JOSH STEIN
ATTORNEY GENERAL

STATE OF NORTH CAROLINA
DEPARTMENT OF JUSTICE

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September 1, 2018

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North Carolina General Assembly
Raleigh, North Carolina 27601-1096

RE: G.S. §114-2.5A; Report on Activities of Medicaid Fraud Control Unit

Dear Members:

G.S. §114-2.5A requires the Attorney General to report by September 1 on the activities of the Medicaid Fraud Control Unit of the Department of Justice, which is the Medicaid Investigations Division, during the previous fiscal year to the Chairs of the Appropriations Subcommittees on Justice and Public Safety and Health and Human Services of the Senate and House of Representatives and the Fiscal Research Division of the Legislative Services Office. Pursuant to that statute, I have enclosed the Medicaid Investigations Division Activities Report for July 1, 2017 through June 30, 2018.

We will be happy to respond to any questions you may have regarding this report.

Sincerely,

Seth Dearmin
Chief of Staff

cc: William Childs, NCGA Fiscal Research Division
John Poteat, NCGA Fiscal Research Division

REPORT TO THE
NORTH CAROLINA GENERAL ASSEMBLY

BY THE
MEDICAID INVESTIGATIONS DIVISION
OF THE
NORTH CAROLINA DEPARTMENT OF JUSTICE

State Fiscal Year July 1, 2017 through June 30, 2018

TABLE OF CONTENTS

I. INTRODUCTION ……1

II. OVERVIEW ……2

III. INFORMATION REQUIRED ON UNIT ACTIVIITES …… 3

1. The number of matters reported to the Unit. …….. 3

2. The number of cases investigated. ……. 4

3. The number of criminal convictions and civil settlements. ……. 4

a. Criminal Convictions …….. 4

b. Civil Settlements ……5

4. The total amount of funds recovered in each case. ……5
The allocation of recovered funds in each case to
(i) the federal government; (ii) the State Medical Assistance
Program; (iii) the Civil Penalty and Forfeiture Fund; (iv) the
N.C. Department of Justice; and (v) other victims. …… 5

Table A Funds Recovered ……6

IV. CRIMINAL CONVICTIONS …… 7

V. CIVIL RECOVERIES …… 15

VI. PROSPECTUS …… 23

I. INTRODUCTION

Pursuant to N.C.G.S. § 114-2.5A "each year the Medicaid Fraud Control Unit of the Department of Justice," which is the Medicaid Investigations Division (MID), "shall file a written report about its annual activities" with the General Assembly. This report covers the activities of the MID for the State Fiscal Year 2017-2018 (FY 17/18), covering the period of July 1, 2017 through June 30, 2018.

G.S. § 114-2.5A requires the report on the MID's activities during the previous state fiscal year to include specific information as follows:

(1) The number of matters reported to the MID.
(2) The number of cases investigated.
(3) The number of criminal convictions and civil settlements.
(4) The total amount of funds recovered in each case.
(5) The allocation of recovered funds in each case to (i) the federal government; (ii) the State Medical Assistance Program; (iii) the Civil Penalty and Forfeiture Fund; (iv) the N.C. Department of Justice; and (v) other victims.

Because the MID receives 75% of its funds from a Federal source, the MID is required by its Federal funding source to maintain statistics and report its activities based on the Federal fiscal year, which is October 1 through September 30. The General Assembly requires that this report present statistics based on the state fiscal year of July 1 through June 30. Pursuant to G.S. § 1-617, the General Assembly also requires a report on *qui tam* cases for the calendar year of January 1 through December 31. While these three reports overlap, the statistics presented in these three reports will vary because they each cover different time periods.

II. OVERVIEW

The MID has worked hard to combat Medicaid provider fraud, the physical abuse of patients in Medicaid funded facilities, the misappropriation of patient funds, and fraud in the administration of the Medicaid program during its 39-year history. In that time over 625 providers have been convicted of crimes relating to Medicaid provider fraud, the physical abuse of patients in Medicaid funded facilities, the misappropriation of patient personal funds, and fraud in the administration of the Medicaid program, and the MID has recovered over $850 million in fines, restitution, interest, penalties, and costs.

The MID continues to maintain strong relationships with the North Carolina Department of Health and Human Services (NC DHHS), the state agency that administers the North Carolina Medicaid Program, and with other law enforcement and prosecutorial agencies. Throughout FY 17/18, the MID continued joint investigations of fraud and patient abuse cases with a number of law enforcement and investigatory agencies, including the United States Department of Health and Human Services Office of Inspector General (OIG), Office of Investigations District Office in Greensboro, N.C.; the Federal Bureau of Investigation (FBI); the Internal Revenue

Service; the United States Department of Justice; N.C. State Bureau of Investigation; and local law enforcement agencies, along with integrity Special Investigations Units (SIUs) within private insurance companies and managed care companies. These relationships serve as a valuable resource for future case referrals.

Medicaid Fraud Control Units from other states seek advice and guidance in the areas of administration, investigation, and prosecution from the MID. The MID strives to maintain and build on this reputation and to assist other units directly and through participation with the National Association of Medicaid Fraud Control Units (NAMFCU). During FY 17/18, MID Director Charlie Hobgood served as a member of the NAMFCU Executive Committee and NAMFCU working groups. MID Criminal Chief Doug Thoren served as a member of the NAMFCU Training Committee and a working group. MID Civil Chief Eddie Kirby served as a member of the NAMFCU Global Case Committee, *Qui Tam* Subcommittee, and Training Committee. MID Civil Attorney Steve McCallister served on NAMFCU working groups. The MID continues to be actively involved in national global cases being coordinated through NAMFCU with the United States Department of Justice and other federal and state agencies. Civil Chief Eddie Kirby, Assistant Attorney Generals Steve McCallister, Stacy Race, Mike Berger, and Lareena Phillips, and Financial Investigators Camille Carrion and Jennifer Brock served on NAMFCU global teams appointed by NAMFCU's Global Case Committee.

The United States Attorney's Offices for the Eastern, Middle, and Western Districts have appointed a number of MID attorneys as Special Assistant United States Attorneys (SAUSA) to pursue criminal and civil Medicaid fraud matters. MID attorneys receive many benefits from this appointment. MID attorneys are collaborating with attorneys in the United States Attorney's Offices for the Western, Middle and Eastern Districts of North Carolina on substantial criminal and civil fraud cases against a variety of Medicaid providers.

The MID has a strong relationship with the North Carolina Division of Health Service Regulation (NC DHSR), the primary agency designated to receive patient physical abuse complaints from or involving long-term care providers in North Carolina. During FY 17-18 the MID continued to provide an extensive training program for its staff through NAMFCU courses. Classes range from multi-level fraud investigation techniques to technical skills training. The MID and Division of Medical Assistance held their yearly joint training to inform all staff of various policies of both agencies and investigative best practices to further our common mission.

The North Carolina General Assembly enacted the North Carolina False Claims Act, G.S. §§ 1-605 through 1-618, effective January 1, 2010. This act established a state *qui tam* law that has improved the MID's ability to prosecute and investigate Medicaid provider fraud and abuse. Since the North Carolina False Claims Act became effective, the MID has received information from and filings by whistleblowers alleging approximately 641 cases of Medicaid fraud and abuse.

It is important to note that during the 2017-2018 session of the North Carolina General Assembly, SB 368, "Update False Claims Act" was enacted effective June 22, 2018. This bill

amended the North Carolina False Claims Act (NCFCA). If the United States Inspector General certifies that these amendments make the NCFCA at least as effective in rewarding and facilitating *qui tam* actions for false and fraudulent claims as those described in the federal False Claims Act, and we believe they do, then the State will qualify under the Deficit Reduction Act to receive a 10% "bump" in recoveries. We have submitted the bill to the Inspector General and have requested that it be certified. If certified the State will be able to retain 43 cents of every dollar recovered instead of 33 cents, which will effectively result in a 30% increase in the State's recovery.

In summary, the MID's activities over the past year in both the criminal and non-criminal areas have proven productive. Our successful investigation and prosecution of a variety of Medicaid providers during FY 17/18 enhanced our reputation as an effective and professional Medicaid Fraud Control Unit that vigorously, but fairly, pursues and prosecutes fraud and abuse.

III. INFORMATION REQUIRED ON MID ACTIVITIES

1. The number of matters reported to the MID.

There were 308 referrals made to the MID during the State FY 17/18; an increase from FY 16/17. The referrals came from varied sources. Referral sources include private citizens, *qui tam* relators, the Office of Compliance and Program Integrity of the Division of Medical Assistance of the NC DHHS, Managed Care Organizations (MCO) in connection with behavioral health services, the Division of Health Service Regulation, local departments of Social Services, former employees, State Survey and Certification, Licensing Boards, the National Association of Medicaid Fraud Control Units, United States Attorney's Offices, and other law enforcement agencies such as Office of Inspector General.

Of those 308 new referrals, the MID opened new case files on 129 matters. The remaining 179 were referred to another agency for review, declined for insufficiency of the evidence, or rolled into existing MID investigations. In many instances, it is appropriate to refer a matter to the North Carolina Division of Medical Assistance for further review or administrative action. DMA can compare the allegation to its history of the provider and conduct billing analysis and reviews to determine whether further investigation is appropriate. Persippany,DMA may then refer the matter back to the MID with the additional data and analysis. In that case, the MID can reconsider whether to open an investigation. Alternatively, DMA may decide to apply one of the administrative remedies or sanctions it has at its disposal. It is also possible that the matter could be referred to another appropriate investigatory agency for action.

A number of referrals were declined on the grounds that the referral did not sufficiently allege Medicaid provider fraud, were not substantiated by a preliminary review, or the potential for successful criminal prosecution was low. Some of the allegations pertained to Medicaid recipient fraud, but the MID's federal grant does not allow the MID to use funding to investigate Medicaid recipient fraud. Therefore, the MID refers recipient fraud allegations to

the Division of Medical Assistance and the county Department of Social Services. Please note that allegations of Medicaid recipient fraud should be referred to the Recipient Services Section of the Division of Medical Assistance, 919-813-5340, or the Fraud Section of the local county Department of Social Services.

Medicaid fraud investigations are complex and labor intensive. The consequences of a fraud conviction on a provider can be severe. Therefore, the MID takes great care to ensure that allegations are substantiated before proceeding with criminal charges or civil actions.

2. The number of cases investigated.

During FY 17/18 the MID staff investigated 514 cases; a decrease from FY 16/17. Due to the length of time required to properly investigate a case, a number of these cases were referred and/or opened prior to FY 17/18. The subjects of investigations included ambulance transportation providers, dentists, durable medical equipment providers, home care providers, laboratories, medical doctors, mental health providers, pain management centers, pharmaceutical manufacturers, pharmacies, and psychiatrists. The MID also investigated caregivers accused of patient physical abuse at Medicaid funded facilities, and the misappropriation of patient personal funds.

3. The number of Criminal Convictions and Civil Settlements.

a. Criminal Convictions

During FY 17/18, the MID had a higher number of convictions and an increase in the amount of restitution from FY 16/18. The MID successfully convicted 22 providers; an increase from FY 16/17. These criminal convictions resulted in more than 780 months of incarceration and in the recovery of $9,640,815.17 in restitution, fines, courts costs, supervision fees, and community services fees. A number of the convicted defendants were connected to each other in some fashion. The various types of connections included family relationships, selling Medicaid patient information to each other, loaning their provider numbers to each other, use of the same billing company, and teaching fraud techniques to each other. While these judgments ordered the repayment of over $13 million in restitution, fines, court costs, and fees, because many of the crimes were related, many of the judgments were “joint and several.” We adjusted our report of the total recoveries to reflect these joint and several judgments; therefore, we are reporting $9.6 million in recoveries rather than $13 million. Details of these convictions are set forth in Section IV of this report.

Of particular note was the criminal conviction of Shephard Lee Spruill, the owner of Carolina Support Services located in Greenville, North Carolina. This matter arose out of the MID investigation into Terry Speller and related cases. The investigation revealed that from January 2013 through June 2015, Spruill conspired with Terry Speller to bill for services not rendered. Spruill also billed for services not rendered with his own companies, including Carolina Support Services. During the Speller investigation, Spruill was subpoenaed to testify before the grand jury. During his testimony, Spruill stated that he had no business interest

involvement with Terry Speller. The investigation revealed that Spruill did have common business interests with Speller and was fraudulently billing the Medicaid Program through his own businesses, specifically, in North Carolina and South Carolina, through Carolina Support Services, Inc. On August 3, 2017, in the United States District Court for the Eastern District of North Carolina, Shephard Spruill pled guilty to Conspiracy to Commit Health Care Fraud, in violation of Title 18, United States Code, Section 1347(a) and 1349 and Perjury, in violation of Title 18, United States Code, Section 1623. On May 1, 2018, Shephard Spruill was sentenced to 96 months imprisonment on Count 1 (Conspiracy) and 60 months imprisonment on Count 2 (Perjury), with the sentences to run concurrent. Spruill was also sentenced to 2-3 years of supervised release for each count to run concurrent. He was given a special assessment of $200.00. He was ordered to pay restitution to the North Carolina Medicaid Program in the amount of over $2.5 million, restitution to the South Carolina Medicaid Program in the amount of over $3.3 million, and restitution to Dr. Punitha Rathnam of over $122,000. This matter was jointly investigated by MID, OIG, and IRS and jointly prosecuted by the USAO and a MID prosecutor appointed to serve as a Special Assistant United States Attorney, and illustrates the effectiveness of joint investigations and prosecutions. Details of this case are set forth in Section V of this report.

b. Civil Settlements

During FY 17/18, the MID had a higher number of civil settlements and an increase in amounts recovered from FY 16/18. The MID successfully obtained 20 civil settlements and recovered $34,060,814.38 in damages, interest, civil penalties, and costs; an increase from FY 16-17.

Of significance was a civil settlement agreement with Mylan, Inc., a Pennsylvania corporation with its principal place of business in Canonsburg, Pennsylvania. Mylan manufactures, distributes, markets and/or sells pharmaceutical products throughout the United States. This matter was referred to the MID by the *qui tam* plaintiff. It was alleged that from July 29, 2010 through March 31, 2017, Mylan knowingly submitted false statements to CMS and/or state governments that incorrectly classified Epipen as a "noninnovator multiple source" drug, as opposed to a "single source" or "innovator multiple source" drug. It was also alleged that Mylan did not report its Best Price to CMS. On August 21, 2017, in conjunction with a national settlement, a settlement agreement was executed between Mylan and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $21.4 million. MID's Civil Chief Eddie Kirby was a leader on a NAMFCU team that helped negotiate a settlement between North Carolina, 49 other states, the District of Columbia, and the United States. This case highlights MID's work on national cases and its cooperation with other states and the United States in our common goal of combating Medicaid fraud. Details of this case are set forth in Section V of this report.

4. The total amount of funds recovered in each case; Allocations.

Together, these 22 criminal convictions and 20 civil recoveries represent a total of $43, 701,629.55 recovered for the State of North Carolina. Consistent with federal reporting

instructions, recoveries are amounts individual and organizational defendants are ordered to pay in criminal cases and must pay in civil judgments and settlements and may not reflect actual collections. A case by case breakdown of the amounts recovered in each case and allocation of recovered funds is shown below in Table A.

Table A Funds Recovered 07/01/2017 - 06/30/2018						
Name	**Federal Government**	**NC Medicaid**	**Civil Penalty & Forfeiture Fund**	**NC DOJ Costs**	**Other**	**Total**
Shephard Lee Spruill	1,662,551.51	867,069.90			3,469,453.45	5,999,074.86 *
Justin Lawrence Daniel / Old Main Pharmacy	314,013.95	165,909.55			1,961,276.56	2,441,200.06
Dr. Duke Ellington Ellis, II	707,254.35	370,712.96			200.00	1,078,167.31
Dr. Jannetta Jordan / Jordan Counseling & Consulting	571,346.55	308,595.78			1,015.00	880,957.33
Darryl Vashaun Stanford	498,221.93	257,003.07			100.00	755,325.00 *
Christopher Leon Brown / Prominence Consulting & therapeutic Services, LLC.	498,221.93	257,003.07			100.00	755,325.00 *
Mark Rayfield Brown, Jr. / Christian Medical, Inc.	293,259.48	152,220.52			100.00	445,580.00 *
Joseph Fran Korezlius / Western Professional Counselor					436,329.08	436,329.08
Carlos Lenard Brown	257,022.00	135,978.00			100.00	393,100.00
Atoya Bellamy	219,398.89	116,484.29			100.00	335,983.18 *
Derek Battle	79,207.48	42,338.52			100.00	121,646.00
Rosa Marie Powell / Designing the Future Home Care, Inc..	32,492.62	16,945.86			772.50	50,210.98
Barbara McDuffie					38,352.89	38,352.89
Christian Hicks Thomas	24,615.45	12,646.81			100.00	37,362.26 *
Idris Lukman Talib / New Horizons Community Services	10,635.80	5,566.20			852.50	17,054.50
Charles Ingram	9,641.37	5,076.03			450.00	15,167.40
Tammy Thompson	6,169.00	3,182.70			425.00	9,776.70
Anthony Brown	5,579.73	2,982.51			625.00	9,187.24 *
Phillip Earl Freeman	5,579.73	2,982.51			460.00	9,022.24 *
Ashley Sawyer					8,421.16	8,421.16
Melissa Mayer					2,792.13	2,792.13
Luis Gomez					557.50	557.50
Total Criminal Recoveries	5,195,211.77	2,722,698.28	0.00	0.00	5,922,682.77	9,640,815.17 *
Sanofi-Aventis US, LLC v. Mylan, Inc.	14,043,534.28	4,408,970.83	1,517,950.70	305,772.03	1,214,512.93	21,490,740.77
McGuire v. Charlotte-Mecklenburg Hospital Authority, Inc., et al	5,413,983.05	608,006.25	168,898.43	79,094.31	230,017.96	6,500,000.00
Brown v. Celgene, Inc.	1,262,614.50	212,812.56	212,812.55	43,331.61	186,926.81	1,918,498.03
James Taggart	822,268.00	156,771.56		15,960.44		995,000.00
Kmart (Garbe v. Kmart)	628,144.59	99,750.20	105,090.35	7,914.49	91,592.48	932,492.11
Piedmont Pathology Associates, Inc.	562,127.89	39,200.65		3,853.46	10,818.00	616,000.00
Carlos Privette, D.D.S.	309,871.00	79,956.48	79,095.72	5,956.80		474,880.00
Atlanticare	213,102.50	48,911.79	59,013.24	3,972.47		325,000.00
Dr. Sassan Basiri, D.D.S.	109,281.19	57,617.54		3,718.43		170,617.16
Rehoboth Consulting Agency	86,263.45	42,407.05		4,042.50		132,713.00
US Bioservices (Kester v. Novartis Pharmaceuticals	77,917.47	31,750.34		2,102.05		111,769.86
Boise v. Cephalon, Inc.	73,248.35	23,078.48		1,533.31	10,426.69	108,286.83
Brooke Stiles, D.D.S.	66,060.00	15,912.77	16,764.66	1,262.57		100,000.00
Javeria Nasir, D.D.S/Javeria Nasir, D.D.S, PLLC	66,330.00	31,572.36		2,097.64		100,000.00
Hale v. Rptech Healthcare, Inc..	31,415.40		10,072.70	123.09	2,083.49	43,694.68
Sanford Pediatric Dentistry/Antonio Braithwaite, DDS	16,812.15	3,942.55	3,942.54	802.76		25,500.00
Allergan, Inc.		5,900.12		600.67		6,500.79
East Carolina Home Care, Inc..	3,009.60	1,397.54		92.86		4,500.00
Gallian & Jones v. DaVita Rx, LLC	2,187.72	606.84	348.78	43.87	63.62	3,250.83
EmCare, Inc.	892.97	178.08	171.01	12.87	115.39	1,370.32
Total Civil Recoveries	23,789,064.11	5,868,743.99	2,174,160.68	482,288.23	1,746,557.37	34,060,814.38
Total Recoveries	28,984,275.88	8,591,442.27	2,174,160.68	482,288.23	7,669,240.14	43,701,629.55 *

* These defendants were ordered to repay $13,840,592.82 joint and severally. The Criminal Recoveries totals have been adjusted to reflect these joint and several judgments.

IV. CRIMINAL CONVICTIONS

The MID reports all criminal convictions to the United States Department of Health and Human Services Exclusion Program which, in turn, will take administrative action to exclude these providers from future participation as providers in Medicaid and any other federally funded health care program for a period of years.

State v. Charles Ingram

Charles Ingram was a Quality Professional at Singleton Care, Inc. located in Greensboro, North Carolina. This case was referred to the MID by the Division of Medical Assistance, Office of Compliance and Program Integrity. Sandhills MCO/LME provided substantial assistance in this investigation.

The investigation revealed that from January 1, 2013 through March 31, 2013, Ingram submitted time sheets and treatment records used to bill the Medicaid program for services he did not render.

On August 1, 2017, Ingram pled guilty to one count of felony Attempted Medical Assistance Provider Fraud in Guilford County District Court. Ingram was sentenced to 45 days in jail, which was suspended. Ingram was placed on 24 months supervised probation. The court ordered Ingram to pay $14,717.40 in Medicaid restitution, $250.00 in community service fees and $200.00 in court costs.

State v. Luis Gomez

Luis Gomez was a Nurse Aide I at the Brian Center Health and Rehabilitation, a Medicaid provider located in Waynesville, North Carolina. This matter was referred to the MID by the Department of Health and Human Resources, Division of Health Service Regulation, Nursing Home Section. It was jointly investigated with the Waynesville Police Department.

The investigation revealed that from January 31, 2016 through February 28, 2016, Gomez sexually abused nursing home residents at his facility.

Gomez was tried in Haywood County Superior Court the week of August 7, 2017. Gomez was convicted by a jury of two counts of felony Second Degree Rape (NCGS 14-27.22(a)), three counts of felony Sexual Activity by a Custodian (NCGS 14-27-31(b)), and one count of felony Second Degree Sexual Offence (NCGS 14-27.27(a)). On August 11, 2017, Gomez was sentenced to a total of 276 months (23 years) to 513 months (42.75 years) in prison. Gomez was ordered to undergo sex offender treatment and pay court costs of $352.50 and $205.00. Gomez was ordered to register as a sex offender for the rest of his life and to enroll in satellite monitoring for life upon his release from prison.

State v. Melissa Mayer

Melissa Mayer was a Personal Care Aide working for A Primary Choice, Inc., a Medicaid provider of personal care services located in St. Pauls, North Carolina. This case was referred to the MID by the Division of Health Services Regulation.

The investigation revealed that from May 26, 2014 through July 21, 2014, Mayer submitted time sheets for services billed to Medicaid that were not rendered.

On August 14, 2017, in Wilson County Superior Court, Mayer pled guilty to one count of misdemeanor Attempted Medical Provider Fraud in violation of NCGS 108A-63(A). Mayer was sentenced to 120 days in jail, sentence suspended, 24 months supervised probation, 90 days electronic monitoring and 72 hours of community service. She was ordered to pay restitution to A Primary Choice, Inc. in the amount of $1,387.13. She was also ordered to pay a $350 fine, $540 in attorney's fees, $205 in court costs, $250 community service fee and $60 in miscellaneous fees.

State v. Anthony Brown

Anthony Brown was a co-owner of Consumer Solutions, LLC, a Medicaid behavioral health provider located in Garner, North Carolina. This matter was referred to the MID by the Division of Medical Assistance, Office of Compliance and Program Integrity.

The investigation revealed that from July 22, 2011 through March 21, 2013, Brown billed Medicaid for services that were not rendered.

On October 4, 2017, in Wake County District Court, Brown pled guilty to one count of felony Medical Assistance Provider Fraud. Brown was sentenced to 6 months to 17 months in prison. Brown was placed on supervised probation for 3 years. Brown was ordered to pay restitution to the Medicaid program in the amount of $8,562.24, plus a fine and costs of $525.00.

State v. Phillip Freeman

Phillip Freeman was a co-owner of Consumer Solutions, LLC, a Medicaid behavioral health provider located in Garner, North Carolina. This matter was referred to the MID by the Division of Medical Assistance, Office of Compliance and Program Integrity.

The investigation revealed that from July 22, 2011 through March 21, 2013, Freeman billed Medicaid for services that were not rendered.

On October 4, 2017, in Wake County District Court, Freeman pled guilty to one count of felony Medical Assistance Provider Fraud. Freeman was sentenced to 6 months to 17 months in prison, which was suspended. Freeman was placed on supervised probation for 2 years. Brown

was ordered to pay restitution to the Medicaid program in the amount of $8,562.24, $200.00 in fines, and $260.00 in court costs.

US v. Justin Daniel

Justin Daniel was a pharmacist and owner of Old Main Pharmacy, Inc., a Medicare and Medicaid provider located in Rowland and Pembroke, North Carolina. This matter was referred to the MID by the Department of Insurance. It was jointly investigated with the Office of Inspector General (OIG).

The investigation revealed that from June 2011 through August 2015, Daniel fraudulently billed Medicare and Medicaid for Ketoprofen Extended-Release Capsules that Old Main had not used in compounding a topical pain relief cream it sold to beneficiaries.

On June 12, 2017, in the United States District Court for the Eastern District of North Carolina, Daniel pled guilty to one count of felony conspiracy to commit health care fraud. On October 10, 2017, Daniel was sentenced to one year and one day of an active prison sentence and 3 years of supervised release. He was ordered to pay restitution to the Medicare program in the amount of $1,961,176.56, $479,923.50 in restitution to the Medicaid program and a $100 special assessment fee.

State v. Rose Marie Powell

Rose Marie Powell was a registered nurse and owner of Designing the Future Home Care, Inc., a Medicaid provider located in Greenville, North Carolina. This matter was referred to the MID by the Division of Medical Assistance, Office of Compliance and Program Integrity.

The investigation revealed that from January 1, 2013 through July 14, 2015, Powell and Designing the Future Home Care fraudulently billed Medicaid for in-home personal care services that were not provided, falsified service documents and paid illegal kickbacks to recipients for referrals.

On October 30, 2017, in Pitt County Superior Court, Powell pled guilty to one count of felony scheme to defraud by a medical assistance provider and one count of felony anti-kickback violation. Powell was sentenced to 60 months supervised probation. Powell will face two consecutive prison sentences of 6-17 months if she violates her probation. Powell was ordered to pay restitution to the Medicaid program in the amount of $49,438.48, $330 and $382.50 in attorney's fees and court costs. Powell was also ordered not to own or manage any business that submits billing claims to the government while on probation.

State v. Ashley Sawyer

Ashley Sawyer was a speech-language pathologist working for Venture Rehabilitation Group, Inc., a Medicaid provider of speech therapy and treatment services located in

Greenville, North Carolina. This matter was referred to the MID by Venture Rehabilitation Group.

The investigation revealed that from January 9, 2015 through September 18, 2017, Sawyer submitted timesheets for services billed to Medicaid that were not rendered.

On November 13, 2017, in Wake County District Court, Sawyer pled guilty to one count of misdemeanor Attempted Medical Provider Fraud in violation of NCGS 108A-63(A). Sawyer was sentenced to 30 days in jail, which was suspended and 12 months unsupervised probation. Sawyer was ordered to pay restitution to Venture in the amount of $8,241.16 and $180.00 in court costs.

U.S. v. Christine Hicks Thomas

Christine Hicks Thomas was a licensed Nurse Practitioner for Premium Human Services, Inc. located in Kinston, North Carolina. This case arose out of an investigation into Terry Speller's many schemes to defraud the Medicaid Program. Terry Speller was convicted of felonious health care fraud in 2015, and Reggie Saunders was convicted of felonious conspiracy to commit health care fraud in 2016. This case investigated a complicated scheme with a large amount of money and monetary transactions involved in the conspiracy. It was jointly investigated with the Office of Inspector General (OIG) and the Internal Revenue Service (IRS).

The investigation revealed that from November 25, 2014 to November 25, 2015, Christine Thomas provided orders authorizing various Medicaid recipients to receive outpatient behavioral health services from Reggie Saunders, in exchange for money. Thomas never evaluated the patients or made any clinical assessment of whether the services were medically necessary for the recipients. These orders were then used to fraudulently bill the Medicaid program.

On September 20, 2017, in the United States District Court for the Eastern District of North Carolina, Christine Thomas pled guilty to felony Illegal Remuneration in violation of Title 42, United States Code, Section 1320a-7b(b) (1) (B). On November 22, 2017, Thomas was sentenced to 24 months probation and 100 hours of community service. She was given a special assessment of $100.00. She was ordered to pay restitution to the Medicaid program in the amount of $37,262.26 of which, $2,386.18 is joint and severally liable with co-conspirator, Reggie Saunders.

State v. Jannetta Jordan

Dr. Jannetta Jordan was a licensed professional counselor and owner of Jordan Counseling and Consulting, a Medicaid behavioral health provider located in Fayetteville and Raeford, North Carolina. This case was referred to the MID by the Division of Medical Assistance, Office of Compliance and Program Integrity.

The investigation revealed that from 2009 through 2015, Jordan billed Medicaid for excessive hours of service per day, billed for in-office services on the same days as patients

were receiving inpatient services in hospitals and lack of supporting documents for services billed.

On December 11, 2017, in Wake County Superior Court, Jordan pled guilty to one count of felony fraud by a medical assistance provider, one count of felony accessing a government computer to defraud, and two counts of felony obstruction of justice. On December 12, 2017, Jordan was sentenced to 34-80 months in prison, suspended for 36 months of supervised probation. Jordan was ordered to pay $879,942.33 as a civil judgment. Jordan was ordered to complete 250 hours of community service. Jordan was ordered to pay $1,015.00 in court costs and attorneys' fees.

State v. Tammy Thompson

Tammy Thompson provided homecare services for recipients in Columbus County. She was employed by A Primary Choice. A Primary Choice was a Medicaid provider in Whiteville, North Carolina. This case was referred to the MID by the Division of Health Service Regulations.

The investigation revealed that from May 23, 2014 through July 15, 2016, Thompson submitted time sheets for services billed to Medicaid that were not rendered.

On December 18, 2017, in Columbus County District Court, Thompson pled guilty to one count Attempted Medical Assistance Provider Fraud, a class 1 misdemeanor, in violation of NCGS 108A-63(A). Thompson was sentenced to 90 days in jail, which was suspended and 24 months supervised probation. She was ordered to pay $9,351.70 in Medicaid restitution, $200.00 in court costs, and $165 in attorney's fees. Thompson was ordered not to attempt to gain employment with any state organization or bill any medical provider services.

U.S. v. Derek Battle

Derek Battle was provisionally licensed individual (LCAS-Associate) and an operator of NoDa Counseling Center, Inc. NoDa was a Medicaid provider of professional counseling services, located in Charlotte, North Carolina. NoDa was owned and operated by Girarud Hope, a former Medicaid provider who was sentenced to 15 months in prison for Medicaid fraud related to his operation of Hope and Family Behavioral Resources in Charlotte, North Carolina. When Hope went to prison, he turned over operations of NoDa to Derek Battle. This matter was referred to the MID by the Division of Medical Assistance, Office of Compliance and Program Integrity. It was jointly investigated with the Office of Inspector General (OIG).

The investigation revealed that from February 2011 through February 2013, Battle billed services purportedly provided by NoDa counseling listing various licensed professionals as the individuals who provided services to Medicaid recipients. In reality, the licensed professionals did not provide services as billed to Medicaid. The investigation revealed that the vast majority of recipients did not receive services at all. Those that did receive services received those services from non-licensed, non-Medicaid approved providers, making those services ineligible for Medicaid reimbursement.

On June 26, 2017, in United States District Court for the Western District of North Carolina, Battle pled guilty to one count of felony Healthcare Fraud and Aiding and Abetting in violation of 18 U.S.C. §§ 1347 and 2. On November 28, 2017, Battle was sentenced to 6 months in prison, followed by 6 months electronic house arrest. Battle was also sentenced to 2 years supervised release. Battle was ordered to pay restitution to the Medicaid program in the amount of $121,546.00.

U.S. v. Joseph Frank Korzelius

Joseph Frank Korzelius was a Licensed Professional Counselor and the owner/operator of Western Carolina Counseling Services, a Medicaid behavioral health provider located in Tryon, North Carolina. This case was referred to the MID by the Division of Medical Assistance, Office of Compliance and Program Integrity.

The investigation revealed that from October 2013 through November 2016, Korzelius was employed as a school counselor for the Polk County School System. Korzelius identified students at his school, their siblings, and other family and community members as Medicaid beneficiaries. Korzelius then submitted false and fraudulent billings to the Medicaid program using these recipients' identifying information to support those claims. The claims lacked any supporting medically necessary documentation. In almost every billing submitted, Korzelius failed to provide any type of service, authorized or not, to the majority of the Medicaid beneficiaries listed in his claim.

On June 7, 2017, in the United States District Court for the Western District of North Carolina, Korzelius pled guilty to one count of felony Health Care Fraud in violation of 18 U.S.C. 1347. On November 30, 2017, Korzelius was sentenced to 24 months of imprisonment and 3 years of supervised release. Korzelius was ordered to pay a $100 assessment and $436,229.08 in restitution to Vaya Health, the new corporate name for the managed care organization formerly known as Smoky Mountain Center.

State v. Idris Talib

Idris Talib was the owner and operator of New Horizons Community Services located in Charlotte, North Carolina. A New Horizons provided behavioral health services. This matter was referred to the MID by the Division of Medical Assistance, Office of Compliance and Program Integrity.

The investigation revealed that from March 6, 2013 through October 23, 2013, Talib submitted claims to the Medicaid program for services she did not provide.

On January 29, 2018, in Mecklenburg County Superior Court, Talib pled guilty to one count of felony Medical Assistance Provider Fraud. Talib was sentenced to 5-15 months suspended with 24 months unsupervised probation. Talib was ordered to pay restitution to the Medicaid program in the amount of $16,202.00, a $500 fine and $325.00 in court costs. Talib was ordered to be excluded as a medical assistance provider for the North Carolina Medicaid Program and any Managed Care Organization within the North Carolina Medicaid Program.

State. v. Barbara McDuffie

Barbara McDuffie was an autism support professional working for the Autism Society of North Carolina, Inc., a Medicaid behavioral health and medical services provider located in Fayetteville, North Carolina. This matter was referred to the MID by the Division of Health Service Regulation, Health Care Personnel Investigations.

The investigation revealed that from February 8, 2016 through November 30, 2016, McDuffie submitted fraudulent timesheets and service notes to the Autism Society for autism support services that McDuffie did not provide or work. Believing McDuffie's timesheets and service notes were true, Autism Society submitted billing claims to the North Carolina Medicaid Program for McDuffie's services.

On March 15, 2018, in Cumberland County Superior Court, McDuffie pled guilty to one count of Felony Medical Assistance Provider Fraud. She was sentenced to 6-17 months in prison, suspended for 60 months on supervised probation. McDuffie was ordered to pay $37,440.39 in restitution to the Autism Society and $912.50 in court costs and attorney's fees. McDuffie was ordered to complete 48 hours of community service within 90 days of the judgment. McDuffie was ordered to maintain employment of at least 30 hours a week and abide by a curfew set by the probation officer. She was also ordered to be evaluated for mental health treatment. Finally, the court ordered that McDuffie cannot work for any medical provider who submits billing claims to the Medicaid Program.

U.S. v. Mark Brown

Mark Rayfield Brown, Jr. was the owner of Christian Medical, Inc. located in Elizabeth City, North Carolina. This case was referred to the MID by the Federal Bureau of Investigation (FBI). It was jointly investigated with the FBI.

The investigation revealed that from April 2014 through May 2015, Christian Medical sold the company name and NPI to co-defendants Chris Brown and Mark Brown. The purchase was part of a scheme to obtain the Health Choice and Medicaid beneficiary numbers in the possession of Christian Medical, Inc. and to use these numbers to bill Medicaid for services not rendered. Darryl Vashaun Stanford entered into this scheme as the biller who submitted the false claims to the Medicaid Program.

On February 16, 2017, in the United States District Court for the Eastern District of North Carolina, Mark Brown pled guilty to felony Conspiracy to Commit Health Care Fraud, in violation of Title 18, United States Code, Section 1347 and 1349. On March 20, 2018, Mark Brown was sentenced to 30 months imprisonment to be followed by 3 years of supervised release. He was given a special assessment of $100.00. Mark Brown was ordered to pay restitution to the Medicaid Program in the amount of $445,580.00. The restitution is ordered to be joint and severally liable with co-conspirators, Christopher Brown and Darryl Stanford. Mark Brown was ordered to forfeit $178,902.00 in proceeds from the offense.

U.S. v. Christopher Brown

Christopher Leon Brown was the owner/operator of two Medicaid providers, Christian Medical, Inc. and Prominence Consulting and Therapeutic Services, LLC located in Elizabeth City, North Carolina. This case was referred to the MID by the Federal Bureau of Investigation. It was jointly investigated with the FBI.

The investigation revealed that from April 2014 through February 2016, Christian Medical sold the company name and NPI to co-defendants Chris Brown and Mark Brown. The purchase was part of a scheme to obtain the Health Choice and Medicaid beneficiary numbers in the possession of Christian Medical, Inc., Prominence Consulting, and Therapeutic Services, LLC and to use these numbers to bill Medicaid for services not rendered. Darryl Vashaun Stanford entered into this scheme as the biller who submitted the false claims to the Medicaid Program.

On May 17, 2017, in the United States District Court for the Eastern District of North Carolina, Christopher Brown pled guilty to felony Conspiracy to Commit Health Care Fraud, in violation of Title 18, United States Code, Section 1347 and 1349. On March 20, 2018, Christopher Brown was sentenced to 40 months imprisonment to be followed by 3 years of supervised release. He was given a special assessment of $100.00. Christopher Brown was ordered to pay restitution to the Medicaid Program in the amount of $755,225.00, of which $755.225.00 is joint and severally liable with Darryl Stanford and $445,480.00 with Mark Brown. Christopher Brown was ordered to forfeit $302,090.00 in proceeds from the offense.

U.S. v. Darryl Vashaun Stanford

Darryl Vashaun Stanford was the biller for Christian Medical, Inc. and Prominence Consulting and Therapeutic Services, LLC located in Elizabeth City, North Carolina. This case was referred to the MID by the Federal Bureau of Investigation. It was jointly investigated with the FBI.

The investigation revealed that from April 2014 through February 2016, Christian Medical sold the company name and NPI to co-defendants Chris Brown and Mark Brown. The purchase was part of a scheme to obtain the Health Choice and Medicaid beneficiary numbers in the possession of Christian Medical, Inc., Prominence Consulting, and Therapeutic Services, LLC and to use these numbers to bill Medicaid for services not rendered. Darryl Vashaun Stanford entered into this scheme as the biller who submitted the false claims to the Medicaid Program.

On April 13, 2017, in the United States District Court for the Eastern District of North Carolina, Stanford pled guilty to felony Conspiracy to Commit Health Care Fraud, in violation of Title 18, United States Code, Section 1347 and 1349. On February 22, 2018, Stanford was sentenced to 34 months imprisonment to be followed by 3 years of supervised release. He was given a special assessment of $100.00. Stanford was ordered to pay restitution to the Medicaid Program in the amount of $755,225.00, of which $755.225.00 is joint and severally liable with

Christopher Brown and $445,480.00 with Mark Brown. Stanford was ordered to forfeit $75,500.00 in proceeds from the offense

U.S. v. Atoya Bellamy

Atoya Bellamy was the Program Manager and biller for Carolina Support Services, owned by Shephard Lee Spruill, located in Greenville, North Carolina. This matter arose out of the MID investigation into Terry Speller and related cases. It was jointly investigated with the Office of Inspector General (OIG).

The investigation revealed that from January 2011 through December 2013, Bellamy, as the biller for Carolina Support Services, billed Medicaid for services not rendered. Spruill, as the owner of Carolina Support Services, conspired with Speller to bill Medicaid for services not rendered.

On November 29, 2017, in the United States District Court for the Eastern District of North Carolina, Atoya Bellamy pled guilty to felony Conspiracy to Commit Health Care Fraud, in violation of Title 18, United States Code, Section 1347(a) and 1349. On May 1, 2018, Atoya Bellamy was sentenced to 12 months and one day imprisonment to be followed by three years of supervised release. She was given a special assessment of $100.00. She was ordered to pay restitution to the Medicaid Program in the amount of $335,883.18, joint and severally liable with Shephard Lee Spruill.

U.S. v. Shephard Spruill

Shephard Lee Spruill was the owner of Carolina Support Services located in Greenville, North Carolina. This matter arose out of the MID investigation into Terry Speller and related cases. It was jointly investigated with the Office of Inspector General (OIG).

The investigation revealed that from January 2013 through June 2015, Spruill conspired with Terry Speller to bill for services not rendered. Spruill also billed for services not rendered with his own companies, including Carolina Support Services. During the Speller investigation, Spruill was subpoenaed to testify before the grand jury. During his testimony, Spruill stated that he had no business interest involvement with Terry Speller. The investigation revealed that Spruill did have common business interests with Speller and was fraudulently billing the Medicaid Program through his own businesses, specifically, in North Carolina and South Carolina, through Carolina Support Services, Inc.

On August 3, 2017, in the United States District Court for the Eastern District of North Carolina, Shephard Spruill pled guilty to felony Conspiracy to Commit Health Care Fraud, in violation of Title 18, United States Code, Section 1347(a) and 1349 and Perjury, in violation of Title 18, United States Code, Section 1623. On May 1, 2018, Shephard Spruill was sentenced to 96 months imprisonment on Count 1 (Conspiracy) and 60 months imprisonment on Count 2 (Perjury), with the sentences to run concurrent. Spruill was also sentenced to 2-3 years supervised release for each count to run concurrent. He was given a special assessment of $200.00. Spruill was ordered to pay restitution to the North Carolina Medicaid Program in the amount of $2,529,621.41, $3,346,633.45 in restitution to the South Carolina Medicaid Program

and $122,620.00 to Dr. Punitha Rathnam. This restitution is joint and severally liable with Terry Speller and Donnie Phillips ($1,968,957.00, each) and Atoya Bellamy ($335,883.18). Spruill was ordered to forfeit $939,989.50 in proceeds from the offense.

U.S. v. Carlos Brown

Carlos Brown was a recruiter and regional office manager working for Nature's Reflections, LLC, a Medicaid behavioral health provider with offices throughout North Carolina. Nature's Reflections was headquartered in Durham, North Carolina. This matter was predicated upon information developed during the course of the investigation of Nature's Reflections, which was referred by the Internal Revenue Service. It was jointly investigated with the Internal Revenue Service and the Office of Inspector General (OIG).

The investigation revealed that from October 2011 through March 2013, Brown submitted falsified medical documents resulting in millions of dollars of fraudulent claims to the Medicaid Program, and Brown had committed violations of the anti-kickback statute by recruiting Medicaid recipients for the sole intent of receiving a percentage of the fraudulent claims billed to the Medicaid Program.

On September 21, 2017, in the United States District Court for the Middle District of North Carolina, Carlos Brown pled guilty to one count of felony illegal healthcare kickbacks. On May 24, 2018, Carols Brown was sentenced to 5 years of supervised probation with one year home detention. Brown was ordered to pay restitution to the Medicaid Program, in the amount of $393,000.00. He was given a special assessment of $100.00. Carlos Brown was also ordered to not work in the healthcare field involving federal funded healthcare programs.

U.S. v. Duke Ellington Ellis, II

Duke Ellington Ellis, II was a social worker who was contracted to sign medical service orders for Nature's Reflections, LLC which was a Medicaid behavioral health provider with offices throughout North Carolina. Nature's Reflections was headquartered in Durham, North Carolina. This matter was predicated upon information developed during the course of the investigation of Nature's Reflections, which was referred by the Internal Revenue Service. It was jointly investigated with the Internal Revenue Service and the Office of Inspector General (OIG).

The investigation revealed that from 2011 through 2015, Duke Ellis was paid by Eric Leak, owner, and operator of Nature's Reflections, to forge the signature of Dr. Sylvia Ellis on fraudulent medical service orders. Dr. Sylvia Ellis was a licensed psychologist and wife of Ellis. Nature's Reflections submitted false billing claims to Medicaid based on the forged service orders.

On January 10, 2018, in the United States District Court for the Middle District of North Carolina, Duke Ellis pled guilty to one count of felony healthcare fraud and one count of felony false medical entries. On June 12, 2018, Duke Ellis was sentenced to 13 months imprisonment to be followed by 3 years of post-release supervision. Ellis was ordered to pay restitution to the

Medicaid Program, in the amount of $1,077,967.31. He was given a special assessment of $200.00.

V. CIVIL RECOVERIES

MYLAN, INC.

Mylan, Inc. is a Pennsylvania corporation with its principal place of business in Canonsburg, Pennsylvania. Mylan manufactures, distributes, markets and/or sells pharmaceutical products throughout the United States. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from July 29, 2010 through March 31, 2017, Mylan knowingly submitted false statements to CMS and/or state governments that incorrectly classified Epipen as a "noninnovator multiple source" drug, as opposed to a "single source" or "innovator multiple source" drug. It was also alleged that Mylan did not report its Best Price to CMS.

On August 21, 2017, in conjunction with a national settlement, a settlement agreement was executed between Mylan and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $21,490,740.77. Of that amount, the federal government received $14,043,534.28 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $7,447,206.49. Of this amount, $4,408,970.83 was paid to the North Carolina Medicaid Program as restitution and interest, $1,517,950.70 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $1,214,512.93 was paid to the *qui tam* plaintiff, and $305,772.03 was paid to the North Carolina Department of Justice for costs of collection and investigation.

CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY

Charlotte-Mecklenburg Hospital Authority is a non-profit hospital authority with a principal place of business in Charlotte, North Carolina. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2011 through December 31, 2015, Charlotte-Mecklenburg Hospital Authority upcoded certain drug tests to obtain higher payment than they should have received for those tests.

On June 29, 2017, a settlement agreement was executed between Charlotte-Mecklenburg Hospital Authority and the State of North Carolina in settlement of these allegations. The settlement funds were received on August 15, 2017. Under the terms of North Carolina's settlement, the State of North Carolina recovered $6,500,000.00. Of that amount, the federal government received $5,413,983.05 to satisfy North Carolina's obligation to return the federal portion of Medicaid and Medicare recoveries to the federal government. The North Carolina State share of the settlement was $1,086,016.95. Of this amount, $608,006.25 was

paid to the North Carolina Medicaid Program as restitution, $168,898.43 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $230,017.96 was paid to the *qui tam* plaintiff, and $79,094.31 was paid to the North Carolina Department of Justice for costs of collection and investigation.

CELGENE, INC.

Celgene, Inc. is a Delaware corporation with its principal place of business in New Jersey. Celgene distributes, sells and markets pharmaceutical products throughout the United States, including the drugs Thalomid and Revlimid. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from April 27, 2000 through June 30, 2015, Celgene engaged in a variety of marketing schemes to promote the use of its drugs Thalomid and Revlimid for off-label use, and paid kickbacks to induce prescribing of these drugs.

On July 12, 2017, in conjunction with a national settlement, a settlement agreement was executed between Celgene, Inc. and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $1,918,498.03. Of that amount, the federal government received $1,262,614.50 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $655,883.53. Of this amount, $212,812.56 was paid to the North Carolina Medicaid Program as restitution, $212,812.55 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $186,926.81 was paid to the *qui tam* plaintiff, and $43,331.61 was paid to the North Carolina Department of Justice for costs of collection and investigation.

JAMES TAGGART

James Taggart was the president and an owner of Physicians Pharmacy Alliance, Inc., a corporation that provides pharmacy services. This matter was discovered in the course of another MID investigation.

It was alleged that from January 1, 2008 through April 30, 2013, James Taggart and Physicians Pharmacy Alliance provided gift cards to patients, physician office employees, and community health center employees in order to induce them to enroll or refer patients to Physicians Pharmacy Alliance.

On May 30, 2017, a settlement agreement was executed between James Taggart and the State of North Carolina in settlement of these allegations. On August 25, 2017, a check in payment of this settlement was received. Under the terms of North Carolina's settlement, the State of North Carolina recovered $995,000.00. Of that amount, the federal government received $822,268.00 to satisfy North Carolina's obligation to return the federal portion of Medicaid and Medicare recoveries to the federal government. The North Carolina State share of the settlement was $172,732.00. Of this amount, $156,771.56 was paid to the North

Carolina Medicaid Program as restitution and $15,960.44 was paid to the North Carolina Department of Justice for costs of investigation.

KMART CORPORATION

Kmart Corporation operates approximately 250 in-store pharmacies throughout the United States. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units and the *qui tam* plaintiff.

It was alleged that from September 1, 2004 through December 31, 2016, Kmart failed to include discounted generic drug prices when billing the Medicaid Program.

On December 22, 2017, in conjunction with a national settlement, a settlement agreement was executed between Kmart and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $932,492.11. Of that amount, the federal government received $628,144.59 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $304,347.52. Of this amount, $99,750.20 was paid to the North Carolina Medicaid Program as restitution, $105,090.35 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $91,592.48 was paid to the *qui tam* plaintiff, and $7,914.49 was paid to the North Carolina Department of Justice for costs of collection and investigation.

PIEDMONT PATHOLOGY ASSOCIATES, INC.

Piedmont Pathology Associates is a private pathology laboratory located in Hickory, North Carolina. This matter was referred to MID by the U.S. Attorney's Office in the Western District of North Carolina.

It was alleged that from August 14, 2012 through February 3, 2015, Piedmont Pathology conducted confirmatory Alcian Blue, Periodic Acid Schiff and Immunohistochemistry stains on gastric biopsy specimens before the specimens were reviewed by a pathologist to determine if the stains were medically necessary.

Pursuant to a settlement between Piedmont Pathology and the United States entered on May 2, 2017, the State of North Carolina recovered $616,000.00 in July 2017. Of that amount, the federal government received $562,127.89 to satisfy North Carolina's obligation to return the federal portion of Medicaid and Medicare recoveries to the federal government. The North Carolina State share of the settlement was $53,872.11. Of this amount, $39,200.65 was paid to the North Carolina Medicaid Program as restitution and interest, $10,818.00 was paid to the *qui tam* plaintiff, and $3,853.46 was paid to the North Carolina Department of Justice for costs of and investigation.

CARLOS PRIVETTE, D.D.S.

Carlos Privette, D.D.S. provides general dentistry services to Medicaid beneficiaries in and around Wake County, North Carolina. This matter was referred to the MID by the North Carolina State Board of Dental Examiners.

It was alleged that from January 1, 2012 through June 9, 2017, Privette billed for inhalation of nitrous oxide/anxiolysis, analgesia, full mouth debridement to enable comprehensive evaluation and diagnosis, limited oral evaluation – problem focused, removal of impacted tooth – completely bony, with unusual surgical complications, comprehensive oral evaluation – new or established patient, removal of impacted tooth – completely bony, and removal of residual tooth roots which were medically unnecessary and had no supporting clinical documentation.

On April 17, 2018, a settlement agreement was executed between Carlos Privette, D.D.S. and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $474,880.00. Of that amount, the federal government received $309,871.00 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $165,009.00. Of this amount, $79,956.48 was paid to the North Carolina Medicaid Program as restitution and interest, $79,095.72 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $5,956.80 was paid to the North Carolina Department of Justice for costs of collection and investigation.

ATLANTICARE HOME CARE AGENCY

Atlanticare Home Care Agency provides home care services to Medicaid recipients in and around Greenville, North Carolina. This matter was referred to the MID by the Division of Medical Assistance, Office of Compliance and Program Integrity.

It was alleged that from March 1, 2011 through November 20, 2015, Atlanticare failed to check the Health Care Personnel Registry to verify aide qualifications. As a result, improperly qualified aides provided services. Atlanticare failed to maintain patient records supporting the level of aide services required by patients. Atlanticare also produced falsified documents in response to a Division of Medical Assistance request for Nurse Aide Registry check verifications. It was also alleged that Atlanticare paid recruiters to recruit patients to its home care business.

On April 27, 2018, a settlement agreement was executed between Atlanticare and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $325,000.00. Of that amount, the federal government received $213,102.50 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $111,897.50. Of this amount, $48,911.79 was paid to the North Carolina Medicaid Program as restitution, $59,013.24 was paid to the Civil Penalty Forfeiture Fund for

the support of public schools, and $3,972.47 was paid to the North Carolina Department of Justice for costs of collection and investigation.

SASSAN BASSIRI, D.D.S

Sassan Bassiri, D.D.S. provides dentistry services to Medicaid beneficiaries in the Middle District of North Carolina. This matter was referred to the MID through the course of a parallel MID criminal case.

It was alleged that from December 1, 2003 through December 31, 2009, Bassiri submitted claims for payment using CDT code D0160 when other lesser codes should have been used.

On September 26, 2016, a settlement agreement was executed between Sassan Bassiri, D.D.S. and the State of North Carolina in settlement of these allegations. On April 5, 2018, a check was received from the U.S. Attorney's Office. Under the terms of North Carolina's settlement, the State of North Carolina recovered $170,617.16. Of that amount, the federal government received $109,281.19 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $61,335.97. Of this amount, $57,617.54 was paid to the North Carolina Medicaid Program as restitution, and $3,718.43 was paid to the North Carolina Department of Justice for costs of investigation.

REHOBOTH CONSULTING AGENCY

Rehoboth Consulting Agency provided behavioral health services to Medicaid beneficiaries in Raleigh, North Carolina. This matter was referred to the MID by the Division of Medical Assistance Office of Compliance and Program Integrity.

It was alleged that from January 1, 2011 through December 31, 2011, Rehoboth billed for individual, group and family outpatient behavioral health services that were not rendered, individual, group and family outpatient behavioral health services rendered by unqualified therapists, and individual, group and family outpatient behavioral health services with no supporting clinical documentation that were not medically necessary.

On May 31, 2017, a settlement agreement was executed between Rehoboth and the State of North Carolina in settlement of these allegations. On July 10, 2017, a check was received. Under the terms of North Carolina's settlement, the State of North Carolina recovered $132,713.00. Of that amount, the federal government received $86,263.45 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $46,449.55. Of this amount, $42,407.05 was paid to the North Carolina Medicaid Program as restitution and interest, and $4,042.50 was paid to the North Carolina Department of Justice for costs of investigation.

US BIOSERVICES CORPORATION

US Bioservices Corporation is a specialty pharmacy headquartered in Frisco, Texas. US Bioservices is a wholly owned subsidiary of AmerisourceBergen Specialty Group. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from August 2010 through March 31, 2012, US Bioservices participated in an arrangement with Novartis under which US Bioservices received additional patient referrals and related benefits in return for achieving a higher refill percentage for Exjade patients as compared to the refill percentage among Exjade patients at other "Exjade Patient Assistance and Support Services" pharmacies.

On September 14, 2017, in conjunction with a national settlement, a settlement agreement was executed between US Bioservices and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $111,769.86. Of that amount, the federal government received $77,917.47 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $33,852.39. Of this amount, $31,750.34 was paid to the North Carolina Medicaid Program as restitution and $2,102.05 was paid to the North Carolina Department of Justice for costs of investigation.

CEPHALON, INC.

Cephalon, Inc. is a Delaware corporation with its headquarters in Frazer, Pennsylvania. Cephalon manufactured and sold pharmaceutical products in the United States. This matter was referred to MID by the National Association of Medicaid Fraud Control Units and the *qui tam* plaintiff.

It was alleged that from June 24, 2006 through April 6, 2012, Cephalon off-label marketed its drugs Treanda and Fentora.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $108,296.83. Of that amount, the federal government received $73,248.35 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $35,048.48. Of this amount, $23,078.48 was paid to the North Carolina Medicaid Program as restitution, $10,426.69 was paid to the *qui tam* plaintiff, and $1,533.31 was paid to the North Carolina Department of Justice for costs of investigation.

JAVERIA NASIR, D.D.S.

Javeria Nasir, D.D.S. provides general dentistry services to Medicaid beneficiaries in and around Raleigh, North Carolina. This matter was discovered during the course of a separate ongoing MID investigation involving a different dental provider.

It was alleged that from January 1, 2015 through July 31, 2015, Nasir submitted claims to the Medicaid Program for extended care visits to skilled nursing facilities in violation of Medicaid policy. Nasir also billed for full mouth debridements that were not medically necessary.

On November 29, 2017, a settlement agreement was executed between Javeria Nasir, D.D.S. and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $100,000.00. Of that amount, the federal government received $66,330.00 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $33,670.00. Of this amount, $31,572.36 was paid to the North Carolina Medicaid Program as restitution, and $2,097.64 was paid to the North Carolina Department of Justice for costs of investigation.

BROOKE STILES, D.D.S.

Brooke Stiles, D.D.S. provides general dentistry services to Medicaid beneficiaries in and around Duplin County, North Carolina. This matter was discovered during the course of a separate ongoing MID investigation involving a different dental provider.

It was alleged that from January 1, 2013 through June 30, 2017, Stiles billed for palliative (emergency) treatment of dental pain – a minor procedure which was medically unnecessary and had no supporting clinical documentation.

On March 27, 2018, a settlement agreement was executed between Brooke Stiles, D.D.S. and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $100,000.00. Of that amount, the federal government received $66,060.00 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $33,940.00. Of this amount, $15,912.77 was paid to the North Carolina Medicaid Program as restitution, $16,764.66 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $1,262.57 was paid to the North Carolina Department of Justice for costs of collection and investigation.

ROTECH HEALTHCARE, INC.

Rotech Healthcare, Inc. is a Delaware corporation with its headquarters in Orlando, Florida. Rotech rents, sells and distributes oxygen and oxygen equipment in the United States. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2009 through March 31, 2012, Rotech implemented new billing software that automatically billed for portable oxygen contents for Medicaid beneficiaries who did not use oxygen contents.

On April 4, 2018, in conjunction with a national settlement, a settlement agreement was executed between Rotech and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $43,694.68. Of that amount, the federal government received $31,415.40 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $12,279.28. Of this amount, $10,072.70 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $2,083.49 was paid to the *qui tam* plaintiff, and $123.09 was paid to the North Carolina Department of Justice for costs of collection.

STANFORD PEDIATRIC DENTISTRY

Sanford Pediatric Dentistry is a North Carolina Medicaid provider that provides pediatric dental services. This matter was discovered during the course of a separate ongoing MID investigation involving a different dental provider.

It was alleged that from January 1, 2012 through December 31, 2016, Sanford Pediatric Dentistry submitted claims to the Medicaid program for Palliative Treatment of dental pain that was not medically necessary.

On July 17, 2017, a settlement agreement was executed between Sanford Pediatric Dentistry and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $25,500.00. Of that amount, the federal government received $16,812.15 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $8,687.85. Of this amount, $3,942.55 was paid to the North Carolina Medicaid Program as restitution, $3,942.54 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $802.76 was paid to the North Carolina Department of Justice for costs of collection and investigation.

ALLERGAN, INC.

Allergan, Inc. is a Delaware corporation with its principal place of business in Parsippany, New Jersey. Allergan develops, manufactures, distributes, markets and sells pharmaceutical products in the United States, including the drugs Restasis, Alphagan, Combigan, Lumigan, Ganfort, Acular, Acular PF, Acular LS, Acuvail, Pred Forte, Zymar, Zymaxid, Alocril, and Elestat. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

It was alleged that from January 1, 2002 through December 31, 2015, Allergan provided kickbacks to providers to induce them to prescribe Restasis, Alphagan, Combigan, Lumigan, Ganfort, Acular, Acular PF, Acular LS, Acuvail, Pred Forte, Zymar, Zymaxid, Alocril, and Elestat.

On May 26, 2017, in conjunction with a national settlement, a settlement agreement was executed between Allergan and the State of North Carolina in settlement of these allegations. On July 7, 2017, a check was received. Under the terms of North Carolina's settlement, the State of North Carolina recovered $6,500.79. Of this amount, $5,900.12 was paid to the North Carolina Medicaid Program as restitution, and $600.67 was paid to the North Carolina Department of Justice for costs of investigation.

EAST CAROLINA HOME CARE, INC.

East Carolina Home Care is a North Carolina Medicaid provider that provides attendant home health services in and around eastern North Carolina. This matter was discovered during the course of a MID criminal investigation.

It was alleged that from May 1, 2017 through June 23, 2017, East Carolina Home Care submitted claims to the Medicaid program for attendant care services that were not performed and had no supporting clinical documentation.

On February 6, 2018, a settlement agreement was executed between East Carolina Home Care and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $4,500.00. Of that amount, the federal government received $3,009.60 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $1,490.40. Of this amount, $1,397.54 was paid to the North Carolina Medicaid Program as restitution, and $92.86 was paid to the North Carolina Department of Justice for costs of investigation.

DAVITA RX, LLC

DaVita Rx, LLC is a Delaware corporation with its principal place of business in Dallas, Texas. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2010 through June 30, 2016, DaVita billed the Medicaid program for prescription medications shipped but returned, prescription medications that were billed but never shipped, and prescription medications that were automatically refilled without sufficient documentation of patient consent.

On December 5, 2017, in conjunction with a national settlement, a settlement agreement was executed between DaVita and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $3,250.83. Of that amount, the federal government received $2,187.72 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal

government. The North Carolina State share of the settlement was $1,063.11. Of this amount, $606.84 was paid to the North Carolina Medicaid Program as restitution and interest, $348.78 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $63.62 was paid to the *qui tam* plaintiff, and $43.87 was paid to the North Carolina Department of Justice for costs of collection and investigation.

EMCARE, INC.

EmCare contracts to provide qualified physicians and related medical professionals to staff Emergency Departments and provide inpatient hospitalist services to hospitals throughout the United States. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units and the *qui tam* plaintiff.

It was alleged that from January 1, 2008 through December 31, 2012, EmCare submitted claims to the Medicaid program for certain inpatient admissions that were medically unnecessary and should have been billed as outpatient or observation services.

On February 28, 2018, in conjunction with a national settlement, a settlement agreement was executed between EmCare and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $1,370.32. Of that amount, the federal government received $892.97 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $477.35. Of this amount, $178.08 was paid to the North Carolina Medicaid Program as restitution and interest, $171.01 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $115.39 was paid to the *qui tam* plaintiff, and $12.87 was paid to the North Carolina Department of Justice for costs of collection and investigation.

VI. PROSPECTUS

Each year the MID has consistently endeavored to achieve a high standard of excellence in our efforts to effectively and efficiently combat fraud and abuse within the Medicaid Program. We continue to be optimistic about the overall progress of our efforts to combat fraud and abuse in the Medicaid Program. Our optimism is based on a number of factors.

- ✓ MID criminal and civil attorneys and investigators are working jointly with other DOJ Sections and the SBI/DECU, providing research, conducting investigations, and conducting criminal prosecutions and civil litigation to combat the opioid epidemic. For example, MID recently filed an intervention complaint against drug manufacturer Insys Therapeutics, Inc., alleging violations of the N.C. False Claims Act. Insys produces and sells Subsys, a highly potent fentanyl painkiller that is sprayed under the tongue and used to treat breakthrough cancer pain. Fentanyl is 50 times stronger than heroin and 100 times more potent than morphine and is highly addictive. MID alleges that Insys paid kickbacks to entice doctors and nurse practitioners to prescribe Subsys to patients. These kickbacks ranged from speaker payments for phony speeches to lavish meals and

entertainment. The complaint also alleges that Insys employees pushed prescribers to prescribe Subsys for patients who were not diagnosed with cancer, and lied to insurance companies about patient diagnoses to obtain Medicaid reimbursements for Subsys prescriptions. The North Carolina Medicaid Program paid over $4.8 million dollars for Subsys prescriptions. North Carolina is leading a team of seven states that have intervened in this case.

- ✓ The MID has been working as part of the United States Department of Justice "Operation Synthetic Opioid Surge" on the Opioid Task Force of the U.S. Attorney for the Middle District. The MID is currently investigating a number of providers for fraudulent activities related to their opioid prescribing practices, in addition to actual patient harm caused by those practices. The MID has also participated in Attorney General Stein's opioid roundtable and provided assistance in the development of the "Stop Act" and the "HOPE Act."
- ✓ MID continues to have a reliable exchange with our Medicaid single-state agency, DMA, especially the DMA/Office of Compliance and Program Integrity, as well as other state and federal investigative and prosecutorial agencies. These relationships have played an important role in the MID's success to date and should significantly contribute to the MID's accomplishments in future fiscal years.
- ✓ MID investigators continue to uncover and obtain evidence showing complex fraud schemes. MID criminal enforcement attorneys continue to make a significant impact by prosecuting felony cases resulting in active time. MID civil enforcement attorneys continue to be actively involved in numerous state cases and national global/multi-state civil cases which have potential for successful conclusions and the recovery of funds for the state in future fiscal years.
- ✓ Each of the Managed Care Organizations (MCOs) managing North Carolina's Behavioral Health Managed Care 1915(b)(c) Waiver program has appointed a Compliance Officer and Committee whose duties include implementing an effective system for identifying and reporting fraud. DMA and MID have provided training to the MCOs in identifying and reporting fraud. DMA and MID have been meeting on a quarterly basis with the MCO compliance staff. MCO compliance staff has shown serious interest in the training and meetings and an understanding of the importance of reporting fraud. MCO compliance staff members have become an important source of fraud referrals in connection with the Medicaid behavioral health program, and we are optimistic that this collaboration will increase.
- ✓ MID continues to have a robust and creative training program that will increase the skill and abilities of MID staff and increase proficiency in investigating and prosecuting fraud and abuse. The Office of Inspector General has highlighted our partnering with another state agency to create a Financial Investigator Academy as a best practice.
- ✓ Utilization of the latest technology for data analytics allows attorneys and investigators to obtain necessary information expeditiously and efficiently in complex fraud investigations. MID software has significantly improved the speed with which MID investigators can import and analyze bank records.

- ✓ The Affordable Care Act (ACA), Title 42 C.F.R. 455.23, requires DMA to suspend payments to any Medicaid provider where there is a credible allegation of fraud unless the MFCU requests that suspension not be imposed if suspension would jeopardize an ongoing investigation. Consistent with procedures established by MFCUs nationwide, the MID and DMA have created a process whereby when DMA refers a provider to the MID, the MID may not object to the suspension of the provider or MID may request that DMA not suspend the provider consistent with the regulation. As a result of this regulation, DMA has been able to suspend Medicaid providers when appropriate in order to prevent further losses of taxpayer money to fraud, and in appropriate cases, MID has been able to request that suspension not be imposed if suspension might compromise or jeopardize an investigation. For a full description of the regulation, please see 42 C.F.R. 455.23.
- ✓ With the implementation of the Medicare Part D prescription drug coverage, states began helping pay for Part D through a phased down State contribution mechanism popularly known as "clawback." It is estimated that in 2017 the North Carolina Medicaid Program will pay over $306 million to the federal government in clawback payments. During this time the federal government received millions for fraud and overpayment cases involving Part D drugs. Despite the states' contributions to the Medicare Part D program, states have not received a single dollar of those recoveries. MID worked with Attorney General Josh Stein, the National Association of Medicaid Fraud Control Units, and the National Association of Attorneys General to lead a bi-partisan effort to address this inequity. MID civil attorneys are part of a NAMFCU team working to bring this to the attention of Congress. If successful, this effort should result in the return of considerable funds to North Carolina.
- ✓ During the 2017-2018 session of the North Carolina General Assembly, SB 368, "Update False Claims Act" was enacted effective June 22, 2018. This bill amended the North Carolina False Claims Act (NCFCA). If the United States Inspector General certifies that these amendments make the NCFCA at least as effective in rewarding and facilitating qui tam actions for false and fraudulent claims as those described in the federal False Claims Act, and we believe they do, then the State will qualify under the Deficit Reduction Act to receive a 10% "bump" in recoveries. We have submitted the bill to the Inspector General and have requested that it be certified. If certified the State will be able to retain 43 cents of every dollar recovered instead of 33 cents, which will effectively result in a 30% increase in the State's recovery.

- ✓ The MID developed and submitted an application to the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services to allow the MID to use its federal grant funding to engage in data mining. On November 13, 2017, OIG granted the MID permission to engage in data mining for three years with three years renewals upon application. On February 18, 2018, NC DHHS agreed to an amendment to the Memorandum of Understanding between the MID and DHHS to establish procedures in which the MID would engage in data mining in cooperation with DHHS. We are optimistic that this new permission to engage in data mining will allow the MID to

identify additional fraud cases to investigate and prosecute and to recover additional funds lost to fraud.

Our optimism must be tempered by identified challenges for the MID as follows: (1) the need to upgrade and enhance our case and document management systems which cannot be accomplished with the current amount of state 25% funding, and (2) the need to address the N.C. Medicaid Program transformation to managed care.

Document and Case Management Systems

One of our most pressing challenges is the need to modernize our current case and document management systems. The Office of Inspector General, our federal oversight agency, sent an audit report to MID recommending that MID replace its current case and document management systems. We concur with OIG's audit finding. Unfortunately, as a result of the July 2017 Attorney General's Office budget reduction, MID had to postpone the purchase of new case and document management systems. While MID's federal grant would pay for 75% of the cost of a new case and document management system used by MID, these federal funds would not be approved unless state funds are made available to pay for 25% of the systems used by MID. In the meantime, the MID is researching the potential of purchasing a smaller system for the Division. MID will continue to work with the Department of Justice IT and Fiscal staffs to accomplish this.

Medicaid Transformation to Managed Care

In 2019 the North Carolina Medicaid Program will transition to managed care. MID has been making recommendations to DHHS regarding provisions needed in contracts with managed care companies to ensure that the managed care companies identify and report fraud. MID will also request that the General Assembly make statutory amendments as necessary to ensure that fraud in the context of managed care can continue to be adequately investigated and prosecuted. MID already has experience coordinating fraud cases with managed care companies that have for a number of years provided Medicaid behavioral health services. MID will continue to develop and strengthen relationships with managed care companies and coordinate with them with respect to fighting Medicaid fraud.

We want to emphasize that the MID civil and criminal operations continue to recover funds resulting in a positive return on investment for every state dollar invested in MID. MID operations also saved state funds by deterring potential fraudsters.

In conclusion, we remain optimistic as to the long-term success of the MID. We are committed to fighting fraud and abuse in the Medicaid Program as efficiently and effectively as possible and pledge our best efforts toward the accomplishment of that goal.