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September 1, 2012

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Senator Thom Goolsby
Representative James L. Boles, Jr.
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Representative Pat B. Hurley
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Representative Marilyn Avila
Representative Justin P. Burr
Co-Chairs, Appropriations Subcommittees on Health and Human Services

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 ("Medicaid Investigations Unit") of the Department of Justice 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 Unit Activities Report for July 1, 2011 through June 30, 2012.

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

Very truly yours,

Kristi Hyman
Chief of Staff

cc: Kristine Leggett, NCGA Fiscal Research Division
Nels Roseland, NCDOJ Deputy Chief of Staff

TO THE
NORTH CAROLINA GENERAL ASSEMBLY

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

SUBMITTED
September 1, 2012

TABLE OF CONTENTS

I. **INTRODUCTION**

The Medicaid Fraud Control Unit, which in North Carolina is the Medicaid Investigations Division ("MID") of the North Carolina Attorney General's Office, is required to prepare and deliver this report pursuant to N.C.G.S. § 114-2.5A, reporting its activities to the General Assembly.

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 requires a report on qui tam cases for the calendar year of January 1 through December 31. While these three reports overlap, the final statistics presented in these three reports will vary because they each cover different time periods.

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

Information Required

(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.

II. OVERVIEW

The MID is proud to present this report 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 to the Fiscal Research Division of the Legislative Services Office. The report covers the activities of the MID for the State Fiscal Year 2011-2012 ("FY 11/12"), covering July 1, 2011 through June 30, 2012.

The MID has worked hard to combat Medicaid provider fraud and the physical abuse of patients in Medicaid funded facilities during our thirty-two year history. In that time over 500 providers have been convicted of crimes relating to fraud and abuse, and the MID has recovered over $530 million in fines, restitution, interest, penalties, and costs.

The MID continues to enjoy excellent 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 11/12, 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 Defense Criminal Investigative Service; the Drug Enforcement Administration; the North Carolina Department of Insurance; the Internal Revenue Service; the United States Department of Justice, along with local law enforcement agencies, and integrity MIDs within private insurance companies. These relationships serve as a valuable resource for future case referrals.

In the spring of 1994, through the efforts of the MID and the FBI, a Federal-State Health Care/Insurance Fraud Information Sharing Task Force was organized and began its operation. Charlie Hobgood, Director of the MID, serves as co-chair of the Group. In addition to the MID and the FBI, agencies with representatives on the Task Force include the Office of Inspector General (OIG), Internal Revenue Service, Postal Inspectors, Defense Criminal Investigative Service, United States Department of Labor, Food and Drug Administration, North Carolina Department of Insurance, and Drug Enforcement Administration. Each United States Attorney's Office in North Carolina has assigned criminal and civil attorneys to work with the Task Force. Also participating are representatives from the Program Integrity Units for many governmental and private health care programs. The Task Force meets quarterly for discussions of ongoing cases, information sharing and training. The MID also participates in the North Carolina Medicare Medicaid (MediMedi) Project. Director Charlie Hobgood is a member of the North Carolina MediMedi Steering Committee.

As in past years, 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 11/12, Director Charlie Hobgood served as President of NAMFCU and a member of the NAMFCU Executive Committee and Finance Committee. Director Hobgood also chaired a number of NAMFCU work groups. MID Criminal Chief Doug Thoren served as Co-Chair of the NAMFCU Training Committee. Civil Chief Eddie Kirby was a member of the NAMFCU Qui Tam Subcommittee. The MID continues to be actively involved in global cases being coordinated through NAMFCU with the United States Department of Justice and other federal and state agencies. Director Hobgood, Deputy Director Pete Krupp, Civil Chief Eddie Kirby, Financial Investigator David Haire and Assistant Attorney Generals Steve McCallister, Stacy Race and Clark Walton served on NAMFCU global teams appointed by NAMFCU's Global Case Committee.

The MID has worked to foster joint federal and state investigations and prosecutions of providers. 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. Our MID attorneys reap 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 providers that began as investigations conducted by the MID. We will continue to foster our relations with these offices in the future.

The MID has an excellent 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. We anticipate our relationship with this agency will continue, which will provide the MID with a valuable source of referrals.

The MID, working with other agencies, was instrumental in developing a course through the North Carolina Justice Academy entitled, "Investigating Crimes Against the Elderly and Disabled." The course provides 24 hours of instruction and has been attended by approximately 200 law enforcement officers. This course is now being offered nationally and has been attended by officers from South Carolina and Georgia. MID Criminal Chief Doug Thoren is responsible for six hours of instruction on the legal issues surrounding abuse investigations.

During FY 11/12 the MID continued to provide a good training program for its staff. This training included sending staff to the NAMFCU Introduction to Medicaid Fraud Training Program; the NAMFCU Annual Training Conference; the NAMFCU Global Case Training; the ABA/NAMFCU National Institute on Health Care Fraud Conference; and various courses relevant to fraud and abuse investigations and the use of computer programs in investigations offered by the Justice Academy of the N. C. Department of Justice, State Personnel Development Center, and Office of State Personnel. The MID and Division of Medical Assistance held a joint training over two (2) days in January to inform all staff of various policies of both agencies to further our common mission.

During the past fiscal year, the Division continued to hire new positions awarded in the 2010 legislative expansion budget and hired one new attorney and four new investigators. In order to train the new attorneys and investigators hired in 2010 and 2011, the MID reached out to NAMFCU, and NAMFCU agreed to present an Introduction to Medicaid Fraud 101 in Raleigh in November 2011 to train new MID employees. This course was taught by experienced attorneys and investigators from Medicaid Fraud Control Units across the country and it was attended by other MFCU staff from all around the country as well as our own staff.

The North Carolina General Assembly enacted the North Carolina False Claims Act, G.S. §§ 1-605 through 1-618, which established a state qui tam law that went into effect on January

1, 2010. Since going into effect, this law 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 received information from and filings by whistleblowers alleging approximately 197cases of Medicaid fraud and abuse.

The federal Deficit Reduction Act ("DRA") provides that if a state enacts a state false claims act that is certified by the Inspector General of the United States Department of Health and Human Services as being as effective as the Federal False Claims Act in rewarding a facilitating qui tam actions by relators (whistleblowers), then the state is allowed to retain an additional ten percent of the Federal share of recoveries. Unfortunately, the Inspector General has determined that the North Carolina False Claims Act does not comply with DRA because it does not contain the latest revisions to the Federal False Claims Act. In order to comply with DRA, the state False Claims Act would have to be amended.

The MID enjoys the full support and confidence of Attorney General Roy Cooper. Attorney General Cooper is firmly committed to the detection and prosecution of fraud and abuse by providers in the Medicaid Program. He has also been a strong advocate for our enforcement efforts to protect the elderly from physical or financial abuse. Attorney General Cooper has worked to enhance cooperation between government agencies in fighting the health care fraud problem and supports the MID's participation in the federal-state Task Force. Unquestionably, the support and assistance provided by Attorney General Cooper has significantly contributed to the overall success of the MID during FY 11/12.

In summary, the MID's activities over the past year in both the criminal and non-criminal areas have proven highly productive. Our successful investigation and prosecution of a variety of Medicaid providers during FY 11/12 have served to maintain and enhance our reputation as an effective and professional investigative MID that vigorously, but fairly, pursues and prosecutes fraud and abuse.

III. INFORMATION REQUIRED ON MID ACTIVIITES

1. Matters reported to the MID.

There were 347 referrals made to the MID during the State FY 11/12. The referrals came from varied sources. The most valuable referrals came from the Program Integrity Section of the Division of Medical Assistance of the North Carolina DHHS. Referrals also came from citizens, health care professionals, law enforcement, and other governmental agencies including the Division of Health Service Regulation. Referrals also came from federal governmental agencies and contractors including the Department of Health and Human Services Office of Inspector General, Office of Investigations, and U.S. Department of Justice, U.S. Attorney's Office. Referrals were also received from the NAMFCU and qui tam plaintiffs.

Of those 347 new referrals plus six referrals that were pending at the beginning of the fiscal year, the MID opened new case files on 206 matters. Four were still under preliminary review at the end of the fiscal year. The remaining 143 were either referred to another agency for review or declined for insufficiency. 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. 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. Some of the allegations were not substantiated by a preliminary review. In some instances the dollar amount of fraud alleged was low or the potential for successful criminal prosecution was low. Some of the allegations did not pertain to Medicaid provider fraud but rather pertained to Medicaid recipient fraud. 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, 919-855-4000, 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 11/12 the MID staff actively investigated 502 cases. 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 11/12. The subjects of current investigations include community support providers; personal care service providers; mental and behavioral health facilities; physicians; dentists; psychiatrists; pharmacies; pharmaceutical manufacturers; durable medical equipment suppliers; transportation providers; home health care providers and aides; nursing facilities; and hospitals. The MID is also investigating care givers accused of patient physical abuse and neglect at nursing facilities and hospitals, and the theft of recipients' personal funds.

3. Criminal Convictions and Civil Settlements.

a. Criminal Convictions

During FY 11/12, the MID successfully convicted 33 providers. These criminal convictions resulted in the recovery of $10,493,286.99 in restitution, fines, courts costs, supervision fees, and community services fees. Details of these convictions are set forth in Section IV of this report.

FY 11/12 was a year of significant accomplishments. Of particular note was the criminal conviction of Shirlene Boone, the owner of Metropolitan Counseling, a Medicaid community support service provider located in Murfreesboro, North Carolina. A joint MID and IRS investigation revealed that between January 2000 and May 2010 Metropolitan Counseling Services was billing for community support services and HIV case management services that were not provided and in many cases were not necessary. Boone pled guilty in United States District Court for the Eastern District of North Carolina to one (1) count of Conspiracy to Commit Health Care Fraud and Mail Fraud, one (1) count of Aggravated Identity Theft, and Aiding and Abetting and one (1) count of Failure to Collect and Pay Over Payroll Taxes. Boone was sentenced to twelve (12) years incarceration and placed on three (3) years, eighteen (18) months active probation after she is released. Boone was also ordered her to pay restitution in the amount of $3,550,840.30 to the Medicaid program, $46,059.00 to the North Carolina Employment Security Commission, and $1,061,820.00 to the IRS for a total restitution of $4,658,719.30. Along with Boone, two of her employees, Darick Brant and Lemuel Cobb, were convicted of Conspiracy to Commit Health Care Fraud. Bryant and Cobb cooperated with authorities and were sentenced to probation and ordered to pay restitution of $4,659,129.30 jointly and severally with Shirlene Boone.

Another notable accomplishment was the criminal conviction of Angela Almore, a Nurse at Britthaven of Chapel Hill, a nursing home located in Chapel Hill, North Carolina. A joint MID and SBI Drug Diversion investigation revealed that Almore unlawfully gave morphine to patients causing injury to the patients transferred and death of one of the patients by a morphine overdose. Almore pled guilty in Orange County Superior Court to the reduced charge of involuntary manslaughter and six (6) counts of Patient Abuse. Almore was sentenced to sixteen (16) to twenty (20) months incarceration. The sentence was suspended and Almore was ordered to serve (5) months incarceration and placed on supervised probation for thirty (30) months. Almore was ordered not to work in any health care related field or any health care facility in any capacity.

In December 2011 the MID organized a “round up” of 20 individuals, statewide, alleged to commit Medicaid fraud against the Medicaid program. To date sixteen (16) of twenty (20) defendants have been convicted.

b. Civil Recoveries

During this period the MID obtained 17 civil settlements and recovered $42,207,767.56 in damages, interest, civil penalties, and costs. Of significance was a civil settlement agreement executed between Merck & Co. and the state of North Carolina in settlement of allegations that Merck promoted Vioxx for rheumatoid arthritis, an indication for use not approved by the federal Food and Drug Administration. This settlement also resolves allegations that Merck promoted the cardiovascular safety of Vioxx with certain statements by representatives and promotional speakers in written materials that were inaccurate, misleading and inconsistent with the approved labeling for the drug and also made false representations concerning the safety of Vioxx to state Medicaid agencies. Under the terms of North Carolina's settlement, the State of North Carolina recovered $19,131,562.93. Details of civil recoveries are provided in Section V of this report.

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

Together, these 33 criminal convictions and 17 civil recoveries represent a total of $52,701,054.55 recovered for the State of North Carolina. A case by case breakdown of the amounts recovered in each case and allocation of recovered funds is shown in Table A below.

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 of Justice; and (v) other victims.

The allocation of recovered funds in each case is case is shown in Table A as follows:

Table A Funds Recovered						
Name	Federal Government	NC Medicaid	Civil Penalty & Forfeiture Fund	NC DOJ Costs	Other	Total
Metropolitan/S. Boone	3,324,961.72	1,287,698.58			46,359.00	4,659,019.30*
Darick Bryant	2,168,303.48	1,233,736.84			100.00	3,402,140.32*
Giraud Hope	1,264,934.59	683,516.72			100.00	1,948,551.31*
Erika Rankin Holland	1,032,371.07	552,721.93			200.00	1,585,293.00*
Universal Services/Reynolds Home care/Michelle McLain	1,313,753.87	46.27			500.00	1,314,300.14*
Reynolds / Universal / R. McLain	1,313,753.87	46.27			400.00	1,314,200.14*
Sarah L. Willis	846,061.65	384,177.13			325.00	1,230,563.78
Janet Johnson-Hunter	458,343.80	16,745.20			10,100.00	485,189.00
Michele Jackson	190,085.84	103,196.16			100.00	293,382.00*
Lemuel Cobb	96,114.88	52,685.12			100.00	148,900.00*
Mecklenburg Open Doors/E. Payton					131,494.98	131,494.98
Tung Nguyen	46,999.02	26,370.46			20,300.00	93,669.48
Latesha Daniels					50,000.00	50,000.00
Ronnie Thompson	28,762.34	16,470.16			205.00	45,437.50
Crystal Brewster	17,102.29	9,382.09			210.00	26,694.38
Malcolm Xosha Burns					19,613.14	19,613.14
Jessie Absher	5,090.06	2,790.10			200.00	8,080.16*
Tammy Williams	3,852.75	2,086.89			435.00	6,374.64
Cynthia Denise McLean	2,961.94	1,638.06			300.00	4,900.00
Deidra Holloway	2,134.90	1,186.10			424.50	3,745.50
Billie Jo Castillo (Bingman)	1,803.08	988.36			535.00	3,326.44
Patricia Atkins	1,632.29	893.59			591.00	3,116.88*
Reliable Healthcare Serv.	1,509.82	842.66			590.00	2,942.48
Dwana Sanchez	1,057.37	579.43			310.00	1,946.80*
Rena Mahan	980.47	537.29			210.00	1,727.76*
Geralyn Brown	988.49	566.71				1,555.20
Tara Whitted					1,323.00	1,323.00
Desiree Payne	311.54	169.90			590.00	1,071.44
Lisa Cook	359.67	192.57			380.00	932.24
Perry Reese					300.00	300.00
Doug Davis					155.00	155.00
Timothy Batts #2						0.00
Angela Almore						0.00
Total Criminal Recoveries	7,613,577.40	2,593,258.97	0.00	0.00	286,450.62	10,493,286.99
Merck & Co. (Vioxx)	11,257,481.87	3,451,140.81	4,230,512.61	192,427.64		19,131,562.93
KV Pharmaceutical Company (KV)	196,034.75	156,957.93		3,656.23		356,648.91
Medtronic, Inc.	39,023.43	12,178.85	11,542.58	596.78		63,341.64
Dava Pharmaceuticals, Inc.	475,999.27	334,907.51		7,583.69		818,490.47
Hawthorn Pharmaceuticals & Cypress Pharmaceuticals	53,723.07	30,731.36		794.45		85,248.88
Maxim	7,809,995.20	3,862,995.19		94,280.61		11,767,271.00
Millicent Francis-Lane	610,755.00	169,422.43	161,473.89	8,348.68		950,000.00
Ameritox, LTD	157,964.03	26,203.52	61,997.73	3,902.61		250,067.89
Roanoke Valley	1,414,320.00	83,520.86		2,159.14		1,500,000.00
Lakita Patel	479,700.00	131,744.22	131,744.22	6,811.56		750,000.00
NOVO (NOVOSEVEN)	164,494.45	44,908.92	48,119.23	2,374.82		259,897.42
Eisai, Inc. (Zonegran)	301,978.39	91,815.54	89,319.34	4,618.05		487,731.32
Elan Corporation (Zonegran)	2,110,196.22	462,888.82	897,890.41	34,644.45		3,505,619.90
Equistat LLC & Stasis, LLC	333,294.17	14,387.94	7,193.97	557.92		355,434.00
UCB(Keppra)	541,456.24	134,230.21	106,829.93	6,134.67		788,651.05
Mariner Health Care, Inc. & Sava Senior Care Administrative Services, LLC	565,146.48	165,280.85	159,152.08	8,228.62		897,808.03
Pfizer (Detrol)	151,269.06	44,049.86	42,478.92	2,196.28		239,994.12
Total Civil Recoveries	26,662,831.63	9,217,364.82	5,948,254.91	379,316.20	0.00	42,207,767.56
Total Recoveries	34,276,409.03	11,810,623.79	5,948,254.91	379,316.20	286,450.62	52,701,054.55

*These defendants were ordered to repay $6,296,659.02 joint and severally. The Criminal Recoveries totals have been adjusted to reflect these joint and several judgments.

IV. CRIMINAL CONVICTIONS

U.S. v. SHIRLENE BOONE (METROPOLITAN COUNSELING)

Shirlene Boone was the owner of Metropolitan Counseling Services, a Medicaid provider located in Murfreesboro, North Carolina. This matter was referred to the MID by the North Carolina Division of Medical Assistance, Program Integrity section.

A joint MID and IRS investigation revealed that between January 2000 and May 2010 Metropolitan Counseling Services was billing for community support services and HIV case management services that were not provided and in many cases were unnecessary. Many of the patients for whom Metropolitan billed counseling services were not in need of counseling services and in some cases were not even aware Metropolitan was billing for services on their behalf. Some patients for whom Metropolitan was billing HIV case management services were not HIV positive. Ms. Boone also engaged in a scheme that involved falsely laying off all of her staff so they could file for unemployment and then using the ESC checks to pay her staff their salaries.

On December 13, 2010 Shirlene Boone was indicted by a Federal Grand Jury for the Eastern District of North Carolina. A subsequent Superseding Information was filed on January 3, 2011. Boone pled guilty on January 3, 2011 to one (1) count of Conspiracy to Commit Health Care Fraud and Mail Fraud, one (1) count of Aggravated Identity Theft, and Aiding and Abetting and one (1) count of Failure to Collect and Pay Over Payroll Taxes. On April 26, 2011 the United States District Court for the Eastern District of North Carolina sentenced Boone and ordered her to pay restitution in the amount of $3,550,840.30 to the Medicaid program, $46,059.00 to the North Carolina Employment Security Commission, and $1,061,820.00 to the IRS for a total restitution of $4,658,719.30. Boone was also sentenced to twelve (12) years incarceration and placed on three (3) years, eighteen (18) months active probation after she is released.

U.S. v. DARICK BRYANT (METROPOLITAN COUNSELING)
U.S. v. LEMUEL COBB (METROPOLITAN COUNSELING)

Darick Bryant was employed as the Agency Director and Lemuel Cobb was employed as the HIV Supervisor of Metropolitan Counseling Services, a Medicaid provider located in Murfreesboro, North Carolina. This matter was referred to the MID by the North Carolina Division of Medical Assistance, Program Integrity section.

A MID investigation revealed that between January 2000 and May 2010 Metropolitan Counseling Services was billing for community support services that were not provided. During the execution of a search warrant, Bryant and Cobb confessed to fabricating at least 80-85% of the treatment notes previously indicated as possibly being fraudulent. Bryant and Cobb continued to provide assistance to the government in their investigation of Metropolitan Counseling Services and its owner Shirlene Boone. This information led to the conviction and imprisonment of Boone.

On December 6, 2010 Bryant pled guilty to one (1) count of Conspriacy to Commit Health Care Fraud. On March 24, 2011 Bryant appeared in the U.S. District Court for the Eastern District of North Carolina and was sentenced to five (5) years probation, ordered to pay a $100.00 assessment and $3,402,040.32 in restitution both jointly and severally with Boone and Cobb. On April 16, 2011 Cobb appeared in the U.S. District Court for the Eastern District of North Carolina and pled guilty to one (1) count of Conspiracy to Commit Health Care Fraud. Cobb was sentenced to five (5) years probation and ordered to pay $100.00 assessment and restitution to the Medicaid Program in the amount of $148,800.00 both jointly and severally with Bryant and Boone. These defendants, along with Boone, were ordered to pay a total restitution of $4,659,129.30 jointly and severally.

U.S. v. MICHELLE MCLAIN (UNIVERSAL SERVICES/REYNOLDS HOMECARE)
U.S. v. RUBEN MCLAIN (UNIVERSAL SERVICES/REYNOLDS HOMECARE)

Michelle and Ruben McLain were the owners of Universal Services d/b/a/ Reynolds Home Care, a Medicaid provider located in Winston-Salem, North Carolina. This matter was referred to the MID by the North Carolina Division of Medical Assistance, Program Integrity Section.

A joint MID, HHS-OIG and IRS investigation revealed that between January 2004 and December 2008 Universal Services d/b/a Reynolds Home Care was engaging in a number of fraudulent practices related to the provision of personal care services, including but not limited to billing for services not provided, billing for services not necessary and forging documentation.

On September 27, 2010 McLain and McLain were both indicted in the U.S. District Court for the Middle District of North Carolina on numerous counts including Health Care Fraud, Tax Evasion, and Conspiracy to Defraud the United States. The basis of the health care fraud allegations were confined to instances of billing for services not provided. The indictment alleged a number of instances the McLains, through their company, billed for personal care services provided to individuals who were deceased. On January 24, 2011 Michelle and Ruben McLain entered into plea agreements with the Government in which they pled guilty to the charges enumerated above, as well as making false entries involving a health care benefit program and failure to pay payroll taxes. On August 10, 2011 the McLains were sentenced in U.S. District Court for the Middle District of North Carolina, to each serve an active sentence of twenty-four (24) months incarceration, followed by three (3) years of supervised release. Michelle McLain was ordered to pay an assessment of $500.00; Ruben McLain was ordered to pay an assessment of $400.00. Each was ordered restitution in the amount of $1,313,800.14 with $1,313,671.14 being restitution to the IRS and $129.00 to the Medicaid Program. These defendants were ordered to pay $1,313,800.14 joint and severally.

U.S. v. GIRAUD HOPE

Giraud Hope was the owner of Hope & Family Behavioral Resources (HFBR), a Medicaid Mental Health provider located in Charlotte, North Carolina. This matter was discovered during the course of another MID investigation.

A joint MID and HHS-OIG investigation revealed between November 2009 and October 2010, Hope was unable to obtain his own Medicaid provider number, so he approached Joanna Patronis about assisting in applying for a provider number for HFBER using a licensed doctor as the attending provider. HFBR received a Medicaid provider number and Patronis started submitting billings for services performed by Hope and Licensed Professional Counselors (LPCs) who worked with Hope. Later, Patronis told Hope she knew several licensed or provisionally licensed individuals who were unable to bill claims to Medicaid on their own. Patronis asked Hope if he would allow these individuals to bill their services to Medicaid using HFBR's provider number. Hope agreed to this arrangement and claims for these individuals were billed to Medicaid using HFBR's Medicaid provider number. Hope was given ten (10) percent of the Medicaid reimbursement for these claims.

On February 9, 2011 Hope pled guilty to one (1) count of Conspiracy to Commit Health Care Fraud. The United States District Court, for the Western District of North Carolina sentenced Hope on October 18, 2011 to a term of fifteen (15) months incarceration. Upon release from prison, Hope was ordered to serve a term of three (3) years on supervised probation, pay a $100.00 assessment fee and a total of $1,948,451.31 in restitution to the Medicaid Program, which he is jointly and severally liable along with other co-conspirators.

U.S. v. MICHELE JACKSON

Michele Jackson (Jackson) was the owner of Star Freedom, Inc., a mental and behavioral health service company located in Hamlet, North Carolina. This matter was discovered during the course of another MID investigation.

A joint MID and HHS-OIG investigation revealed that between April 2009 and October 2010 Jackson was not licensed to provide mental and behavioral health services, and neither Jackson nor her company was approved by the Medicaid Program to provide mental and behavioral health services. Co-conspirators Joanna Patronis, Giraud Hope and others, agreed to submit Medicaid claims under their respective Medicaid provider numbers, for the unauthorized and fraudulent services purportedly provided by Jackson and her company. In exchange for submitting the Medicaid claims, Jackson agreed to pay the co-conspirators a percentage of the total paid Medicaid claims.

On June 9, 2010, Michele Jackson pled guilty to one (1) count of Conspiracy to Commit Healthcare Fraud. The United States District Court for the Western District of North Carolina sentenced Jackson on March 5, 2012. The Court sentenced Jackson to a term of fifteen (15) months incarceration. Upon release from prison, Jackson is ordered to serve a term of two (2)

years on supervised probation. Jackson was further ordered to pay a $100.00 assessment fee and a total of $293,282.00 in restitution to the Medicaid Program, which she is jointly and severally liable along with other co-conspirators in the following apportions: $213,952.00 joint and several with Joanna Patronis; $58,947.00 joint and several with Giraud Hope; and $20,383.00 joint and several with Teresa Marible.

U.S. v. ERIKA RANKIN HOLLAND

Erika Holland was the owner of several companies including: Faithful Shepard's Home Care, LLC; Faithful Shepard's Family Services; Open Arms; Berry, Inc.; and New Covenant Community Development Center located in the Charlotte/Gastonia area. Each of the Companies allegedly provided mental and behavioral health services. This matter was discovered during the course of another MID investigation.

A joint MID and HHS-OIG investigation revealed that between October 2009 and September 2010 Holland was not licensed to provide mental and behavioral health services, nor did she employ any licensed individuals at her companies. Neither Holland nor any of her companies were approved by the Medicaid Program to provide mental and behavioral health services. Co-conspirators, Joanna Patronis and Giraud Hope, agreed to submit Medicaid claims under their respective Medicaid provider numbers, for the unauthorized and fraudulent services purported provided by Holland and her companies. In exchange for Patronis and Hope submitting Medicaid claims for Holland and her companies, Holland agreed to pay the co-conspirators a percentage of the total paid Medicaid claims.

On September 2, 2011 Holland pled guilty to one (1) count of Conspiracy to Commit Healthcare Fraud, and one (1) count of Money Laundering. The United States District Court for the Western District of North Carolina sentenced Holland on March 5, 2012. The Court sentenced Holland to a term of fifty-four (54) months incarceration. Upon release from prison, Holland is ordered to serve a term of three (3) years on supervised probation, imposing the standard conditions of probation. Holland was ordered to pay a $200.00 assessment fee and a total of $1,585,093.00 in restitution to the Medicaid Program, some of which she is jointly and severally liable along with other co-conspirators in the following apportions: $122,293.00 joint and several with Joanna Patronis and $1,370,475.00 joint and several with both Joanna Patronis and Giraud Hope.

U.S. v. SARAH WILLIS

Sarah Willis was the owner of Adolescent and Adult Services, a Medicaid provider located in Charlotte, North Carolina. This matter was referred to the MID from the North Carolina Division of Medical Assistance, Program Integrity section.

A joint MID and HHS-OIG investigation revealed that between 2007 and January 2010 Willis billed for services not allowed under her provider credentials, submitted billings for

services after her license had expired, failed to obtain prior approvals for services, and failed to furnish medical records to support services billed.

On February 10, 2011 Willis entered a plea agreement to one (1) count of Healthcare Fraud, one (1) count of Money Laundering, and one (1) count of Failing to File Tax Returns. On October 17, 2011, the United States District Court for the Western District of North Carolina consolidated a second case file and sentenced Willis to ninety-two (92) months incarceration on each count in case 3:10 CR 056 and to the healthcare fraud and money laundering counts in case 3:10 CR 240. The sentences were ordered to run concurrently. Upon release from prison, Willis was ordered to serve a term of three (3) ears on supervised probation. Willis was also ordered to pay a $325 assessment fee and a total of $1,230,238.78 in restitution, with $1,085,041.78 payable to the Fund for Medical Assistance and $145,197.00 payable to the Internal Revenue Service.

U.S. v. JANET JOHNSON-HUNTER

Janet Johnson-Hunter was the owner of Coastline Care, Inc., a Medicaid and Medicare provider located in Wilmington, North Carolina. This matter was referred to the MID by HHS/OIG/OI.

A MID investigation revealed that between January 2002 and October 2006, Coastline Care, Inc. was transporting patients who were ambulatory and billed as if they were bed confined.

On May 9, 2011, Johnson-Hunter pled guilty to one (1) count of Conspiracy to Make False Statements Relating to Health care Matters. The United States District Court in the Eastern District of North Carolina sentenced Johnson-Hunter to a term of twenty-eight (28) months incarceration. Johnson-Hunter was also ordered to pay $475,089.00 in restitution to the Medicaid and Medicare Programs and a $10,000.00 fine and a $100.00 assessment.

U.S. v. EDWARD PAYTON (MECKLENBURG OPEN DOOR)

Edward Payton was the former Executive Director of Mecklenburg Open Door, a Mental and Behavioral Health Medicaid provider located in Charlotte, North Carolina. This matter was referred to the MID by the Western District Health Care Fraud Task Force.

A joint MID, FBI and IRS investigation revealed that between January 2006 and May 2010 Payton had embezelled approximately $200,000 from Mecklenburg Open Door.

On April 8, 2011, Payton pled guilty to one (1) count of Theft, Embezzlement, or Misapplication in Connection with Health Care and one (1) count of Failure to File Taxes. The United States District Court for the Western District of North Carolina sentenced Payton to a term of eighteen (18) months incarceration on the theft count and twelve (12) months on the

tax count, with the sentences to run concurrently. Upon release from prison, Payton was ordered to serve a term of two (2) years on supervised probation and was ordered to pay a $125.00 assessment fee and a total of $131,169.96 in restitution to the Bankruptcy Trustee on behalf of Mecklenburg Open Door.

U.S. v. TUNG NGUYEN

Tung Nguyen was a Dentist in individual practice located in Greensboro, North Carolina. This matter was referred to the MID by the North Carolina State Board of Dental Examiners.

A joint MID and HHS-OIG investigation revealed that Nguyen was billing the Medicaid Program for dental work not actually rendered. The Dental Board based its allegation upon the results of a dental review of several of Nguyen's patients.

On October 27, 2011, Tung Nguyen pled guilty to two (2) counts of Health Care Fraud and one (1) count of Making a False Entry or Statement. On February 22, 2012, the United States District Court for the Middle District of North Carolina sentenced Nguyen. The Court sentenced Nguyen to a term of two (2) months incarceration for each count to run concurrently. Upon release from prison, Nguyen is ordered to serve a term of one (1) year on supervised probation, imposing the standard conditions of probation. Nguyen was further ordered to pay a $300.00 assessment fee, a $20,000.00 fine, and a total of $73,369.48 in restitution to the Medicaid Program. The full restitution payment was ordered to be deposited with the Clerk of Court no later than March 7, 2012.

U.S. v. PERRY REESE

Dr. Perry Reese III was the owner of Roseboro Urgent Care, a Medicaid provider located in Roseboro, North Carolina. This matter was referred to the MID by the Diversion and Environmental Crimes Unit of the North Carolina State Bureau of Investigation.

A MID investigation with the SBI and DEA revealed that Reese was providing Oxycodone to street level drug dealers, taking cash for the drugs and selling them without a prescription from his office in Roseboro.

On February 18, 2010, Reese pled guilty in the U.S. District Court in the Eastern District of North Carolina to two (2) counts of Distribution of Oxycodone and one (1) count of Interstate Travel/Transport in Aid of Racketeering Enterprise. Reese was sentenced to two hundred and forty (240) months in prison and ordered to pay a $300.00 assessment fee.

STATE v. ANGELA ALMORE

Angela Almore was a Nurse at Britthaven of Chapel Hill, a nursing home located in Chapel Hill, North Carolina. This matter was predicated upon a request for assistance from Orange County District Attorney James Woodall.

A joint MID and SBI Drug Diversion investigation revealed that Almore unlawfully gave morphine to patients causing injury to the patients transferred and death of one of the patients by a morphine overdose.

On June 4, 2012 Almore pled guilty to the reduced charge of involuntary manslaughter and six (6) counts of Patient Abuse. Orange County Superior Court sentenced Almore to sixteen (16) to twenty (20) months incarceration. The sentence was suspended and Almore was ordered to serve (5) months incarceration and placed on supervised probation for thirty (30) months. Almore was ordered not to work in any health care related field or any health care facility in any capacity.

STATE V. GERALYN BROWN

Geralyn Brown was employed for We Care For You, Inc., a Home Health Medicaid provider located in Lumberton, North Carolina. This matter was referred to the MID by the Division of Health Services Regulation.

A MID investigation revealed that between September 2005 and December 2005 Brown was submitting timesheets to her employer for services she did not perform.

On March 23, 2012, Geralyn Brown pled guilty to one (1) count of Attempted Medical Provider Fraud. Robeson County District Court sentenced Brown to a forty-five (45) day suspended sentence and ordered to pay restitution of $1,555.20, of which she paid $440.00. Brown was placed on unsupervised probation for eighteen (18) months.

STATE v. TARA WHITTED

Tara Whitted was employed with A Brighter Future, Inc., a Home Health Medicaid provider located in Durham, North Carolina. This matter was referred to the MID by the Division of Health Services Regulation.

A MID investigation revealed that between November 2007 and March 2008 Whitted submitted fraudulent flow sheets to her employer for services she did not perform.

On October 11, 2011, pursuant to a plea agreement, Whitted pled guilty to the two (2) counts of misdemeanor Attempt to Commit Medical Provider Fraud. Durham County District court placed Whitted on six (6) months of unsupervised probation and ordered to pay restitution of $1323.00 and costs.

STATE v. DESIREE PAYNE

Desiree Payne was employed with Cooks Home Care, a Home Health Medicaid provider located in Sparta, North Carolina. This matter was discovered during the course of another MID investigation.

A joint MID and HHS-OIG investigation revealed that from at least March 9, 2011 to June 10, 2011 Payne submitted fraudulent timesheets to her employer for services she did not perform.

On April 18, 2012, Payne pled guilty to one (1) count of misdemeanor Conspiracy to Commit Medicaid Fraud. Alleghany County District Court sentenced Payne to forty-five (45) days, suspended for thirty-six (36) months of supervised probation, and ordered her to pay restitution of $481.44, a $100.00 fine, court costs of $210.00, attorney's fee of $220.00 and a miscellaneous fee of $60.00.

STATE v. MALCOLM BURNS

Malcolm Burns was a community support specialist for Arc Services, Inc. (now known as Monarch), a Medicaid provider located in Charlotte, North Carolina. This matter was referred to the MID by the Division of Health Services Regulation.

A MID Investigation revealed that between July 16, 2007 and March 5, 2008 Burns had submitted billing and service notes for clients when no services had been rendered.

On May 30, 2012, Burns pled guilty to two (2) counts of misdemeanor attempted Medicaid Fraud. Union County District Court sentenced Burns to forty-five (45) days in custody on each count, which were suspended, and sixty (60) months supervised probation was imposed. Burns was further ordered to perform seventy-two (72) hours of community service, pay restitution to Monarch in the amount of $18,790.64 (as Monarch had already repaid the Medicaid Program through PBH), pay $210.00 in court costs, $60.00 probation fee, $302.50 in attorney's fees, and a $250.00 community service fee.

STATE v. CYNTHIA DENISE MCLEAN

Cynthia McLean was an employee for Basic Home Health Care, a Home Health Medicaid provider located in Lillington, North Carolina. This matter was discovered during the course of another MID investigation.

On or about August 10, 2010, during a MID Investigation, McLean admitted to submitting timesheets for work she had not performed.

On June 5, 2012, McLean pled guilty to three (3) counts of Attempted Medical Provider Fraud. Harnett County District Court sentenced McLean to two (2) consecutive forty-five (45)

day sentences, which were suspended and thirty-six (36) months. McLean also further ordered to pay court costs and make restituition in the amount of $4600.00, $200.00 in court costs and $100.00 in fines.

STATE v. MARILYN CHAVIS-WATFORD (RELIABLE HEALTHCARE SERVICES)

Marilyn Chavis-Watford was the owner of Reliable Healthcare Services, Inc., a Home Health Medicaid provider located in Ahoskie, North Carolina. This matter was referred to the MID by the North Carolina Division of Medical Assistance, Program Integrity Section (DMA).

A MID investigation revealed that Chavis-Watford billed Medicaid for personal care services she did not provide to a Medicaid recipient.

On December 16, 2011, Chavis-Watford pled guilty to two (2) counts of Attempted Medical Assistance Provider Fraud. Hertford County District Court consolidated the counts and ordered Chavis-Watford to pay a $400 fine, court costs of $190.00 and $2,352.48 in restitution to the North Carolina Fund for Medical Assistance.

STATE v. TIMOTHY BATTS

Timothy Batts was the owner of 1 New Direction, a Group Home Medicaid provider located in Goldsboro, North Carolina. This matter was discovered during the course of another MID investigation.

A MID investigation revealed that between February 2003 and September 2004 Batts billed for services for five Medicaid recipients for the group home. The home did not have space for five clients as it was a two-bed facility. Furthermore, during the course of the investigation, investigators discovered that 1 New Direction did not provide services to the recipients or billed for unauthorized services for the recipients.

On January 27, 2012, Batts pled guilty to one (1) count of misdemeanor Attempted Medicaid Fraud. The Wayne County District Court sentenced him to seven (7) days in the custody of the Wayne County Sherriff.

STATE v. LISA COOK

Lisa Cook was an employee of Families First Home Health Care, a Home Health Medicaid provider located in Sparta, North Carolina. This matter was discovered during the course of another MID investigation.

An joint MID and HHS-OIG investigation revealed that between October 10, 2009 and October 30, 2009 Cook submitting time sheets for personal care services not actually rendered.

On February 28, 2012, Lisa Cook pled guilty to one (1) count of misdemeanor Conspiracy to Commit Medicaid Fraud. The Alleghany County District Court sentenced Cook to forty-five (45) days, suspended for eighteen (18) months of supervised probation, and ordered Cook to pay restitution of $552.24, pay court costs of $210.00, attorney's fees of $110.00, a miscellaneous fee of $60.00, and to abide by the signed plea arrangement whereby Cook agreed to provide substantial assistance in other on-going related investigations.

STATE v. CRYSTAL BREWSTER

Crystal Brewster was both an employee and a client of Families First Home Health Care, a Home Health Medicaid provider located in Sparta, North Carolina. This matter was discovered during the course of another MID investigation.

A joint MID and HHS-OIG investigation revealed that between February 2007 and July 2010 Brewster participated in criminal activity while she was both an employee and a client of Families First Home Health Care (FFHHC). The activity included Brewster submitting time sheets for personal care services not actually rendered; engaging in a fee-splitting arrangement with recipients whereby she would pay recipients in lieu of receiving services; and receiving payments for herself and her husband, another FFHHC client, in lieu of actually receiving personal care services.

On February 28, 2012, Crystal Brewster pled guilty to one (1) count of misdemeanor conspiracy to commit Medicaid fraud. The Alleghany County District Court sentenced Brewster to forty-five (45) days, suspended for sixty (60) months of supervised probation, and ordered Brewster to pay restitution of $26,484.38, court costs of $210.00, and to abide by the signed plea arrangement whereby Brewster agreed to provide substantial assistance in other on-going related investigations.

STATE v. BILLIE JO CASTILLO (BINGMAN)

Billie Jo Castillo was an employee of Families First Home Health Care, a Home Health Medicaid provider located in Sparta, North Carolina. This matter was discovered during the course of another MID investigation.

A joint MID and HHS-OIG investigation revealed that between August 2008 and January 2010 Castillo participated in criminal activity while she was an employee of Families First Home Health Care (FFHHC). The activity included Castillo submitting time sheets for personal care services not actually rendered, signing blank time sheets knowing they would be used to support Medicaid billings for services not provided, and engaging in a fee-splitting arrangement with other FFHHC employees, whereby the employees would sign time sheets as though services were provided to Castillo's sister, a client of FFHHC, the employees and Castillo would then split the wage amount paid for the purported services when no services were actually being provided.

On February 28, 2012, Billie Jo Castillo pled guilty to one (1) count of misdemeanor Conspiracy to Commit Medicaid Fraud. The Alleghany County District Court sentenced Castillo to forty-five (45) days, suspended for sixty (60) months of supervised probation, and ordered Castillo to pay restitution of $2,791.44, court costs of $200.00, attorney's fees of $275.00, miscellaneous fee of $60.00, and to abide by the signed plea arrangement whereby Castillo agreed to provide substantial assistance in other on-going related investigations.

STATE v. TAMMY WILLIAMS

Tammy Williams was an employee of Families First Home Health Care, a Home Health Medicaid provider located in Sparta, North Carolina. This matter was discovered during the course of another MID investigation.

A joint MID and HHS-OIG investigation revealed that between March 2009 and July 2010 Williams submitted time sheets for personal care services not actually rendered.

On February 28, 2012, Tammy Williams pled guilty to one (1) count of misdemeanor Conspiracy to Commit Medicaid Fraud. The Alleghany County District Court sentenced Williams to forty-five (45) days, suspended for sixty (60) months of supervised probation, and ordered Williams to pay restitution of $5,939.64, court costs of $210.00, attorney's fees of $165.00, a miscellaneous fee of $60.00, and to abide by the signed plea arrangement whereby Williams agreed to provide substantial assistance in other on-going related investigations.

STATE v. RENA MAHAN

Rena Mahan was an employee of Families First Home Health Care, a Home Health Medicaid provider located in Sparta, North Carolina. This matter was discovered during the course of another MID investigation.

A joint MID and HHS-OIG investigation revealed that between April 2009 and June 2009 Mahan submitted time sheets for personal care services not actually rendered, and engaged in a fee-splitting arrangement with recipients whereby she would pay recipients in lieu of receiving personal care services.

On February 28, 2012, Rena Mahan pled guilty to one (1) count of misdemeanor Conspiracy to Commit Medicaid Fraud. The Alleghany County District Court sentenced Mahan to forty-five (45) days, suspended for twelve (12) months of supervised probation, and ordered Mahan to pay restitution of $1,517.76 (of which $848.16 is jointly and severally liable with co-conspirator Dwana Sanchez), to pay court costs of $210.00, and to abide by the signed plea arrangement whereby Mahan agreed to provide substantial assistance in other on-going related investigations. Mahan paid $500.00 toward her restitution order, which was remitted to the Alleghany County Probation Office for forwarding to the North Carolina Fund for Medical Assistance.

STATE v. DWANA SANCHEZ

Dwana Sanchez was a client of Families First Home Health Care, a Home Health Medicaid provider located in Sparta, North Carolina. This matter was discovered during the course of another MID investigation.

A joint MID and HHS-OIG investigation revealed that from at least May 2009 to June 19, 2009 Sanchez received payments for herself in lieu of actually receiving personal care services. Sanchez also admitted to signing blank time sheets knowing they would be used to bill the Medicaid Program for services she did not receive.

On April 18, 2012, Sanchez pled guilty to one (1) count of misdemeanor Conspiracy to Commit Medicaid Fraud. Alleghany County District Court sentenced Sanchez to forty-five (45) days, suspended for eighteen (18) months of supervised probation, and ordered to pay restitution $1,636.80 (of which $848.16 is jointly and severally liable with co-conspirator Rena Mahan), to pay a $100.00 fine and court costs of $210.00, and to abide by the signed plea arrangement whereby Sanchez agreed to provide substantial assistance in other on-going related investigations.

STATE v. JESSIE ABSHER

Jessie Absher was an employee of Families First Home Health Care (FFHHC), a Home Health Medicaid provider located in Sparta, North Carolina. This matter was discovered during the course of another MID investigation

A joint MID and HHS-OIG investigation revealed that between November 12, 2007 and November 30, 2009 Absher submitted time sheets for personal care services not actually rendered to FFHHC clients, signed blank time sheets knowing they would be used to support services not rendered, and falsified client records.

On February 28, 2012, Jessie Absher pled guilty to one (1) count of misdemeanor Conspiracy to Commit Medicaid Fraud. The Alleghany County District Court sentenced Absher to 45 days, suspended for 60 months of unsupervised probation, and ordered Absher to pay restitution of $7,880.16 (of which $1,748.40 is jointly and severally liable with co-conspirator Patricia Atkins), court costs of $200.00, and to abide by the signed plea arrangement whereby Absher agreed to provide substantial assistance in other on-going related investigations.

STATE v. PATRICIA ATKINS

Patricia Atkins was a client of Families First Home Health Care (FFHHC), a Home Health Medicaid provider located in Sparta, North Carolina. This matter was discovered during the course of another MID investigation.

A joint MID and HHS-OIG investigation revealed that between November 2007 through October 2010 Atkins participated in criminal activity while she was a client for Families First Home Care. The activity included Atkins receiving payments for herself and her boyfriend, another FFHHC client, in lieu of actually receiving personal care services. Atkins also admitted to signing blank time sheets knowing they would be used to bill the Medicaid Program for services she did not receive.

On February 28, 2012, Patricia Atkins pled guilty to one (1) count of misdemeanor Conspiracy to Commit Medicaid Fraud. The Alleghany County District Court sentenced Atkins to 45 days, suspended for 18 months of supervised probation, and ordered Atkins to pay restitution of $2,525.88 (of which $1,748.40 is jointly and severally liable with co-conspirator Jessie Absher), court costs of $210.00, attorney's fees of $321.00, a miscellaneous fee of $60.00, and to abide by the signed plea arrangement whereby Atkins agreed to provide substantial assistance in other on-going related investigations.

STATE v. RONNIE THOMPSON

Ronnie Thompson was an employee of Pediatric Services of America (PSA), a Home Health Medicaid provider located in Charlotte, North Carolina. This matter was referred to the MID by the Pediatric Services of America.

A MID investigation revealed that between of May 13, 2001 and June 4, 2007 Thompson was working for Interim Healthcare (Interim), another home healthcare provider, at the same time he was working for PSA. PSA alleged that Thompson was providing care to Interim clients for dates and times he was also billing for hours worked with his PSA client. PSA also alleged that Thompson had an arrangement with the parent of his PSA client to clock Thompson in and out of the provider's timekeeping system when he failed to show up or left work early.

On February 23, 2012, Ronnie Thompson pled no contest to seven (7) counts of misdemeanor Attempted Medicaid Fraud. The Gaston County District Court consolidated the charges for sentencing into three (3) counts and sentenced Thompson to forty-five (45) days, suspended for twelve (12) months of supervised probation, and ordered Thompson to pay a fine of $25.00, court costs of $180.00 on one (1) count with those amounts waived for the remaining counts, and indicating that the sentences in the three (3) counts shall run consecutively if time is activated. Thompson paid the full restitution amount of $45,232.30 directly to the North Carolina Fund for Medical Assistance, prior to entering his guilty plea.

STATE v. LATESHA DANIELS

Latesha Daniels was employed as a Medication Technician at China Grove Retirement Center, a Medicaid provider located in China Grove, North Carolina. This matter was referred to the MID by the North Carolina Department of Insurance.

A MID investigation with the Rowan County Sheriff's Office revealed that between January 2007 and January 2008 Daniels was diverting prescription drugs from the residents at China Grove Retirement Center.

On June 17, 2011, Daniels pled guilty to thirty-four (34) counts of drug trafficking and other drug related charges and one (1) unrelated count in Rowan County Superior Court. The charges were consolidated under one case for sentencing purposes. The Rowan County Superior Court sentenced Daniels to a term of incarceration for a minimum term of seventy (70) months and a maximum term of eighty-four (84) months at the North Carolina Department of Corrections. Daniels was also fined $50,000.00.

STATE v. DEIDRA HOLLOWAY

Deidra Holloway was employed as a Home Health Aide for Allegiance Home Care, Inc., a Medicaid provider located in Charlotte, North Carolina. This matter was referred to the MID by the Division of Health Services Regulation, Health Care Personnel Registry.

A MID investigation revealed that between April 2007 and January 2008, Holloway submitted time sheets for personal care services she did not provide to a Medicaid recipient.

On August 3, 2011 Holloway pled guilty to one (1) count of Attempted Medicaid Provider Fraud. Rowan County Superior Court sentenced Holloway to one hundred and twenty (120) days incarceration. Holloway was given credit for six (6) days spent in confinement prior to the date of the judgment and to be applied toward the sentence. The remainder one hundred and fourteen (114) days was suspended for twenty-four (24) months supervised probation. Additionally, Holloway was ordered to complete twenty-four (24) hours community or reparation service during the first ninety (90) days of the period of probation, as directed by the community service coordinator and pay the fee prescribed by G.S. 143B-262.4(b). Holloway was ordered to pay $3,321.00 in restitution and $424.50 court costs and not obtain employment in the medical field during the probationary period.

On February 9, 2011 Hope pled guilty to one (1) count of Conspiracy to Commit Health Care Fraud. The United States District Court for the Western District of North Carolina sentenced Hope on October 18, 2011 to a term of fifteen (15) months incarceration. Upon release from prison, Hope was ordered to serve a term of three (3) years on supervised probation, pay a $100.00 assessment fee and a total of $1,948,451.31 in restitution to the Medicaid Program, which he jointly and severally liable along with other co-conspirators.

STATE v. DOUG DAVIS

Doug Davis was employed as a Nurse Aide at Cherry Hospital, a Medicaid provider located in Goldsboro, North Carolina. This matter was referred to the MID by Cherry Hospital Police Department.

A MID investigation revealed on or about April 17, 2011, Davis was involved in an altercation with a patient. He drove the patient's head into the ground and drove his elbow into the patient's head.

On July 15, 2011 Davis pled guilty upon agreement with the State to the reduced charge of Simple Assault. Upon hearing arguments of counsel, the judge entered a prayer for judgment continued upon payment of court costs. The Judge indicated that because the victim did not suffer any serious injuries and Davis voluntarily left his employment in healthcare and asserted he will not work in the healthcare field, he felt compelled to enter the PJC. The court costs paid by Davis were $155.00.

CIVIL RECOVERIES

MERCK (VIOXX)

Merck & Co. was a New Jersey corporation with its principle place of business in Whitehouse Station, New Jersey, and was the operating company for Merck's pharmaceutical business in the United States. As a result of a reverse merger in 2009, Merck & Co., Inc. became a wholly-owned subsidiary of the acquiring company and was renamed Merck Sharp & Dohme Corp. The acquiring company was renamed Merck & Co., Inc. The new Merck & Co., Inc. is a holding company for Merck Sharp & Dohme Corp. and other corporate entities. Currently, Merck Sharp & Dohme Corp is the operating company in the United States for the pharmaceutical business formerly conducted by Merck & Co., Inc. Merck developed, distributed, marketed and sold pharmaceutical products in the United States, including the drug sold under the trade name Vioxx. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that between May 20, 1999 and September 30, 2004, Merck promoted Vioxx for rheumatoid arthritis, an indication for use not approved by the federal Food and Drug Administration. This settlement also resolves allegations that Merck promoted the cardiovascular safety of Vioxx with certain statements by representatives and promotional speakers in written materials that were inaccurate, misleading and inconsistent with the approved labeling for the drug and also made false representations concerning the safety of Vioxx to state Medicaid agencies.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $19,131,562.93. Of that amount, the federal government received $11,257,481.87 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 $7,874,081.06. Of this amount, $3,451,140.81 was paid to the North Carolina Medicaid Program as restitution and interest, $4,230,512.61 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $192,427.64 was paid to the North Carolina Department of Justice for costs of collection and investigation.

MAXIM HEALTHCARE SERVICES, INC.

Maxim Healthcare Services, Inc. is a Maryland corporation with its principle place of business in Columbia, Maryland that provides in-home health and nursing services. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that between October 1, 1998 and May 31, 2009, Maxim submitted false claims to the Medicaid Program for services not rendered, for services not reimbursable because Maxim lacked adequate documentation to support the services purported to have been performed and for services not reimbursable because the offices were unlicensed.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $11,767,271.00. Of that amount, the federal government received $7,809,995.20 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 $3,957,275.80. Of this amount, $3,862,995.19 was paid to the North Carolina Medicaid Program as restitution and interest and $94,280.61 was paid to the North Carolina Department of Justice for costs of investigation.

ELAN CORPORATION (ZONEGRAN)

Elan Corporation, PLC is a pharmaceutical company that distributes, markets and sells pharmaceutical products in the United States, including an anti-epileptic drug sold under the trade name Zonegran. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

From April 1, 2000 through April 27, 2004, Elan manufactured, marketed and sold Zonegran, at which time it divested Zonegran, the drug's assets, the United States license to market and sell Zonegran and the Zonegran sales force to Eisai Co., LTD and Eisai, Inc., although Elan continued to manufacture Zonegran for Eisai after April 2004. This settlement resolves allegations that during the period from April 1, 2000 through December 2005, Elan knowingly marketed, sold and promoted Zonegran for certain uses that were not approved by the Food and Drug Administration and offered and paid illegal remuneration to health care professionals to induce them to promote and prescribe Zonegran.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $3,505,619.90. Of that amount, the federal government received $2,110,196.22 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 $1,395,423.68. Of this amount, $462,888.82 was paid to the North Carolina Medicaid Program as restitution and interest, $897,890.41 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $34,644.45 was paid to the North Carolina Department of Justice for costs of collection and investigation.

ROANOKE VALLEY RESCUE SQUAD

Roanoke Valley Rescue Squad is a North Carolina corporation that provides ambulance and medical transportation services in Eastern North Carolina. This matter was referred by and worked jointly with the Office of Inspector General.

This settlement resolves allegations that from January 1, 2004 through September 30, 2006, Roanoke Valley Rescue Squad billed Medicare and Medicaid for non-emergency ambulance transportation for dialysis patients whose transportation was not medically necessary.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $1,500,000.00. Of that amount, the federal government received $1,414,320.00 in Medicare recoveries and 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 $85,680.00. Of this amount, $83,520.86 was paid to the North Carolina Medicaid Program as restitution and interest and $2,159.14 was paid to the North Carolina Department of Justice for costs of investigation.

MILLICENT FRANCIS-LANE, MD

Millicent Francis-Lane is a medical doctor who provides physician services in Western North Carolina. This matter was discovered in the course of investigation in another MID case.

This settlement resolves allegations that from January 1, 2003 through December 31, 2009, Dr. Francis-Lane billed critical care codes for patients whose condition did not support a critical care determination and billed for 3-D ultrasonography, which is not covered under Division of Medical Assistance policy.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $950,000.00. Of that amount, the federal government received $610,755.00 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 $339,245.00. Of this amount, $169,422.43 was paid to the North Carolina Medicaid Program as restitution and interest, $161,473.89 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $8,348.68 was paid to the North Carolina Department of Justice for costs of collection and investigation.

MARINER HEALTH CARE, INC. & SAVASENIORCARE ADMINISTRATIVE SERVICES, LLC

Mariner Health Care, Inc. ("Mariner") is a Delaware corporation with headquarters in Atlanta, Georgia. Mariner through subsidiaries operates nursing homes. SavaSeniorCare ("Sava") is a privately held Delaware limited liability company with headquarters in Atlanta, Georgia. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that from December 2004 through December 2006, Mariner and Sava caused false claims to be submitted to the Medicaid program because the claims resulted from a payment made by Omnicare in return for a pharmacy contract with Mariner and Sava.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $897,808.03. Of that amount, the federal government received $565,146.48 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 $332,661.55. Of this

amount, $165,280.85 was paid to the North Carolina Medicaid Program as restitution and interest, $159,152.08 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $8,228.62 was paid to the North Carolina Department of Justice for costs of collection and investigation.

DAVA PHARMACEUTICALS, INC. (CLARITHROMYCIN, CEFDINIR, METHOTREXATE)

Dava Pharmaceuticals, Inc. ("Dava") is a Delaware corporation headquartered in Fort Lee, New Jersey. Dava markets and sells pharmaceuticals products in the United States, including the drugs Clarithromycin, Methotrexate and Cefdinir. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that from October 1, 2005 through September 30, 2009, Dava misrepresented Clarithromycin, Cefdinir, and Methotrexate as non-innovator drugs when the drugs should have been classified as innovator products in its rebate submission.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $818,490.47. Of that amount, the federal government received $475,999.27 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 $342,491.20. Of this amount, $334,907.51 was paid to the North Carolina Medicaid Program as restitution and interest and $7,583.69 was paid to the North Carolina Department of Justice for costs of investigation.

UCB, INC. (KEPPRA)

UCB, Inc. is a Delaware corporation with its principle place of business in Smyrna, Georgia. UCB distributes, markets and sells pharmaceutical products in the United States, including the drug sold under the trade name Keppra. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that from January 1, 2003 through March 31, 2005, UCB promoted the sale and use of Keppra for certain uses that were not approved by the Food and Drug Administration as safe and effective, specifically, headache, migraine, pain, bipolar and mood disorders and anxiety.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $788,651.05. Of that amount, the federal government received $541,456.24 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 $247,194.81. Of this amount, $134,230.21 was paid to the North Carolina Medicaid Program as restitution and interest, $106,829.93 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $6,134.67 was paid to the North Carolina Department of Justice for costs of collection and investigation.

LATIKA PATEL, MD

Latika Patel is a medical doctor who provides physician services in Western North Carolina. This matter was referred to the MID from the Division of Medical Assistance.

This settlement resolves allegations that from January 1, 2003 through December 31, 2008, Dr. Patel billed critical care codes for patients whose condition did not support a critical care determination, billed for 3-D ultrasonography, which is not covered under Division of Medical Assistance policy, and billed for fetal non-stress tests and fetal contraction stress tests when these tests were actually performed by Carolinas Medical Center-Union.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $750,000.00. Of that amount, the federal government received $479,700.00 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 $270,300.00. Of this amount, $131,744.22 was paid to the North Carolina Medicaid Program as restitution and interest, $131,744.22 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $6,811.56 was paid to the North Carolina Department of Justice for costs of collection and investigation.

EISAI, INC. (ZONEGRAN)

Eisai, Inc. is a Delaware corporation headquartered in Woodcliff Lake, New Jersey. Eisai, Inc. is a pharmaceutical company that distributes, markets and sales pharmaceutical products in the United States, including the anti-epileptic drug sold under the trade name Zonegran. Eisai, Inc. acquired the North American interests in Zonegran on April 27, 2004. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that from April 27, 2004 through December 31, 2005, Eisai knowingly marketed, sold and promoted Zonegran for certain uses that were not medically approved by the Food and Drug Administration. Certain of these unapproved uses were not medically accepted indications for which the United States and state Medicaid programs provided coverage for Zonegran.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $487,731.32. Of that amount, the federal government received $301,978.39 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 $185,752.93. Of this amount, $91,815.54 was paid to the North Carolina Medicaid Program as restitution and interest, $89,319.34 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $4,618.05 was paid to the North Carolina Department of Justice for costs of collection and investigation.

K-V PHARMACEUTICALS

K-V Pharmaceuticals ("K-V") is a Delaware corporation headquartered in St. Louis, Missouri and was the parent of Ethex Corporation ("Ethex"), a company that was dissolved in December 2010. K-V markets and sells pharmaceutical products throughout the United States. Ethex distributed, marketed and sold pharmaceutical products in the United States, including drugs Nitroglycerin Extended Release Capsules, used for treating angina pectoris, and Hyoscyamine Sulfate Extended Release Capsules, an antispasmodic drug used to treat various stomach, intestinal, and urinary tract disorders. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that from April 1999 through December 31, 2007, Ethex submitted to the Centers for Medicare and Medicaid Services ("CMS") false quarterly reports that misrepresented the regulatory status of Nitroglycerin Extended Release Capsules and hyoscyamine Sulfate Extended Release Capsules and failed to advise CMS that both drugs no longer qualified as covered outpatient drugs.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $356,648.91. Of that amount, the federal government received $196,034.75 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 $160,614.16. Of this amount, $156,957.93 was paid to the North Carolina Medicaid Program as restitution and interest and $3,656.23 was paid to the North Carolina Department of Justice for costs of collection and investigation.

EQUISTAT, LLC & STASIS, LLC

Equistat, LLC is a North Carolina limited liability company that operates as Shelby Hearing and Balance Center and Stasis, LLC is a North Carolina limited liability company that operates as the Asheville Balance Center. Both provide, among other services, vestibular therapy and post-therapy diagnostic tests. This matter was referred to the MID by the U.S. Attorney's Office, Western District.

This settlement resolves allegations that from August 1, 2003 through July 1, 2009, Equistat and Stasis engaged in improper Medicare and Medicaid billing practices for CPT codes for vestibular therapy, post-therapy diagnostics tests and diagnostics tests.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $355,434.00. Of that amount, the federal government received $333,294.17 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 $22,139.83. Of this amount, $14,387.94 was paid to the North Carolina Medicaid Program as restitution and interest, $7,193.97 was paid to the Civil Penalty Forfeiture Fund for the support of public

schools, and $557.92 was paid to the North Carolina Department of Justice for costs of collection and investigation.

NOVO NORDISK, INC. (NOVOSEVEN)

Novo Nordisk, Inc., headquartered in Princeton, New Jersey, is a pharmaceutical company that produces pharmaceutical and biological products for diabetes care, hemostasis management, hormone replacement, and growth hormone therapy. Novo Nordisk distributes, markets and sells its pharmaceutical and biological products in the United States, including its hemostasis management drug, Factor VIIa recombinant, sold under the trade name NovoSeven. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that from January 1, 2000 through December 31, 2010, Novo Nordisk promoted NovoSeven to physicians and other health care professionals for certain uses that were not approved by the Food and Drug Administration as safe and effective. NovoSeven is only approved to treat certain bleeding disorders in hemophiliacs, patients with acquired hemophilia, or patients with congenital Factor VII deficiency. Novo Nordisk allegedly promoted NovoSeven as the hemostatic agent that could stop bleeding in situations outside those approved indications, including but not limited to trauma, general surgery, cardiac surgery, liver surgery, liver transplants and intra-cerebral hemorrhage.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $259,897.42. Of that amount, the federal government received $164,494.45 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 $95,402.97. Of this amount, $44,908.92 was paid to the North Carolina Medicaid Program as restitution and interest, $48,119.23 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $2,374.82 was paid to the North Carolina Department of Justice for costs of collection and investigation.

AMERITOX, LTD & AMERITOX TESTING MANAGEMENT, INC.

Ameritox, Ltd is a limited partnership, headquartered in Baltimore, Maryland, engaged in the business of testing urine specimens to detect the presence and quantity of certain medications and drugs, with its principle laboratory facility in Midland, Texas. Ameritox Testing Management, Inc., a Texas corporation, is the general partner of Ameritox, Ltd. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that from January 1, 2003 through June 30, 2010, Ameritox provided cash payments to providers who utilized their testing services and provided specimen collectors to medical offices that were volume users of Ameritox testing services.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $250,067.89. Of that amount, the federal government received $157,964.03 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 $92,103.86. Of this amount, $26,203.52 was paid to the North Carolina Medicaid Program as restitution and interest, $61,997.73 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $3,902.61 was paid to the North Carolina Department of Justice for costs of collection and investigation.

PFIZER, INC. (DETROL)

Pfizer, Inc. is a Delaware corporation with its principle place of business in New York. Pfizer distributes, markets and sells pharmaceutical products in the United States, including the drugs sold under the trade name of Detrol and Detrol LA. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that from January 1, 2003 through December 1, 2010, Pfizer cause false claims to be submitted to the Medicaid program by illegally marketing Detrol by promoting its sale and use in males, either alone or together with an alpha blocker, for: (1) benign prostatic hyperplasia, (2) lower urinary tract symptoms and (3) bladder outlet obstruction, for which uses Detrol was not approved by the Food and Drug Administration.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $239,994.12. Of that amount, the federal government received $151,269.06 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 $88,725.06. Of this amount, $44,049.86 was paid to the North Carolina Medicaid Program as restitution and interest, $42,478.92 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $2,196.28 was paid to the North Carolina Department of Justice for costs of collection and investigation.

HAWTHORN PHARMACEUTICALS, INC., CYPRESS PHARMACEUTICALS, INC. & MAX DRAUGHN

Cypress Pharmceuticals, Inc. ("Cypress") is a privately held American corporation headquartered in Madison, Mississppi. Hawthorn Pharmaceuticals, Inc. ("Hawthorn") is a wholly owned subsidiary of Cypress. Max Draughn is a United States citizen who currently conducts business in Madison, Mississippi. Hawthorn and Draughn distribute, market and sell pharmaceutical products in the United States, including various formulations of hyaluronic acid, sold under the trade name Hylira, and benzoyl peroxide, sold under the trade name Zaclir and Zacare Kit.

This settlement resolves allegations that from January 1, 2003 through December 31, 2009, Hawthorn and Draughn submitted false claims to the Medicaid program for Hylira, Zaclir

and Zacare Kit when these drugs were unapproved prescription medications that did not qualify as covered outpatient drugs.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $85,248.88. Of that amount, the federal government received $53,723.07 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 $31,525.81. Of this amount, $30,731.36 was paid to the North Carolina Medicaid Program as restitution and interest and $794.45 was paid to the North Carolina Department of Justice for costs of investigation.

MEDTRONIC, INC.

Medtronic, Inc. is a Minnesota corporation headquartered in Fridley, Minnesota. Medtronic develops, manufactures, distributes, markets and sells cardiac rhythm management devices in the United States, including pacemakers and implantable cardioverter defibrillators ("ICDs").

This settlement resolves allegations that from November 1, 2003 through August 31, 2011, Medtronic used certain research studies as a vehicle to pay kickbacks to doctors for implanting Medtronic Pacemaker and ICD Devices.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $63,341.64. Of that amount, the federal government received $39,023.43 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 $24,318.21. Of this amount, $12,178.85 was paid to the North Carolina Medicaid Program as restitution and interest, $11,542.58 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $596.78 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. Building on the solid progress of the past several years, it is anticipated that the MID's tradition of outstanding accomplishments will continue in the next fiscal year. This optimism is based upon several factors.

We continue to have an excellent relationship with our single-state agency, 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 the next fiscal years. There are currently a substantial number of cases in prosecutor disposition stage, many of which should be successfully concluded by criminal or civil action during the next fiscal year. Several cases that involve substantial losses to the Medicaid Program and other governmental programs have good potential for successful conclusion during the next fiscal year.

We are involved in numerous global/multi-state cases which have potential for successful conclusions during the next fiscal year. Also, during the next fiscal year we expect to conclude additional substantial civil false claims cases involving a variety of Medicaid providers. The MID has active investigations involving improper billing practices by North Carolina providers that should result in substantial criminal and civil monetary recoveries for the Medicaid Program during the next fiscal year.

New MID positions and staff will allow the MID to more effectively address the problem of Medicaid fraud and abuse in our state. During FY 11/12 MID staff increased the number of actively investigated cases by 34%. The MID will continue to benefit in the upcoming year from greater experience and expertise on the part of our new and existing staff in the various disciplines within the office.

We anticipate that during the upcoming fiscal year the MID will continue to identify and utilize available training opportunities for all staff disciplines and provide training opportunities to its staff. These training opportunities will increase the knowledge, skills, and abilities of MID staff and enable the MID to continue to increase its proficiency in investigating and prosecuting fraud and abuse.

As a result of our efforts to pursue more sophisticated cases in new provider areas, our investigative and prosecutorial personnel will continue to gain valuable experience which can be applied in future cases. This is especially true in the areas of patient abuse, home health care, mental health, and institutional providers. Training and experience have increased proficiency on the part of MID personnel in using computer technology both in conducting investigations and preparing cases for trial. All MID staff have their own personal computers which are interconnected through a local area network and to the N. C. Department of Justice and beyond through a wide area network. This allows attorneys and investigators to obtain

necessary information much more expeditiously and efficiently. Notebook computers are now available for use by all investigators and attorneys in the field or for trial. In view of the current trends by providers toward the greater use of computer technology, we believe our additional resources in this area will greatly enhance our efforts to detect, investigate, and prosecute Medicaid fraud and abuse. Fortunately, we have been able to use asset forfeiture equitable sharing program funds to pay for training and equipment.

The MID has a document imaging system that allows investigators to scan and search voluminous records rather than relying on hard copies. The MID also provides GPS devices for its investigators to allow them to more quickly and accurately drive to and find witnesses. The MID previously purchased this equipment using funds from the Asset Forfeiture Equitable Sharing Program rather than general fund appropriations.

In the upcoming fiscal year the MID will continue to focus on important areas of Medicaid fraud which are deserving of special attention including community support service providers, mental and behavioral health providers, personal care service providers, and transportation providers. At the same time, we will maintain our visibility in more traditional provider areas. During FY 12/13 the MID will continue its strong interest in the important area of patient physical abuse as well as financial exploitation of Medicaid recipients in Medicaid funded facilities. As noted, the MID participates in numerous patient abuse working groups. As our expertise and referral sources continue to expand and improve, successful prosecutions in this area should increase. We will continue to explore the appropriate use of the expanded jurisdiction given to the Medicaid Fraud Control Units by recent federal legislation.

The MID has a branch office in Charlotte, North Carolina. The MID Charlotte Office has enabled the MID to better serve western North Carolina and Mecklenburg County, which has the highest total dollars in Medicaid provider payments of any county in North Carolina and to increase the MID's participation in joint health care fraud cases with the United States Attorney's Office for the Western District of North Carolina.

During the past fiscal year the Affordable Care Act (ACA) was enacted. As part of the 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 compromise an investigation. The MID and DMA have worked diligently this past fiscal year to create a process of referrals and requests not to suspend required by the new regulation. As a result of this regulation, DMA put forty-three (43) Medicaid providers on payment suspension during the initial stage of an investigation in order to prevent further fraudulent expenditures of taxpayer money. For a full description of the regulation please see 42 C.F.R. 455.23.

As the MID has grown, it has made appropriate updates, improvements and revisions to its policy and procedure manual that should result in more efficient investigation and assist the MID overall in its efforts to prosecute Medicaid provider fraud and abuse.

Since the 2010 expansion the MID has worked very hard to make our office space accommodate our staff increase. During the past fiscal year the MID has worked with the Office of State Property and senior officials of the North Carolina Department of Justice to enter into new building lease contracts for the MID Raleigh and Charlotte offices. The Charlotte office remained at the same location but added adjoining office space. The MID Raleigh office moved to a new location July 13, 2012.

We have reason to remain optimistic as to the long term productivity of the MID. We remain committed to fight fraud and abuse in the Medicaid Program as efficiently and effectively as possible and pledge our best efforts toward the accomplishment of that goal.