State would never see its money returned. To date, this Division has lawsuits pending against 50 nursing homes and health related facilities demanding the return of over $23 million in Medicaid overpayments plus punitive damages. Another 20 nursing homes settled their cases with our office for a total of $1,401,438.00. Since the typical complaint filed in such a civil suit often seeks the recovery of the overpayment plus treble damages, the amount to be returned to the State could be considerably higher than the amount demanded in the complaint.

Legally, our authority has been challenged in every conceivable fashion. These challenges come in the form of motions and have caused considerable delay in this Division's activity. One such motion to dismiss a case was finally resolved on November 20, 1978 by the Appellate Division, Second Department, which reversed a lower court decision and upheld the State's authority to maintain an action as sole party plaintiff to recover the full amount of Medicaid overpayments without joining the local Social Service districts. In the same decision, the court also ruled in favor of the form of

the complaint used in most of our cases. (State of New York against Ben Zion Frankel, State of New York against Franklin Nursing Home)

In another case, we were successful in preventing the nursing homes from delaying the trials of our cases by flooding us with lengthy discovery proceedings. The court in its decision warned the defendant's counsel about employing such tactics. (State of New York against Oxford Nursing Home)

Another pending case in the Civil Division will test the extent to which public officials are immune from civil liability for conduct which allegedly neglected and abused the trust reposed in them and resulted in excessive gains to third parties doing business with the State and local governments. (State of New York and the County of Broome against William Ryan, et al)

The Civil Division has also intervened in a number of bankruptcy cases in an effort to have the state's claim survive the bankruptcy or at least receive a share as a regular creditor. In the Medico case, pending in Massachusetts bankruptcy court, the owner claims to have squandered millions of Medicare and Medicaid dollars over the gambling tables of Las Vegas and now seeks to be declared bankrupt. This is a massive and sophisticated case involving nursing homes in Connecticut which cared for New York residents and were paid by the City of New York. We are defending this action and putting the nursing home receivers to their proof as to why New York State residents have to pay $7.50 per day above the Connecticut flat rate.

We have also been representing the State in the Park Crescent Nursing Home Arrangement Proceeding. The State is seeking to secure a disbursal from Park Crescent assets to be applied in partial payment of defendant Bernard Bergman's liability to the State of New York arising out of the prior disposition of criminal charges against him.

We have taken eleven Nursing Home cases from the Corporation Counsel of New York City and have started recovery proceedings to collect overpayments.

Last year's report also mentioned an operator who fled criminal charges, filed for an arrangement of his debts in bankruptcy court and at the same time was collecting $750.00 per week for administering nursing homes while he was a fugitive in a foreign country. During the past year, we were able to convince the court to cut off these weekly payments. Thereafter, the operator returned and is now awaiting trial on his criminal indictment.

For the most part, the Civil Recovery Division will proceed by civil law suit in all nursing home cases where our audit findings exceed $25,000. Thus far, we have selected over 120 nursing homes for civil recovery; and they will be either settled or in suit within a year. Within 18 months we expect to have identified and sued all the homes that have been audited by this office and found to have overcharged the State. It is not possible to project the total amount we will be suing for in a year and a half, but it will certainly exceed the $20 million projected in the 1977 annual report.

In cases where the overpayment amounts to less than $25,000, our audit report is turned over to the Department of Health for recovery through the administrative process. Fifty-six such facilities have already been referred to the Department of Health.

Usually action on a civil lawsuit is deferred until the completion of criminal proceedings. Thereafter, if a civil lawsuit is deemed to be appropriate, the audit findings are placed into a complaint under various causes of action which typically include fraud, conversion, negligence, and breach of contract. The auditor then recomputes the HE-2P* and HE-12B* forms to determine what the correct rate of reimbursement to the facility should have been. The lawyer is then able to arrive at the amount of damages the State should seek in its lawsuit. The HE-12B is forwarded to the Department of Health for certification of the recomputed rate since the Health Department is the rate setting agency of the State. Delays have been encountered in getting these new rates certified; and as a result, an auditor from our Civil Recovery Division has been placed on temporary assignment with the Department of Health to expedite handling of these important cases.

This Division relies on the cooperation of the Department of Health, and we maintain a close working relationship with that agency. The Department of Health has revamped its administrative hearing procedures with a view to expediting cases and recoveries. We look forward to the time when almost all facili-

*Forms used by the Health Department for reimbursement.

ties can be handled through the administrative process. This unit will then be free to work on those extraordinary cases to which the administrative remedy does not readily lend itself--for example, where the home was closed and no prospective recovery can be made against a provider administratively.

We are also aggressively seeking cases we can bring in Federal Court under 31 USCA 231, better known as the "False Claims Act". This law imposes a penalty of $2,000 for each false claim made against the United States, in addition to double the damages and attorney's fees of the plaintiff. Medicaid claims have been ruled to be a proper subject for such a suit, and the state, a proper party plaintiff. We expect such suits to become an invaluable and forceful mechanism in the future for the recovery of falsely obtained taxpayer dollars.

LEGAL ISSUES

One of the more frustrating aspects of this investigation has been the interminable legal challenges of our authority to investigate, to audit, to subpoena, to indict, to report and to prosecute. Illustrative of this problem is the fact that we have litigated more than 400 subpoenas. The fact that we have been successful in more than 95 per cent of these cases is attributable in all candor to a combination of the competence of our lawyers and the frivolousness of the challenges to our subpoenas. Fortunately, we have dealt in the main with reputable adversaries and so, ultimately, we have been able to obtain most of the books and records we sought. However, there have been many claims of destruction of books and records through fire, flood, burglary, and employee thievery as well as unexplained disappearances. These actions, coupled with the complexity of some of the litigation, emphasize the difficulties involved with investigating white collar crime.

The history of one subpoena will give you some understanding of these problems. On April 8, 1975, we subpoenaed the books and records of a large New York City nursing home.

A motion to quash that subpoena was promptly brought in the lower court. We were successful there as well as in the Appellate Division, and in December of 1975 the New York State Court of Appeals. However, the nursing home operator then went into the Federal District Court, then to the Federal Circuit Court of Appeals and finally, to the United States Supreme Court. At all these stages we were again successful. This took us until the fall of 1977. At that time the nursing home operator appeared in the lower State Court and said he could not find his books and records. The judge, in holding the operator in contempt, said eloquently, "Books and records, unlike some ill-starred vessels sailing the Bermuda triangle, do not disappear without explanation upon the presentation of a subpoena from a Special Prosecutor". Now held in contempt, the defendant appealed the contempt citation -- first, to the Appellate Division, then to the Court of Appeals and up through the Federal system, losing all the while. Finally on April 10, 1978, more than three years after the service of the first subpoena, he was incarcerated and ordered to remain there until he produced the books and records or explained why he was unable to produce them. He remained in jail until mid-August, when he petitioned the Court for his release. In the petition, he claimed that he was unable

to produce the books and records and that he did not have to explain what happened to them because that would tend to incriminate him. The petition was dismissed on October 4, 1978 but the Court released him from jail to permit him to appeal that decision. As a result, four years after the issuance of the original subpoena, the defendant is still at liberty, and the books and records have yet to be produced.*

Throughout the year, this office has dealt with many other cases, the most significant of which was Matter of Hynes v. Moskowitz, 44 N.Y. 2d 383 (1978). In this case, the Court of Appeals upheld as constitutional the new amendments to the Criminal Procedure Law and the Civil Practice Law and Rules which authorize a grand jury or government agency that issues a subpoena duces tecum to retain possession of the subpoenaed materials for a reasonable period of time. Our office drafted these amendments, which were signed into law on July 19, 1977, after the Court of Appeals had ruled in Matter of Windsor Park v. Hynes, 42 N.Y. 2d 243 (1977), that the issuer of a subpoena could not retain subpoenaed materials without statutory authorization.

* The Appellate Division affirmed the lower court's order on February 26, 1979 and, the defendant has once again taken his case to the N.Y.S. Court of Appeals.

The New York Freedom of Information Act was also the subject of appellate litigation during the year. The Supreme Court, New York County had ordered our office to provide a complete copy of our investigative manual to an attorney who represents several nursing homes. We appealed this order to the Appellate Division, First Department. We informed the Appellate Division that, while certain portions of the manual could be disclosed without jeopardizing our investigation, the manual did contain some sensitive material which must remain secret, such as detailed descriptions of the techniques used by our auditors and investigators to uncover Medicaid fraud. The Appellate Division accepted our analysis. Thus, in Matter of Fink v. Lefkowitz, 63 A.D. 2d 569 (1st Dept. 1978), the court held that we need not disclose the sensitive portions of the manual because "we are of the view that (the) disclosure (of the Deputy Attorney General's auditing techniques) to subjects of investigation are more likely to assist wrongdoers to evade the law than to give guidance to those concerned to conform their practices to the requirements of law." (Id. at 571)

Several criminal convictions obtained by our office were reviewed on appeal during the year. One of the most significant was the Bergman case. The Court of Appeals for

the Second Circuit denied Bergman's final federal habeas corpus petition on February 1, 1978. Having been unsuccessful in each of his numerous appeals, Bergman finally was required to serve the one year jail sentence which Justice Melia imposed on September 13, 1976.

In People v. Hochberg, 62 A.D. 2nd 239 (1978), the Appellate Division, Third Department affirmed the defendant's conviction for "corrupt use of position or authority" (Election Law §448), "Unlawful fees and payments" (Public Officers Law §77) and "an attempt to fraudulently and wrongfully affect the result of a primacy election" (Election Law §421 (5); Penal Law §110.00). When Hochberg committed these offenses he was a member of the New York State Assembly and chairman of the Assembly's Ethics Committee. Hochberg has now completed the service of a one year term of imprisonment.

The Appellate Division, Second Department affirmed the conviction of Manlio Severino, the founder and business manager of two New York nursing homes, Kent and Sprain Brook Manor, for grand larceny in the second degree and offering a false instrument for filing in the first degree. People v. Severino, 63 A.D.2d 1010, (2d Dept. 1978). Severino had defrauded the Medicaid program by submitting to the Department of Health inflated claims concerning his nursing homes' purported expenditures for patient care. The trial court sentenced

Severino to pay a fine equal to twice the amount of his gain from the larceny and to serve one year in prison. Severino contended on appeal that Penal Law §80.00, which empowers courts to impose a fine "not exceeding double the amount of the defendant's gain from the commission of the crime," did not authorize the fine in his case, because the Medicaid overpayments did not go to him, but to the nursing homes which are nominally owned by his wife and son. The Appellate Division said that the issue raised by Severino was novel. Nevertheless, it upheld the sentence because "as a matter of statutory construction and public policy, a gain to a third party of the defendant's choice constitutes 'the defendant's gain' under the statutes." The Appellate Division also found that Severino's jail sentence was reasonable. Severino paid the fine, and is now serving his jail sentence.

The Appellate Division, Fourth Department, recently affirmed the conviction of Albert Christiano, Jr., former President of the New York State Nursing Home Association, the consulting administrator of Lakeshore Nursing Home, in Rochester, for grand larceny in the second degree. People v. Christiano, 66 A.D.2nd 1032 (4d Dept. December 8, 1978). Christiano committed his larceny in the same manner as did Severino, and argued similar theories on appeal.

As mentioned earlier in this report, criminal prosecutions have been initiated against a number of nursing home operators and suppliers who were involved in unlawful kickback schemes. The principal evidence against these individuals consisted of admissions which they made to undercover agents who secretly tape recorded the defendants' incriminating statements.

Many of the nursing home operators and suppliers who were indicted as a result of these undercover operations argued in the trial courts that such investigative techniques were unfair. These complaints were rejected by each trial court called upon to examine them. However, on the appeal of the first criminal conviction by a jury resulting from these undercover operations, a perjury case, the Appellate Division, Second Department dismissed the indictment. It ruled that the questioning of the defendant, a supplier of goods to approximately 30 New York nursing homes, before a New York grand jury concerning his recorded admissions of involvement in kickbacks deals had no relationship to a legitimate investigation of the nursing home industry in this State. The Appellate Division accused this office of improperly 'trapping' the defendant into perjury.

The Appellate Division's holding in this case, People v. Pomerantz, contradicted the trial's court's earlier opinion

that we had "scrupulously afforded the (defendant) each and every right to which (he was) entitled." The Appellate Division's decision seriously questioned whether we could continue to use information obtained by our undercover agents, clearly the most effective means of combatting kickback schemes. Therefore, we appealed to the Court of Appeals.

On December 20, 1978, the Court of Appeals unanimously reversed the Appellate Division's ruling in the Pomerantz case. 46 N.Y. 2d 240. The Court of Appeals squarely held that "in calling defendant before the grand jury based on the information uncovered by (our agent), had a legitimate law enforcement objective material to an authorized substantive investigation in New York." Moreover, it said that "the contention that the prosecutor's questioning was aimed substantially at trapping defendant into giving false testimony is baseless." The Court of Appeals also held that other criticisms leveled at this office by the Appellate Division were "unsupported in the record." By unanimously reversing the Appellate Division, the Court of Appeals gave its express approval to the substantial efforts which we have exerted to stop a particularly insidious form of nursing home corruption, -- illegal kickbacks between nursing home officials and vendors which have resulted in untold losses to the Medicaid program.

SPECIAL PROJECTS

I. COMMUNICATIONS

During 1978, we were invited to speak at a number of forums across the country. We accepted these invitations in an effort to join with other interested parties in recognizing the need for a proper enforcement function within the Medicaid system. Some of the groups we addressed are as follows:

- Concerned Relatives of Nursing Home Patients, Cleveland, Ohio, January 1978
- American College of Nursing Home Administrators, February 1978
- National Association of Attorneys General Health Conference, March 1978
- Village Nursing Home, March 1978
- Harvard University School of Public Health, May 1978
- Columbia University School of Public Health, May 1978
- National Welfare Fraud Association, June 1978
- United State Senate Committee on Aging, July 1978
- United States Senate Subcommittee on Federal Spending Practices and Open Government, August 1978
- Hospital Association of New York State, October 1978
- State Welfare Finance Officers, October 1978
- FRIA Membership Meeting, November 1978
- White Collar Crime Seminar for U.S. Departments of Agriculture, HEW and Housing & Urban Development, December 1978

On June 19, 1978, many of our Special Assistant Attorneys General were sworn in by group admission to the United States Supreme Court in Washington, D.C.

And of special note, we were invited to speak at the December National Conference on Fraud, Abuse and Error sponsored by the Secretary of Health, Education and Welfare in Washington, D.C. In addition to addressing the attendees of this Conference, we were also asked to prepare guidelines for establishing a Central File System for programs concerned with the enforcement process in health, education and welfare. A copy of these guidelines is attached as Appendix C.

II. GRAND JURY REPORTS

During the past year three Grand Jury Reports were made public:

1. The Broome County Grand Jury Report released in January of the past year. (This report is discussed at length in the Special Inquiries Section of the Report)
2. The Kings County Grand Jury Report released in March 1978, which focused on the deaths of adult home residents in Kings County. (See Adult Homes section of this report for further details)
3. The Monroe County Grand Jury Report released in November, 1978. In its recommendations, the Grand Jury called for greater accountability by owners and administrators of a nursing home for its operation; stricter time records for owners' relatives employed at the nursing home; and stronger professional sanctions for negligent nursing home accountants.

III. LIAISON WITH OTHER AGENCIES AND STATES

At various times our New York Regional office has worked cooperatively with each of the local district attorneys in the New York City area.

A continuing joint investigation is being conducted by this office and the Attorney General's office in the Commonwealth of Massachusetts regarding a particular chain of nursing homes.

This office also continues to assist the Attorney General's office in the State of Vermont in its investigation of a number of nursing homes in that state.

All of our seven regional offices statewide have maintained close and continuing liaison activities with local district attorney's offices in their jurisdiction as well as the New York State Police and local police departments when necessary. As a result of these activities on a local, state and federal level, important information has been received and provided by this office in fulfilling its investigative and prosecutorial responsibilities.

As part of our liaison activities, we provided essential information to the Federal Bureau of Investigation, New York, and the U.S. Attorney's office for the Southern District of New York, which information subsequently led to the indictment and conviction of four individuals for defrauding eight

hospitals in the amount of $385,000 in the New York Metropolitan area.

Since the advent of HR-3, we now maintain liaison with all states who have been certified with Medicaid Fraud Control units. To date,* HEW has certified such units in 23 states.

In December of 1978, Mr. Hynes was elected President of the National Association of Medicaid Fraud Control Units. The aims of this association are to provide a forum for a nationwide sharing of information concerning the problems of Medicaid fraud and to develop the most effective means to contain such fraud.

Our Chief Investigator and Deputy Chief Investigator have been called upon on several occasions to lecture to FBI Agents and other United States Government investigators at White-Collar Crime Seminars held at the FBI Academy, Quantico, Virginia.

Effective working relationships in the interest of good law enforcement, are also maintained, as needed, with various offices throughout the United States, for example:

a) Federal Bureau of Investigation;
b) Health, Education & Welfare;
c) Internal Revenue Service;
d) Federal Trade Commission;
e) Immigration & Naturalization Service;
f) US Postal Service;
g) US Dept. of Labor;
h) US Attorneys' Offices;
i) US Secret Service;
j) US Passport Division.

* As of May 10, 1979.

Our office has continuing liaison with the Royal Canadian Mounted Police (RCMP), Canada, as well as the Crown Attorney, Cornwall, Ontario, Canada.

IV. NYSPIN COMPUTER SYSTEM

The New York State Police have agreed to accept the Office of the Special Prosecutor for Nursing Homes, Health & Social Services into the New York Statewide Police Information Network (NYSPIN). This system will provide access to the following:

NCIC - National Crime Information Center (Wash., D.C.)

DMV - Dept. of Motor Vehicles (Albany, N.Y.)

DCJS - Division of Criminal Justice Services (Albany, N.Y.)

NLETS - National Law Enforcement Telecommunications System (Phoenix, Az.)

These various systems will enable this agency to request or relay, within a matter of seconds, information relating to:

1. Wanted or missing persons;
2. Criminal histories;
3. File sets on:

   a) stolen vehicles;
   b) stolen license plates;
   c) stolen articles;
   d) stolen boats;
   e) stolen guns;
   f) stolen securities.

The NYSPIN system is a police system under the control and authority of the New York State Police.

We are privileged to be part of this modern day communications network and have agreed to abide strictly by the rules and regulations set down by the New York State Police.

V. PROFESSIONAL CONDUCT

This office has maintained a policy of referring allegations of professional misconduct to the appropriate disciplinary bodies. Such referral procedures have been established with the New York State Department of Education, Department of Health and the Office of the Attorney General.

During the past year, a total of 41 cases were referred to the Health Department. This included 11 nursing home administrators and one doctor for license revocation. And, as a result of the felony operator legislation passed in the summer of 1977, 29 nursing home operators, convicted of felonies, were referred for revocation of their operating licenses.

In addition, two nurses were referred to the Department of Education for license revocation.

VI. TAX PROSECUTIONS

Since 1976, Commissioner James H. Tully of the New York State Department of Taxation and Finance and this office have worked together on the investigation and prosecution of tax cases generated from our nursing homes investigations.

As a result of this cooperation, 33 civil cases have been developed jointly. Thirteen have been reviewed by the Department of Taxation and Finance and there are now liens and assessments of over $4 million. On the criminal side, 12 individuals have been indicted and 6 convicted to date. There have been no dismissals or acquittals.

Further joint prosecutions with the Tax Department can be expected in the coming year as we shift our investigative priorities into the areas of ambulatory health care and hospital fraud.

VII. TRAINING

In order to maintain quality staff, continuous exchanges of new ideas and information are essential. Thus, training has become an integral part of this office's operations. Regularly scheduled forums, in-house and inter-office/interstate, have proven to be the most effective vehicles for such training.

1. AUDIT SUPPORT SERVICES -- RESEARCH & LIAISON

This group continues to establish a working liaison between our auditors and various federal and state agencies to better enable us to monitor all aspects of the health care industry presently under our jurisdiction. Its aims are to obtain, track and research not only proposed and current codes, rules and regulations, but also to track the historical updates of those codes, rules and regulations that were applicable throughout the time of our investigation. All rules, regulations and changes in state and local governmental health care policies are analyzed to determine what, if any, impact they have on endeavors in our jurisdiction. This, and other information obtained from reports and studies issued by various governmental agencies,

Social Services, the news media, and independent private firms, is compiled and distributed to our staff as well as the New York State Departments of Health and Social Services.

Finally, this support group has a trouble-shooting function that is extremely important to this office. Any documentation needed to ascertain the procedures of various agencies regarding a unique type of case is requested through this group.

2. IN-HOUSE

In 1978, two 2-day Special Assistant Attorneys General training meetings were held, the first in January and the second in October. Discussions and workshops at the first of the two meetings centered around litigation, investigation and prosecution problems. The purpose of the October meeting was to discuss in-depth problems associated with our recently expanded jurisdiction under HR-3, that is, the investigation and prosecution of individual providers within the Medicaid system. The New York State Department of Social Services and the Attorney General's Office in New Jersey participated at this meeting.

During October all supervisory auditors attended a two-day conference, which covered such topics as Civil Recovery, regulations and the reimbursement of Medicaid providers, report writing, and administrative requirements. The purpose of this meeting was to share information, discuss problem areas, and keep abreast of all legal, audit, and investigative aspects in the development of our investigations.

A two-day audit seminar was also conducted in 1978 for new members of the OSP audit staff. Practical and technical guidelines were provided to stimulate creative audit thinking, in order to familarize newcomers to this office's audit methods and procedures.

In addition, our audit staff conducted many ongoing specific topic reviews across the State throughout the year.

Investigative personnel attended training sessions on such topics as: Interview Techinques; Specialized Investigative Techniques; Construction & Finance Loans; White Collar Crime Investigation; The Ethics of Law Enforcement; Basic Computer Technology for Investigators; Report Writing; The Use of Deadly Force.

All investigators were scheduled to attend two one-day firearms training sessions and were required to attain qualifying scores with their service revolvers. All newly appointed investigators, who had not previously been trained in the use of firearms, were required to successfully complete a five-day recruit firearms training program under the auspices of the New York State Municipal Police Training Council.

3. INTEROFFICE/INTERSTATE

In addition to continuing our tradition of offering up-to-date methods of investigation and prosecution to our own staff, we have also participated at a number of training sessions outside of our office. For example, we worked in conjunction with the New York State Office of the Aging, various county Offices of the Aging, and community programs in their ombudsman training. In addition, we worked with the newly-formed office of the Ombudsman in New Jersey during the past year.

Because of the interest shown across the country in our work, we have developed a training program for the investigation and prosecution of Medicaid fraud

and abuse for interested agencies and units. A number of representatives of Attorney General's Offices and others came to New York during the past year to learn of our methods of operation. On the federal level, the HEW Inspector General's Office sent a representative to our office for training. And to name just a few states, Colorado, Massachusetts, Florida, California, Michigan and Kentucky sent representatives during the past year to attend our program.

Of special note in our interstate training during this past year, however, was that we initiated, developed and participated extensively in a joint program with the New Jersey Attorney General's Office and the U.S. Department of Health, Education and Welfare in training 120 attorneys, auditors and investigators, representing 20 states, in Medicaid fraud and abuse. The week-long program was intensive and the rewards have yet to be measured. In terms of the quality, however, the reaction across-the-board was of the highest order. So much so, in fact, that the U.S. Department of Health, Education and Welfare intends to duplicate this unique federal-state venture again in 1979. Indeed, we received a special commendation from HEW for our sponsorship of this first of its kind conference for State Medicaid Fraud Control Units across the country.

All investigative supervisors, senior investigators and auditors on the associate level in the New York City region of our office attended an Orientation Conference which was conducted by the New York State Department of Social Services.

Selected personnel in the New York City region also attended a five-day NYSPIN (New York Statewide Police Information Network) Terminal Operators' Training School held by the New York State Police.

4. OFFICE MANUALS

My staff again has compiled additional manuals to assist in the work of our investigation. However, their distribution has necessarily been limited to law enforcement agencies only for the same reason cited last year, that is, our Office Manual has been challenged under the Freedom of Information Act. As part of our hospital invesitgation, we are preparing two manuals. One is a manual of techniques used to investigate and prosecute fraud and abuse in the hospital setting. The other is an audit handbook for use by accountants in conducting fraud and abuse audits of hospitals.

CONCLUSIONS & RECOMMENDATIONS

We are proud of our accomplishments over the last four years. Not only have we suceeded in prosecuting white collar criminals and returning to the taxpayers many of their misspent dollars, but more importantly, we have been able to independently analyze the problems inherent in this State's health care programs that have given rise to fraud, waste and abuse and through legislative recommendations are attempting to correct these problems.

In New York's nursing home industry alone we have largely eliminated the fraudulent billing of personal expenses to Medicaid, which in recent years included every conceivable luxury item. In addition, and most importantly, we have largely put an end to the mistreatment of nursing home patients.

To do this required the development of a pioneering patient abuse program and the complete overhauling of New York's patient abuse reporting and care code, work previously unknown to the traditional prosecutor's office.

We have provided technical, educational and actual manpower assistance to many states across the country and to a number of Federal programs in organizing fraud and abuse control efforts throught the nation.

Our work was the model Congress used in 1977 in establishing the Medicaid Fraud Control Unit Program. Here, for the first time, Congress directed the development of meaningful fraud control in the form of 90 per cent reimbursement for three years to the states. It is our firm hope that this concept will establish itself as a model for future administration and management of all Federally funded domestic programs.

This office is now shifting priorities from nursing homes to the more pressing areas of hospitals and the various ambulatory care providers, such as doctors, pharmacists, Medicaid mills and the like. We are also devoting an ever-increasing portion of our staff resources to industry-wide investigations. We know that fraud control cannot merely deal with individuals. If we are to avoid an endless treadmill of scandals, the systemic problems that provide opportunities for greed must be addressed.

Essentially, it is necessary to come to grips with the hitherto unshakeable malaise that has always infected all government programs, local and state, as well as Federal, of non-review of their operation (except in time of scandal), non-enforcement of their standards, and non-prosecution of those who fraudulently profit from them. Quite simply, there persists a national climate of irresponsibility about government money. Those who receive it and those who administer it

have shared a common perception that government money costs nothing; that it may be used in any manner whatsoever and forever; and, that its users are entitled to all they can get and then some. Fraud, abuse, waste and mismanagement have been the inevitable result. They are all different manifestations of the same common problem--namely, a lack of concern about government's money that has left government without any system to enforce a standard of proper use of public funds. And, regardless of whether a particular situation is characterized as fraud, abuse, waste or mismanagement, it costs the public just as much money.

Ending the loss of that money will require basic changes in the attitudes and organization of government. The public, who are the beneficiaries of public programs, must perceive a genuine commitment by government to the proper use of its funds.

To accomplish this goal and to offset the self-contained bureaucracies that administer publicly funded programs, we believe there must be established independent mechanisms of enforcement and review. The agencies who administer public funds cannot be left with the sole responsibility for safeguarding their use. With the best intentions in the world, there is an inherent conflict of interest between administrative agencies, who are tied to their personal decisions and vested contituencies, and the public interest in the agency's decisions about the use of public money. It can no longer

be doubted that programs and prosecution simply do not mix. Only an independent enforcement and review body with appropriate power to prosecute crime, take civil action against fiscal abuse, respond to citizen complaints and address the need for legislative and administrative change, can provide the continual corrective force needed to defend the public's interest in the use of its funds.

In this light, the change in attitude within government in the last two years is encouraging, particularly the development of the Federal Inspector General's programs. Similarly, the need for ongoing long term effort in this area is well illustrated by the experience of the Medicaid Fraud Control Unit program. This program is a precedent-shattering decision by the Federal government to engage in building a new enforcement system within the individual states, a concept that might well and admirably serve as the integrity check on any future National Health Insurance Program.

Fraud, abuse, waste and mismanagement cannot be dealt with as separate problems. They are integral parts of an era of spending irresponsibility. We will eliminate these problems only when we definitely bring that era to a close. That in turn will require a new concept of government, with independent enforcement and review of program performance

as an essential part of any government spending. Fraud control, reform of public programs, cannot be addressed on a catch-as-catch can basis in response to scandal, in answer to media disclosures or as a short-term effort to lower the cost of government. We can never again afford to repeat the monumental miscalculation of the Medicaid/Medicare program, wherein millions of dollars were appropriated to fund a noble and needed program, and not five cents was allocated to the prosecutive agencies of this country to safeguard the moral and fiscal integrity of that very program. On the contrary, enforcement and review systems must be viewed as the essential prelude, the condition precedent, to any government program. Then and only then can we be confident that public funds will be used solely for the public purposes for which they were justly intended.

The history and achievements of this office speak to the dawning of this new era regarding government's awakened role in the safeguarding of its people's money.

APPENDICES

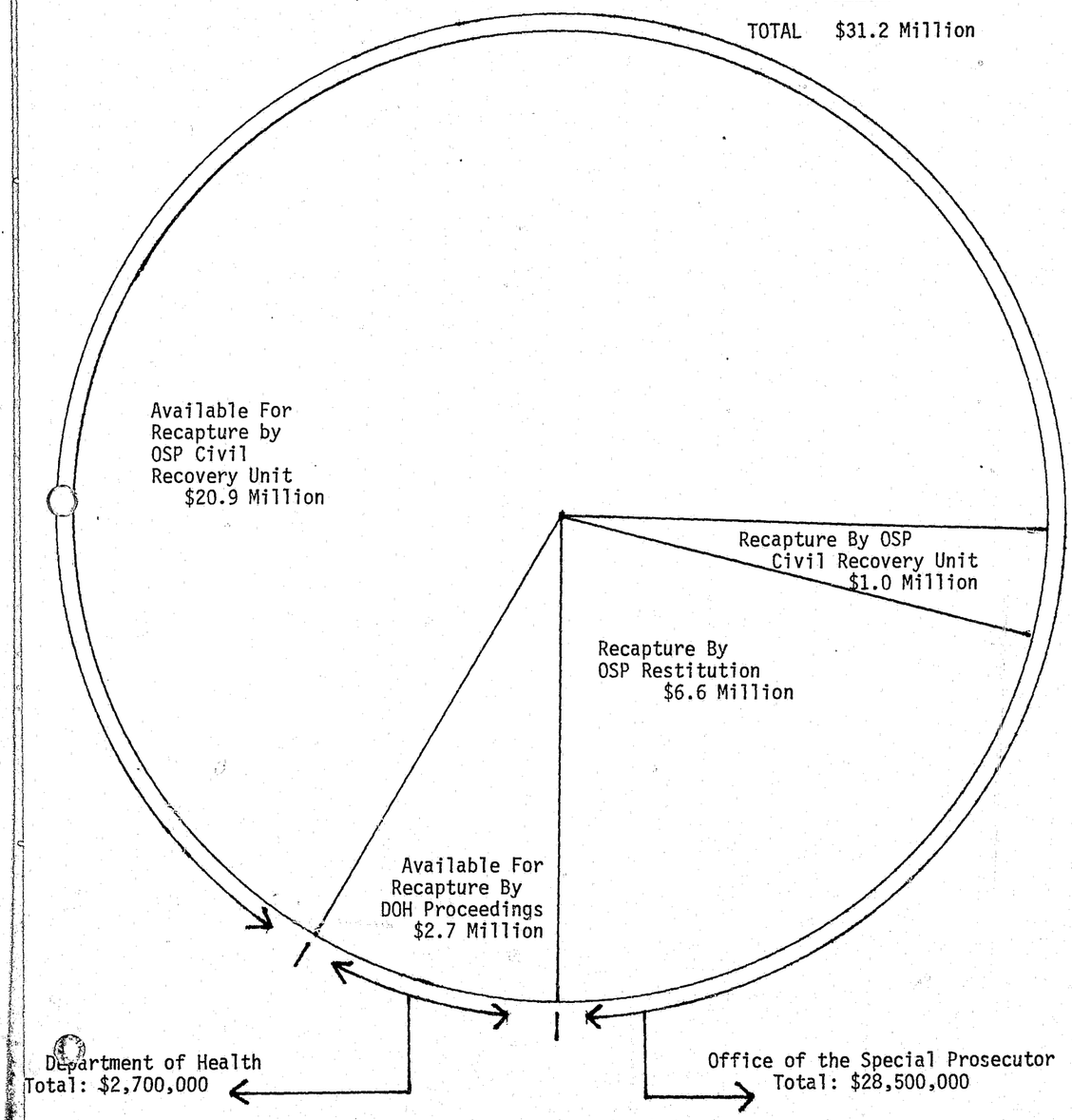
APPENDIX A

ILLUSTRATION I

CHART OF RECOVERABLE MEDICAID FUNDS

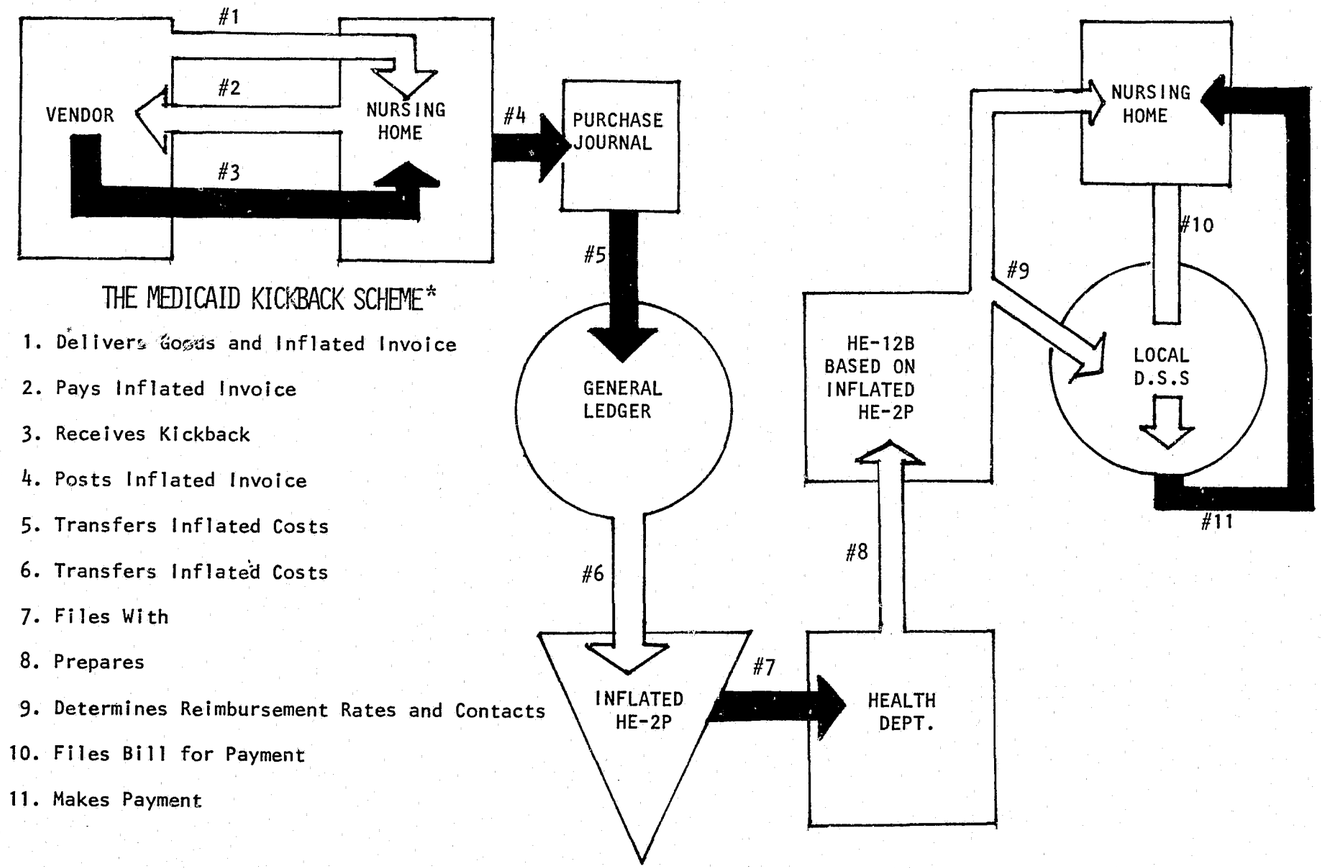
BY: New York State Office of the Special Prosecutor — $28.5 Million
New York State Department of Health — 2.7 Million

TOTAL — $31.2 Million



APPENDIX B

ILLUSTRATION II



THE MEDICAID KICKBACK SCHEME*

1. Delivers Goods and Inflated Invoice
2. Pays Inflated Invoice
3. Receives Kickback
4. Posts Inflated Invoice
5. Transfers Inflated Costs
6. Transfers Inflated Costs
7. Files With
8. Prepares
9. Determines Reimbursement Rates and Contacts
10. Files Bill for Payment
11. Makes Payment

*DARKENED ARROWS DENOTE WHERE CRIMES ARE BEING COMMITTED

APPENDIX C

STATE OF NEW YORK
SPECIAL PROSECUTOR FOR NURSING HOMES
HEALTH AND SOCIAL SERVICES
270 BROADWAY, NEW YORK, N.Y. 10007
(212) 488-2600

CHARLES J. HYNES
DEPUTY ATTORNEY GENERAL

GUIDELINES FOR THE ESTABLISHMENT OF A CENTRAL FILING SYSTEM FOR USE IN THE ELIMINATION OF FRAUD, ABUSE AND ERROR IN HEALTH, EDUCATION AND WELFARE PROGRAMS

* SPECIAL NOTE *

As a result of numerous inquiries to our Office about its Central Files by representatives of government regulatory and law enforcement agencies across the country, we were asked by the U.S. Department of Health, Education and Welfare to describe what we believe to be a very successful filing system and one that is the backbone of the work we have accomplished to date. The purpose of HEW's request to us was to make our information available to those persons attending its National Conference on Fraud, Abuse and Error in Washington, D.C.

What our visitors and inquirers have been told about our standardized filing system is attached, in brief, for your information.

December 1978

INTRODUCTION

The primary purpose of the New York State Office of the Special Prosecutor's* Central File System is the capability of retrieving information in a timely manner. Properly maintained, the system is a source of valuable intelligence data.

When establishing such a system, the following should be considered:

1. how to report the results of an investigation -- should they be set out in a standardized form?

2. how to store and retrieve the information contained in the reports -- should a Central File Unit be established? -- who would be responsible for its maintenance?

Our Office believes that had not consideration been given to such concerns at the outset of our investigation, our project would have failed. We have found that the advantages of a good standardized reporting system are many and include:

1. establishment of a central repository of intelligence information that assists in ongoing and future investigations

2. capability of a reasonably accurate appraisal of current investigations at any time

3. assistance in reallocating personnel where services are needed

4. ready reference when it becomes necessary to reassign an investigation -- in a logical and orderly manner and with a minimum of time and effort

* The Office of the Special State Prosecutor for Nursing Homes, Health and Social Services is an independent operating arm of the Attorney General that was established by the Governor and the Attorney General on January 10, 1975, to deal with the scandals that had been exposed in the Nursing Home industry in New York State. Since that time, it has been designated the "Medicaid Fraud Control Unit" in New York State. Its jurisdiction has been expanded to include the investigation and prosecution of all Medicaid fraud as well as Private Proprietary Homes for Adults, otherwise known as Domiciliary Care Homes or "Adult Homes." There are seven Regional Offices of OSP.

5. assistance in determining the course of an investigation

6. an effective tool in evaluating the quality of an investigation

CLASSIFICATION OF INVESTIGATIVE MATTERS

In order to retrieve information efficiently, any mail, both incoming and outgoing, as well as communications and reports is classified by the Central File Unit according to a standard procedure. The Central Office of the Special State Prosecutor (OSP) has established 26 classifications of the types of investigative matter with which it is normally concerned including, for example:

LIAISON

NEWSPAPER CLIPPINGS

NURSING HOMES (FRAUD AND LARCENY)

PATIENT ABUSE IN NURSING HOMES

PATIENT ABUSE IN ADULT HOMES

PATIENT ABUSE IN HOSPITALS

ADULT HOMES (FRAUD AND LARCENY)

AND ALL OTHER CATEGORIES OF MEDICAID PROVIDERS

Each classification is assigned a number (e.g., Nursing Homes - Fraud and Larceny is No. 6) to distinguish the type of investigation. Within each classification, a new number is given to each case as it is opened and each piece of mail is serialized sequentially within the number.

For example, each piece of mail going into a New York Region Nursing Home file would be classified in a NY-6 classification; the first Nursing Home investigated

CONTINUED

1 OF 2

would be 1, and the first piece of mail dealing with that particular Nursing Home would be 1.

The piece of serialized mail would be read as NY 6-1-1. (If it were a Rochester or Albany Nursing Home file, it would be read as Rochester 6-1-1, or Albany 6-1-1.)

Subsequent mail going into the same Nursing Home file would be placed in date order and be read as:

NY 6-1-2	Rochester 6-1-2	Albany 6-1-2
NY 6-1-3	Rochester 6-1-3	Albany 6-1-3
NY 6-1-4	Rochester 6-1-4	Albany 6-1-4

On the other hand, classification 8 refers to investigation of Vendors. The New York region mail would read NY 8-1-1; NY 8-1-2; NY 8-1-3, etc., for the first Vendor file opened.

When a Supervisor determines a new investigation is to be conducted, he or she must decide the classification of the case. The Central File Unit then assigns the correct classification number, the case file number in sequence; serial numbers then follow sequentially. Legal size cabinets are used to store the files.

ESTABLISHING THE PERMANENT FILE

Once the Supervisor has determined that a new case file should be opened, the case file must be organized in a uniform manner. The file should include such items as background data, reports of interviews, audit reports, reports from confidential informants, reports on the progress of the investigation, newspaper clippings, and any other information that may have evidentiary value, retrieval value, or provide a lead for further investigation.

INDICES*

In order to achieve the primary purpose of the filing system (that is, the retrieval of information), an indices must be established. OSP has found that the easiest and most effective system is a 3 x 5 card index file, the names on which are filed in strict alphabetical order.

When a case file is established, the principal subject (or subjects) of a specific investigation become the title of the case. Before a case is opened, the title is searched through the indices to insure that a prior case file does not exist. If no previous case file exists, the Supervisor underlines the title on the first piece to go into the file. A blue pencil or pen is used for purposes of prominence. The Central File Unit then prepares a 3 x 5 card. In the upper left-hand corner of the index card, the exact title will be typed in capital letters. One space is left between the title and any identifying data such as address, date of birth, employer, etc.

Directly following the exact title, the month and year in which the case arrived in the Central File Unit is noted.

In the upper right-hand corner of the card, the following is typed:

1. regional code -- territory where the investigation takes place (e.g., New York - N.Y.; Buffalo - BU; etc.)

2. classification # -- category of the investigation

3. file # -- number assigned to each new case in that classification

4. serial # -- number assigned to each new piece of mail

* As of November, 1978, OSP Central Files reflects a record of almost 200,000 individual entities in its Indices.

Each serial (i.e., piece of paper, whether mail, memo, report, or the like) to be filed should be marked for indexing -- by underlining in blue pencil all names of individuals, companies, etc. -- of the pertinent information contained therein. The index card would read as follows:

JOHNSTON, WILLIAM J. (MD) 11/78 NY 14-122-32

145 Adams Street
Denver, Colorado

DOB: 11/11/11
SOCIAL SECURITY #: 111-11-1111
Connected with CHILDRENS HOSPITAL

interviewed: 11/11/78

Upon checking the Indices and reviewing the above card, you will note that the New York Regional Office has a record on WILLIAM J. JOHNSTON, MD, of Denver, Colorado, in its Hospital files (14 classification) and that Dr. JOHNSTON is connected with the CHILDRENS HOSPITAL (122nd case opened in the 14 classification) and that his name appears in serial 32 of that file.

When a main case file is opened (CHILDRENS HOSPITAL), the index card will note the file by using an asterisk after the classification and file number. The main case card will appear as follows:

CHILDRENS HOSPITAL 7/78 NY 14-122 *

1515 Main Street
Denver, Colorado

This card indicates, by virtue of the asterisk (*), that a case file has been opened on that particular entity. Once a card is typed for the main subject, it is no longer necessary to mark the subject for indexing in the main file. However, if the title of the main file is changed, a new card will reflect this by typing the name of the new subject and again the asterisk is used.

Once the indexing is completed on a serial, a red "slash mark" is drawn through every blue underline indicating that an index card has been prepared. Some serials may have only one name underlined in blue, others may have 15 or 20; it all depends on the nature of the serial to be indexed. As the cards grow in number and are filed alphabetically, they will be the only means of ascertaining the location of the information in each file.

RETRIEVING INFORMATION

Each case file is placed in numerical sequence within the specified classification. In retrieving material on a particular investigation, OSP staff proceed to the files, pulling that section containing the serial number obtained from the index card for the desired information. If it becomes necessary to remove a file from the Central File Unit, it is done by means of a charge-out card, listing the file number in its entirety, including the last serial # in the file, and signed in the name of the person taking the file and the date taken. This charge-out card is placed where the file is permanently located. Files should always be locatable and OSP requests that all files by returned within five days.

EXHIBITS

Exhibits are those documents, items of evidence, and the like which are pertinent to an investigation. The Central File Unit is the logical place for such documents to be filed. The size and value of the exhibit determine the place where the exhibit should be filed. If an exhibit is of such size that it can be filed in the investigative file, it should be placed in a letter-size manila envelope, referred to as 1A Exhibit, and placed in the first section of the file under serial #1. Each exhibit in the 1A category

is placed in a white envelope showing the file number, cross-referenced to the serial submitting the exhibit, date received by investigating employee, name and address of contributor, name of employee receiving the 1A Exhibit, whether or not it may be returned, and a description of the exhibit. Identical data describing each exhibit is typed on the manila envelope.

When an exhibit is too large or bulky to be placed in the 1A Exhibit manila folder, it should be referred to as a 1B Exhibit and placed in a red-rope envelope and stored in a secure locked cabinet or storeroom. In these cases, a white envelope is made up, containing the same information as in the 1A Exhibit, and filed in the investigative file.

Only authorized OSP staff can charge out either the 1A or 1B type exhibits, again by use of a charge-out card which is then filed as the top serial in the last section of the investigative file. A colored sheet showing the contents of the red-rope envelope is affixed to the outside of the red-rope envelope; a duplicate of the colored sheet is placed on the top of a 1A manila envelope in the first section of the file.

RESPONSIBILITY

The Central File Unit has the responsibility for the orderly receipt, processing and control of all mail, complaints, memoranda, investigative reports, auditor reports, and any related documentary evidence generated during the course of the investigation. Files must be updated daily and the index cards alphabetized and filed as quickly as possible. All cards should be filed within the week. No file should ever be in a "lost status" and to prevent this from happening, a weekly check of charged-out files should be made to ascertain the person working on the file while it is out of the Unit. A physical check of the charged-out file should be made, by ascertaining that the employee still has the file charged to him/her and by reflecting new charge-out dates and names.

COMMENT

Though not an easy task, the system as described above, if properly implemented and administered, will go a long way toward increasing the effectiveness of fraud, abuse and error control. Attention must be given to proper supervision in order to achieve what we believe to be a simple, but elastic, system. Though OSP uses this system in the investigation and prosecution of Medicaid fraud and abuse, we believe this can be adapted to any investigations of fraud, abuse or error.

If we can be of assistance in setting up a Central File Unit, please let us know by writing to MARY E. SUGHRUE, SPECIAL ASSISTANT, OFFICE OF THE SPECIAL PROSECUTOR, 17th Floor, 270 Broadway, New York, New York, 10007.

APPENDIX D

SUMMARY OF PROSECUTIONS
PENDING OR COMPLETED
(MAY 10, 1979)

UNIT OF INVESTIGATION	CASES PENDING* No. of Defendants	CASES COMPLETED No. of Defendants	RESTITUTION PLEDGED/PAID
Regional Offices			
Albany	2	6	$ 22,255.94
Buffalo	4	8	122,194.19
Hauppauge	10	16	1,540,935.00
New York City	23	41	4,020,454.62
Pearl River	7	15	393,992.08
Rochester	0	4	171.500.00
Syracuse	0	5	185,000.00
Adult Homes	3	4	5,697.55
Hospitals	27	2	**
Special Inquiries	1	5	N/A
Patient Abuse	1	5	N/A
Total To Date	78	111	$6,462,029.38
Civil Recovery (total paid -- statewide)			1,222,570.00
		GRAND TOTAL	$7,684,451.38

N/A - Not applicable

Court Fines to date statewide -- $878,030.93

* Includes cases where defendants have been convicted but have not been sentenced and cases where sentences are being appealed.

** At present, Hospital Restitution is included in nursing home figures.

END