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September 1, 2013

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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 of the Department of Justice, which is the Medicaid Investigations Division, during the previous fiscal year to the Chairs of the Appropriations Subcommittees on Justice and Public Safety and Health and Human Services of the Senate and House of Representatives and the Fiscal Research Division of the Legislative Services Office. Pursuant to that statute, I have enclosed the Medicaid Investigations Division Activities Report for July 1, 2012 through June 30, 2013.

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, 2013

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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 state 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 2012-2013 ("FY 12/13"), covering July 1, 2012 through June 30, 2013.

The MID has worked hard to combat Medicaid provider fraud, the physical abuse of patients in Medicaid funded facilities, the misappropriation of patient funds, and fraud in the administration of the Medicaid program during our thirty-three year history. In that time over 520 providers have been convicted of crimes relating to Medicaid provider fraud, the physical abuse of patients in Medicaid funded facilities, the misappropriation of patient personal funds,

and fraud in the administration of the Medicaid program, and the MID has recovered over $600 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 12/13, 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"); U.S. Secret Service; the Internal Revenue Service; the United States Department of Justice; N.C. State Bureau of Investigation; and local law enforcement agencies, along with integrity Special Investigations Units (SIUs) within private insurance companies. 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 North Carolina Division of Medical Assistance Program Integrity Unit (DMA/PI) and other governmental and private health care programs. The Task Force meets quarterly for discussions of ongoing matters, 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 12/13, MID Director Charlie Hobgood served as a member of the NAMFCU Executive Committee, Finance Committee, and Global Case Committee. Director Hobgood has also chaired a number of NAMFCU working groups. MID Criminal Chief Doug Thoren served as Co-Chair of the NAMFCU Training Committee. MID Civil Chief Eddie Kirby was a member of the NAMFCU Qui Tam Subcommittee. MID Assistant Attorney General Steve McCallister served as Co-Chair of the NAMFCU Subpoena Working Group. MID Assistant Attorney General John Parris was a member of the NAMFCU Record Retention Working Group. The MID continues to be actively involved in national global cases being coordinated through NAMFCU with the United States Department of Justice and other federal and state agencies. Director Hobgood, Civil Chief Eddie Kirby, Financial Investigator Winston Harrison and Assistant Attorney Generals

Steve McCallister, Stacy Race, Clark Walton and Mike Berger served on NAMFCU global intake groups and teams appointed by NAMFCU's Global Case Committee. Five MID attorneys and twelve MID Financial Investigators worked on national or multistate qui tam cases.

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 315 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 12/13 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 Program; the NAMFCU Global Case Training Program; 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 have scheduled a joint training over two (2) days in August to inform all staff of various policies of both agencies to further our common mission.

During FY 12/13 the Division developed and held the first Financial Investigator Academy, a joint training program attended by non-sworn Financial Investigators with MID, the SBI Financial Crimes Unit, and DOJ Consumer Protection Division.

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 276 cases 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 12/13.

On June 10, 2013 the MID received the HHS/OIG Inspector General's "State Medicaid Fraud Control Award," from Inspector General Daniel R. Levinson in Washington, D.C. This award was given, "In recognition of efficient and effective management in combating fraud and abuse in the Medicaid program." This award is presented by the Inspector General to one of the fifty Medicaid Fraud Control Units annually.

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 12/13 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. The number of matters reported to the MID.

There were 352 referrals made to the MID during the State FY 12/13. 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, 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. Referrals also came from Local Management Entity (LME)/Managed Care Organization(MCO) entities in connection with behavioral health services.

Of those 352 new referrals plus nine referrals that were pending at the beginning of the fiscal year, the MID opened new case files on 180 matters. Four were still under preliminary review at the end of the fiscal year. The remaining 177 were referred to another agency for review, declined for insufficiency, or rolled into existing MID investigations. In many instances it is appropriate to refer a matter to the North Carolina Division of Medical Assistance for further review or administrative action. DMA can compare the allegation to its history of the provider and conduct billing analysis and reviews to determine whether further investigation is appropriate. 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 12/13 the MID staff investigated 544 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 12/13. The subjects of current investigations include community support providers; mental and behavioral health facilities; counselors and psychologists; physicians; dentists; psychiatrists; pharmacies; pharmaceutical manufacturers; durable medical equipment suppliers; transportation providers; home health care providers and aides; labs; radiological

providers; nursing facilities; and hospitals. The MID is also investigating care givers accused of patient physical abuse at Medicaid funded facilities, and the theft of recipients' personal funds.

3. The number of Criminal Convictions and Civil Settlements.

a. Criminal Convictions

During FY 12/13, the MID successfully convicted 32 providers. These criminal convictions resulted in the recovery of $7,121,169.34 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 12/13 was a year of significant accomplishments. Of particular note was the criminal conviction of Michael Brown, the owner of Michael Shawn Brown, LPC, a Medicaid mental health services provider located in Chadbourn, North Carolina. The MID began its investigation of Brown based upon a request for assistance from the Columbus County Sheriff's Office ("CCSO") in Chadbourn, North Carolina. CCSO was investigating a homicide involving Brown that had occurred at his business on March 29, 2011. The victim, Larry Towns, was initially reported to have done odd jobs for Brown.

MID joined with CCSO, SBI and ATF in this investigation. The investigation revealed that Brown shot and killed Larry Towns at Brown's business after receiving an extortion note from Towns threatening to reveal Brown's practice of submitting fraudulent bills to Medicaid for counseling services. Brown was a Licensed Professional Counselor employed at Chadbourn Elementary School while also operating his counseling business, which advertised tutoring services, snacks, transportation services, and youth activities and games to lower income individuals. As part of the process for registering each "participant," Brown required his employees to obtain a copy of their Medicaid card. Some recipients had no further contact with Brown; however, he billed Medicaid as though he had personally and repeatedly performed counseling services. Towns worked with Brown to obtain Medicaid identification cards from recipients. Brown then used those cards to bill Medicaid when no services were provided. In this manner, Brown executed an ongoing scheme of billing Medicaid for group and individual counseling for recipients when no counseling services were provided. This investigation further revealed that, in response to a request by MID personnel to review Brown's patient records, Brown set a fire in his business to hide the fact that no patient records were present and that he was not providing the services for which he had billed Medicaid from 2008 to 2011.

On August 3, 2011, Brown was indicted in the Eastern District of North Carolina and arrested on charges of Wire Fraud and Aiding and Abetting, Aggravated Identity Theft and Aiding and Abetting, Arson, Arson – Commission of a Federal Felony and Material False Statements. On August 6, 2012, pursuant to a plea agreement, Brown entered pleas of guilty to Wire Fraud and Aiding and Abetting and Arson – Commission of a Federal Felony in Federal District Court in the Eastern District of North Carolina in Wilmington, NC. On January 2, 2013,

Brown was sentenced for these offenses to 360 months in federal prison. Brown was also ordered to pay restitution to Medicaid in the amount of $257,802.00 and to Malcolm Bullock in the amount of $87,500.00 for property damage related to the arson conviction. On June 27, 2013, in Columbus County Superior Court, Brown pled guilty to Second Degree Murder in the shooting of Larry Towns and Felonious Burning of an Uninhabited Building. For these offenses, Brown received state prison sentences of 225 to 279 months and 19 to 32 months, respectively. The court ordered that these sentences run concurrently with Brown's federal prison sentences.

Also of significance, in December 2012 the MID arrested nine health care providers for engaging in various schemes to defraud the North Carolina Medicaid Program as part of its continuing crackdown on Medicaid provider fraud. These arrests were a continuation of the December 2011 sweep of 20 individuals, statewide, alleged to commit Medicaid fraud against the Medicaid program. To date seventeen (17) of the twenty (20) defendants arrested in 2011 have been convicted.

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

b. Civil Recoveries

During this period the MID obtained 19 civil settlements and recovered $85,843,645.22 in damages, interest, civil penalties, and costs. Of significance was a civil settlement agreement executed between Healthpoint, Ltd. / DFB Pharmaceuticals, Inc. and the State of North Carolina in settlement of allegations that Healthpoint caused false claims to be submitted to government healthcare programs when it illegally marketed and sold its wound-care drug Xenaderm as a pre-1962 unapproved drug despite determinations in the 1970's by the United States Food and Drug Administration that Xenaderm's principle ingredient, trypsin, is less than effective for wound debridement. The case was handled by MID Assistant Attorney Generals Stacy Race and Steven McCallister. North Carolina was one of a handful of states that affirmatively intervened in the action at the invitation of the U.S. Department of Justice. MID attorneys thereafter actively collaborated as leaders on both the litigation team and the settlement team, and working closely with the federal government and other intervenor states in the matter, was able to help negotiate a global settlement that was joined by nearly every affected state in the nation. The preparation of the settlement agreement, which was primarily authored by MID attorneys, was especially challenging in that it facilitated global settlement in the context of a contemplated acquisition of Healthpoint by another company. Under the terms of North Carolina's settlement, the State of North Carolina recovered $1,084,720.61.

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

Together, these 32 criminal convictions and 19 civil recoveries represent a total of $92,964,814.56 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	
Joanna Patronis	1,786,084.28	956,253.02			100.00	2,742,437.30	*
Country Layne / A. Sampson	1,409,405.52	778,546.13			100.00	2,188,051.65	
Basic HHC - J. Alspaugh	142,932.89	78,955.16			1,392,315.21	1,614,203.26	
Helen Alspaugh					1,392,215.21	1,392,215.21	*
Teresa Marible Wilson	736,034.84	399,587.72			100.00	1,135,722.56	*
Karen Willis	643,405.33	110,653.02			32,658.39	786,716.74	*
Wendy Gibson	235,530.01	90,542.34			32,558.39	358,630.74	*
Michael Shawn Brown	167,090.07	90,711.93			87,700.00	345,502.00	
Families First HC - B. Cook	209,882.49	115,937.68			200.00	326,020.17	*
Enterpro STC Services, LLC	290,605.66	29,413.02			400.00	320,418.68	*
Derrick Knox	290,605.66	29,413.02			100.00	320,118.68	
Cherry Hamrick	180,581.39	96,681.61			100.00	277,363.00	*
Kelly Svedberg	67,054.44	14,302.15			100.00	81,456.59	
Sassan Bassiri, DDS	44,443.37	24,352.28			10,300.00	79,095.65	
Southern Home HC/S. Hotka	44,803.50	25,196.50			414.50	70,414.50	
Bobby Faison	36,539.26	19,640.42			450.00	56,629.68	
Gloria Rogers	34,648.78	18,722.72				53,371.50	
Crystal Deleon-Evans	21,322.54	11,683.46			100.00	33,106.00	
Deborah Aroche	5,188.51	2,829.59			550.00	8,568.10	
Aprii Fuller					8,498.88	8,498.88	
Loving Way Retreat #1 & #2					5,336.23	5,336.23	
Tammy Atkins	2,560.51	1,437.17			662.50	4,660.18	
Amy Lyall	2,373.20	1,294.24			705.00	4,372.44	
Michelle Bottomley	2,110.53	1,170.51			567.50	3,848.54	*
Kellie Hickman					3,524.90	3,524.90	
April Dyer	1,933.92	1,028.58			310.00	3,272.50	
Jessica Cook	1,460.57	819.79			740.00	3,020.36	
Kawains Ann Jordan	1,481.92	788.18			442.50	2,712.60	
Laketha Ebrahim	921.49	499.13			415.00	1,835.62	
Donald Davis	614.03	344.65			200.00	1,158.68	
Hand To Hand Health Care Agency	336.65	188.95			344.50	870.10	
James Grimes					185.00	185.00	
Total Criminal Recoveries	3,591,532.50	1,949,358.34	0.00	0.00	1,580,278.50	7,121,169.34	*
GlaxoSmithKline	19,829,331.37	7,001,932.08	3,897,354.24	446,269.69	722,524.53	31,897,411.91	
McKesson/Express Scripts	14,363,870.79	7,185,176.44		293,207.92		21,842,255.15	
Abbott Pharmaceuticals, Inc. (Depakote)	10,023,105.25	3,932,919.01	917,553.61	195,472.16	871,088.08	15,940,138.11	
Thakur v. Ranbaxy, Inc. et al	5,760,106.46	1,180,193.25	1,132,429.49	93,386.52	626,875.38	8,792,991.10	
Boehringer Ingelheim Pharmaceuticals (Abbott Labs)(Micardis, Combivent, Atrovent, Aggrenox)	1,200,980.74	294,363.15	286,242.44	23,605.16	164,908.35	1,970,099.84	
Jill Osiecki et al. v. Amgen, Inc. et al.	772,519.51	225,875.76	110,377.76	13,653.56	66,270.63	1,188,697.22	
Healthpoint	639,334.40	427,792.53		17,593.68		1,084,720.61	
Granger v. Next Care, Inc.	368,972.85	290,576.45		11,981.29	66,415.11	737,945.70	
Tung Nguyen	255,952.89	62,316.60	76,026.24	5,704.27		400,000.00	
Amgen (Aranesp)	248,593.39	90,247.49	26,880.42	4,802.88		370,524.18	
Frank Kurnik v. Amgen, Omnicare, PharMerica and Kindred (Aranesp)	234,917.14	50,324.53	49,683.02	4,097.14	21,191.25	360,213.08	
Victory Pharma	195,240.20	34,206.72	61,321.87	3,906.58		294,675.37	
White Oak Medical Transport Services	266,605.52	8,062.06		332.42		275,000.00	
Preferred Medical Transport/OC3	201,194.04	3,655.24		150.72		205,000.00	
Stephen Elliott v. Par Pharmaceuticals (Megace & Megace ES)	129,981.09	41,416.35	13,822.19	2,246.19	15,998.49	203,464.31	
Johnston Ambulance	192,703.55	7,007.51		288.94		200,000.00	
Walgreens (Gift Cards)	33,771.61	9,321.51	9,163.54	473.78		52,730.44	
Continuum Care	15,011.75	2,633.50	5,266.99	325.76		23,238.00	
Right Choice Home Care	2,963.84	756.97	756.97	62.42		4,540.20	
Total Civil Recoveries	54,735,156.39	20,848,777.15	6,586,878.78	1,117,561.08	2,555,271.82	85,843,645.22	
Total Recoveries	58,326,688.89	22,798,135.49	6,586,878.78	1,117,561.08	4,135,550.32	92,964,814.56	

* These defendants were ordered to repay $5,112,168.70 joint and severally. The Criminal Recoveries totals have been adjusted to only count amounts in joint and several judgments once.

IV. CRIMINAL CONVICTIONS

U.S. v. JOANNA PATRONIS

Joanna Patronis was the owner of A Time for Everything, LLC (ATE), a mental and behavioral health service company located in Cramerton, North Carolina. This matter was discovered during the course of another MID investigation.

A joint MID and HHS-OIG investigation revealed that between February 2010 and September 2010, Patronis billed Medicaid for mental health services through ATE using a licensed doctor and licensed professional counselor (LPC) as the attending providers. However, the doctor and LPC verified that neither had ever worked for ATE or provided any services through or on behalf of ATE.

It was also found that Patronis used ATE to fraudulently bill Medicaid for other individuals who either were not able to obtain a Medicaid provider number on their own, or those who sought to bill Medicaid for services prior to receiving approval of their own Medicaid provider number. Patronis conspired with numerous other people to fraudulently bill the Medicaid program for services not rendered or services not rendered by a qualified provider. In exchange for submitting fraudulent billings to Medicaid through ATE, Patronis would keep a percentage of the total billings. Patronis also solicited other providers to allow unauthorized individuals to bill services to Medicaid using the provider's Medicaid number in exchange for a percentage of the total billings submitted.

On April 11, 2011, Joanna Patronis pled guilty to one count of Conspiracy to Commit Health Care Fraud. The United States District Court for the Western District of North Carolina sentenced Patronis on October 31, 2012. The Court sentenced Patronis to a term of fifteen (15) months incarceration. Upon release from prison, Patronis is ordered to serve a term of three (3) years on supervised probation, imposing the standard conditions of supervision. Patronis was ordered to pay a $100.00 assessment fee and a total of $2,742,337.30 in restitution to the Medicaid Program, of which Patronis is solely responsible for $123,534.47, and is jointly and severally liable along with other co-conspirators for the remaining balance.

U.S. v. ANDETRA MICHELLE SAMPSON (COUNTRY LAYNE DAY TREATMENT)

Andetra Michelle Sampson was the principal owner of Country Layne Day Treatment, LLC ("Country Layne"), a Medicaid Day Treatment Services provider located in Pembroke, North Carolina. This matter was initiated by information provided to the MID by former employees of Country Layne.

A joint MID and HHS-OIG investigation revealed that between 2006 and 2010, Sampson directed employees to create false treatment notes for dates when recipients' school and preschool aged children were absent. Sampson also hired employees who were not qualified to provide Day Treatment Services and billed for services for children who did not have valid

Person Centered Plans (PCPs). Investigation revealed that for the PCPs that did bear doctor's signatures, the majority had been forged.

On July 11, 2012 Sampson entered a plea of guilty in Eastern District Federal Court in New Bern, NC to Conspiracy to Commit Health Care Fraud. On January 31, 2013, Sampson was sentenced to sixty (60) months in federal prison and ordered to pay restitution to Medicaid in the amount of $2,187,951.65. Additionally, On July 15, 2013, the United States District Court for the Eastern District of North Carolina ordered the forfeiture of in excess of $300,000.00 in personal property belonging to Sampson and purchased using Medicaid money.

U.S. v. JOHN CURTIS ALSPAUGH

Helen Blue Alspaugh and John Curtis Alspaugh were the owners of Basic Home Health Care, Inc., a Personal Care Service (PCS) provider located in Dunn, N.C. This case was referred to the MID by the Home Care Review Section, Program Integrity, Division of Medical Assistance (DMA). The referral alleged Basic Home Health Care, Inc. was billing for PCS services that were not provided and services that were not properly authorized.

A joint MID and the Internal Revenue Service (IRS) investigation revealed that John Alspaugh billed Medicaid for services not provided to recipients including recipients who were receiving services from other providers, recipients who were deceased, and recipients who were incarcerated during the time that John Alspaugh claimed that his company had provided services to these recipients. John Alspaugh had submitted 3,697 fraudulent claims to DMA between January 2006 and April 2011. Additionally, it was determined that John and his wife, Helen Alspaugh had conspired and failed to truthfully account and pay withholding and F.I.C.A. taxes during 2006 and 2007.

John Alspaugh pled guilty to one (1) count of conspiracy – tax related (18 U.S.C. § 371) and one (1) count of health care fraud (18 U.S.C. § 1347) and was sentenced on April 20, 2013 by the United States District Court for the Eastern District of North Carolina to forty (40) months imprisonment, three (3) years supervised release, a $200 special assessment, and was ordered to pay restitution in the amount of $1,614,003.26. Of this amount $221,888.05 was restitution for the Medicaid program. As a result of DMA's suspension of payments to Basic Home Health Care, Inc., DMA had been withholding $107,798.18 in payments from Basic Home Health Care, Inc. These monies were applied to restitution.

U.S. v. HELEN BLUE ALSPAUGH

Helen Blue Alspaugh and John Curtis Alspaugh were the owners of Basic Home Health Care, Inc., a Personal Care Service (PCS) provider located in Dunn, N.C. This case was referred to the MID by the Home Care Review Section, Program Integrity, Division of Medical Assistance (DMA). The referral alleged Basic Home Health Care, Inc. was billing for PCS services that were not provided and services that were not properly authorized.

A joint MID and IRS investigation revealed that Helen Alspaugh and her husband, John Alspaugh, had conspired and failed to truthfully account and pay withholding and F.I.C.A. taxes during 2006 and 2007.

Helen Alspaugh pled guilty to one (1) count of conspiracy – tax related (18 U.S.C. § 371) and was sentenced on April 20, 2013 by the United States District Court for the Eastern District of North Carolina to eighteen (18) months imprisonment, three (3) years supervised release, a $100 special assessment, and was held jointly and severally liable for restitution in the amount of $1,392,115.21.

U.S. v. TERESA MARIBLE-WILSON

Teresa Marible-Wilson represented herself as a Provisionally Licensed Professional Counselor located in Wadesboro, North Carolina and began billing Medicaid for counseling services through co-conspirators' Medicaid provider numbers. However, Marible-Wilson was not licensed to provide any type of mental and behavioral health services. This matter was discovered during the course of other MID investigations.

A joint MID and HHS-OIG investigation revealed that between March 2009 and April 2011, co-conspirators Joanna Patronis, Giraud Hope, Charlotte Garnes, and others, agreed to submit Medicaid claims under their respective Medicaid provider numbers, for the unauthorized and fraudulent services purportedly provided by Marible-Wilson. In exchange for submitting the Medicaid claims, Marible-Wilson agreed to pay the co-conspirators a percentage of the total paid by Medicaid.

On July 27, 2011, Teresa Marible-Wilson 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 Marible-Wilson on June 19, 2012. The Court sentenced Marible-Wilson to a term of thirty-six (36) months incarceration. Upon release from prison, Marible-Wilson is ordered to serve a term of two (2) years on supervised probation, imposing the standard conditions of probation. Marible-Wilson was further ordered to pay a $100.00 assessment fee and a total of $1,135,622.56 in restitution to the Medicaid Program, which she is jointly and severally liable along with other co-conspirators in the following apportions: $135,658.87 joint and several with Joanna Patronis; $207,416.28 joint and several with Joanna Patronis and Giraud Hope; and $20,383.00 joint and several with Michelle Jackson.

U.S. v. KAREN WILLS

Karen Wills (Wills) worked as the "nurse" at AA Primecare Medical Center located in Charlotte, North Carolina despite having no formal medical training. This case was initiated from an investigation of AA Primecare Medical Center (AA Primecare), and Enterpro STC Services, LLC (Enterpro), owned by Derrick Knox.

The investigation revealed that as the "nurse," Wills was responsible for submitting fraudulent claims for electromyography (EMG) and anorectal manometry (AM) procedures that were medically unnecessary or not provided at all. These fraudulent claims were submitted to Medicare and Medicaid and paid in excess of $400,000.00.

Wills was also found to be working with Enterpro STC Services, LLC, a durable medical equipment company that provided power wheelchairs to multiple patients of AA Primecare in the Charlotte and Gastonia areas. A review of the patients referred to Enterpro by Wills disclosed multiple fictitious referrals for patients to receive medically unnecessary power wheelchairs from Enterpro. In some instances, Wills forged a physician's signature on required qualification documents resulting in Medicare and Medicaid being billed in excess of $300,000.00 for medically unnecessary power wheelchairs. Wills received a kickback for each power wheelchair that was not authorized and not medically necessary.

Wills also used a stolen prescription pad from AA Primecare to forge prescriptions for controlled substances. Wills forged the physician's signature on prescriptions for oxycodone and hydrocodone/acetaminophen pills. Wills used her health insurance prescription benefit program to pay for the fraudulent prescriptions resulting in fraudulent payments in excess of $30,000.00.

In January 2012, Wills pled guilty in federal court in the Western District of North Carolina to two (2) counts of health care fraud conspiracy, one count of paying and receiving illegal kickbacks, and one count of conspiracy to distribute controlled substances. On November 2, 2012, Wills was sentenced by the United States District Court for the Western District of North Carolina to serve ninety-seven (97) months in prison, followed by three (3) years of supervised release. She was ordered to pay an assessment of $400.00 and $786,316.74 as restitution to Medicaid, Medicare and Medco Health Solutions.

The investigation into Wills and Gibson was handled by HHS-OIG, MID, FBI, USSS, NC SBI, CPMD, and Rowan County Sheriff's Office. The prosecution was handled by Assistant U.S. Attorney Kelli Ferry of the U.S. Attorney's Office in Charlotte.

U.S. v. WENDY GIBSON

Wendy Gibson was employed by Enterpro STC Services, LLC (Enterpro), a provider of durable medical equipment, including power wheelchairs, to Medicare and Medicaid recipients in the Charlotte and Gastonia, North Carolina. This case was initiated from an investigation of Enterpro and Derrick Knox, owner of Enterpro.

A joint MID, HHS-OIG, FBI, USSS, NC SBI, CPMD, and Rowan County Sheriff's Office investigation revealed that Gibson was employed by Enterpro and conspired with Karen Wills (Wills), an employee at a medical practice, to submit fictitious referrals for patients to receive medically unnecessary power wheelchairs from Enterpro. In some instances, Wills forged a physician's signature on required qualification documents which Gibson submitted through

Enterpro resulting in Medicare and Medicaid being billed for medically unnecessary power wheelchairs. Gibson and Wills received a kickback for each power wheelchair claim they successfully filed through Enterpro. Gibson and Wills were responsible for more than $300,000.00 being paid by Medicare and Medicaid for medically unnecessary power wheelchairs.

Gibson was also involved with Wills in a scheme to fraudulently obtain and distribute controlled substances. Wills stole a prescription pad from her employer, AA Primecare, and wrote prescriptions for controlled substances in Gibson's name. Gibson used her health insurance prescription benefit to obtain fraudulent prescriptions for oxycodone and hydrocodone/acetaminophen pills. Wills forged the physician's signature on the fraudulent prescriptions. Gibson submitted fraudulent prescriptions resulting in payments in excess of $30,000.00.

In January 2012, Gibson pled guilty in federal court in the Western District of North Carolina to one (1) count of health care fraud conspiracy, one (1) count of paying and receiving illegal kickbacks and one (1) count of conspiracy to distribute controlled substances. On November 2, 2012, Gibson was sentenced by the United States District Court for the Western District of North Carolina to serve forty-eight (48) months in prison, followed by three (3) years of supervised release. She was ordered to pay an assessment of $300.00 and $358,330.74 as restitution to Medicaid, Medicare and Medco Health Solutions.

U.S. v. MICHAEL BROWN

Michael Shawn Brown was a Licensed Professional Counselor and owner of Michael Shawn Brown, LPC, a Medicaid mental health services provider located in Chadbourn, North Carolina. This matter was initiated based on a request for assistance from the Columbus County Sheriff's Office (CCSO) in Chadbourn, NC. CCSO was investigating a homicide involving Brown that had occurred at his business on March 29, 2011. The victim, Larry Towns, was reported to have done odd jobs for Brown.

MID joined with CCSO, SBI and ATF in this investigation. The investigation revealed that Brown shot and killed Larry Towns at Brown's business, Michael Shawn Brown, LPC, after receiving an extortion note from Towns threatening to reveal Brown's practice of submitting fraudulent bills to Medicaid for counseling services. Towns had worked with Brown to obtain Medicaid identification cards from recipients. Brown then used those cards to bill Medicaid when no services were provided. Brown also routinely billed Medicaid for group and individual counseling for recipients when no counseling services were provided by hiring others, in addition to Towns, to provide Brown with Medicaid identification cards. This investigation further revealed that, in response to a request by MID personnel to review Brown's patient records, Brown set a fire in his business to hide the fact that no patient records were present and that he was not providing the services for which he had billed Medicaid from 2008 to 2011.

On August 6, 2012, pursuant to a plea agreement, Brown entered pleas of guilty to Wire Fraud and Aiding and Abetting and Arson – Commission of a Federal Felony in Federal District Court in the Eastern District of North Carolina in Wilmington, NC. On January 2, 2013, Brown was sentenced for these offenses to three hundred and sixty (360) months in federal prison. Brown was also ordered to pay restitution to Medicaid in the amount of $257,802.00 and to Malcolm Bullock in the amount of $87,500.00 for property damage related to the arson conviction.

U.S. v. BETTY COOK

Betty Cook was the owner of Families First Home Health Care (FFHHC), a personal care services company, located in Sparta, North Carolina. This matter was referred to the MID by the Alleghany County Sheriff's Office and by the Division of Health Services Regulation.

A joint MID, HHS-OIG, and IRS investigation revealed that between September 2006 and October 2010, Cook, through FFHHC, engaged in a variety of fraud schemes including: a fee-splitting arrangement whereby recipients would receive a portion of an assigned home health aide's wages in lieu of receiving services; services not rendered; altering or falsifying Physician Authorization and Certification of Treatment forms; operating without a nurse on staff; and forging nurses' signatures on initial assessments.

On April 25, 2012, Betty Cook pled guilty to one count of Health Care Fraud Conspiracy and one (1) count of Money Laundering. The United States District Court for the Western District of North Carolina sentenced Cook on May 6, 2013. The Court sentenced Cook to a term of forty (40) months incarceration on each count to run concurrently. Upon release from prison, Cook is ordered to serve a term of two (2) years on supervised probation, imposing the standard conditions of probation. Cook was further ordered to pay a $200.00 assessment fee and a total of $325,820.17 in restitution to the Medicaid Program, portions of which she is jointly and severally liable along with other co-conspirators.

U.S. v. ENTERPRO STC SERVICES, LLC

Enterpro was a provider of durable medical equipment, including power wheelchairs, to Medicare and Medicaid recipients in the Charlotte and Gastonia, North Carolina. Derrick Knox managed Enterpro. AA Primecare was a "full service" medical clinic located in Charlotte, North Carolina. This case was initiated from an investigation of AA Primecare Medical Center and Derrick Knox.

An investigation revealed that Enterpro and Knox were paying an individual who worked for AA Primecare Medical Center between $400 and $1000 for each patient referred to Enterpro to receive a power wheelchair. The prescribing physician's signature was forged on numerous authorizations resulting in Medicare and Medicaid paying in excess of $300,000.00 for medically unnecessary power wheelchairs. Knox characterized the payments for referrals as

"sales commissions". However, the payments were illegal kickbacks paid for the authorizations to bill for multiple power wheelchairs.

In December 2011, Knox pled guilty in federal court in the Western District of North Carolina to two counts of 18 USC 371 Conspiracy to Defraud the United States – Illegal Kickback Scheme. He was sentenced on May 23, 2012 by the United States District Court for the Western District of North Carolina to one (1) year of probation for one (1) count and to six (6) months active followed by six (6) months of house arrest for the second count. He was ordered to pay restitution to Medicare in the amount of $237,571.54 and to NC Medicaid in the amount of $82,447.14

Defendant Enterpro pled guilty and received a sentence of one (1) year of probation and an order to pay restitution in the amount of $320,018.68 (jointly and severally with Derrick Knox) along with a $400 assessment.

U.S. v. DERRICK KNOX

Derrick Knox managed Enterpro STC Services, LLC, a durable medical equipment company. Enterpro provided durable medical equipment, including power wheelchairs, to Medicare and Medicaid recipients in the Charlotte and Gastonia areas. This case was initiated from an investigation of AA Primecare Medical Center and Enterpro.

An investigation revealed that Enterpro and Knox were paying an individual who worked for AA Primecare Medical Center between $400 and $1000 for each patient referred to Enterpro to receive a power wheelchair. The prescribing physician's signature was forged on numerous authorizations resulting in Medicare and Medicaid paying in excess of $300,000.00 for medically unnecessary power wheelchairs. Knox characterized the payments for referrals as "sales commissions". However, the payments were illegal kickbacks paid for the authorizations to bill for multiple power wheelchairs.

In December 2011, Knox pled guilty in federal court in the Western District of North Carolina to one (1) count of 18 USC 371 Conspiracy to Defraud the United States – Illegal Kickback Scheme. He was sentenced by the United States District Court for the Western District of North Carolina on May 23, 2012 to six (6) months active and two (2) years of supervised probation. He was ordered to pay restitution to Medicare in the amount of $237,571.54 and to NC Medicaid in the amount of $82,447.14

U.S. v. CHERRY HAMRICK

Cherry Hamrick (Hamrick) was the operator of Times R Changing, Inc. (TRC), an outpatient behavioral health service company located in Charlotte, North Carolina. This matter was discovered during the course of another MID investigation.

A joint MID and HHS-OIG investigation revealed that TRC previously had a Medicaid provider number for intensive in-home care services, but lost its LME endorsement for not employing appropriately licensed professionals. Co-conspirator Joanna Patronis was TRC's contract Medicaid biller. After TRC lost its LME endorsement, Patronis offered to begin billing Medicaid for TRC's outpatient services. Between January 2010 and September 2010, Hamrick began submitting TRC's outpatient services billings to Patronis for submission to Medicaid through Patronis' and others' Medicaid provider numbers. TRC's outpatient services billed by Hamrick were not provided by appropriately licensed or supervised professionals, and some services were not rendered at all. Co-conspirators agreed to submit Medicaid claims for Hamrick in exchange for a percentage of the total paid by Medicaid.

On July 1, 2011, Cherry Hamrick 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 Hamrick on July 25, 2012. The Court sentenced Hamrick to a term of eight (8) months of house arrest. Hamrick is ordered to serve a term of five (5) years on supervised probation, imposing the standard conditions of probation. Hamrick was further ordered to pay a $100.00 assessment fee and a total of $277,263.00 in restitution to the Medicaid Program, which she is jointly and severally liable along with co-conspirators in the following apportions: $246,031.00 joint and several with Joanna Patronis, and $31,232.00 joint and several with Joanna Patronis and Giraud Hope.

U.S. v. KELLY SVEDBERG

Kelly Svedberg (Svedberg) was employed by AA Primecare from September 2007 through August 2008 as a licensed physician assistant at the AA Primecare office located at 1407 East 7th Street, Suite 100, Charlotte, NC 28204. AA Primecare was a "full service" medical clinic located in Charlotte, North Carolina. This case was initiated from an investigation of AA Primecare Medical Center (AA Primecare).

The investigation revealed that Svedberg routinely saw patients for problem specific visits as well as routine annual checkups. A review of billing records for his patients revealed that many of his patients were being billed for several uncommon and expensive diagnostic tests on multiple occasions over a short period of time. Svedberg's patients were interviewed, and very few had ever heard of the tests billed and none of them claimed to have any of the symptoms which might have warranted the test. A review of the patients' medical records failed to disclose results of the tests which had been billed and paid by Medicare and Medicaid. Further review disclosed numerous medically unnecessary tests were performed and billed to Medicare and Medicaid or were billed with no procedure ever taking place. The unusual and unnecessary procedures included electromyogram and anorectal manometry treatments. According to filed court documents and statements made in court, from about September 2007 to about August 2008 Svedberg was employed as a licensed physician's assistant at a medical clinic in Charlotte. From 2007 through about December 2008, Svedberg and his co-conspirators participated in a scheme to defraud Medicare and Medicaid by billing Medicare and Medicaid for medical services that were medically unnecessary, not provided, or both.

In July 2011, Svedberg pled guilty in federal court in the Western District of North Carolina to one (1) count of conspiracy to defraud a health care benefit program. Svedberg admitted that the amount of loss to Medicare and Medicaid caused by this scheme exceeded $120,000 but was less than $200,000.

Svedberg was sentenced on July 10, 2012 by Chief U.S. District Judge Robert J. Conrad, Jr. the United States District Court for the Western District of North Carolina to two (2) years' probation. In addition, the court ordered Svedberg to pay $81,365.59 in restitution and an assessment of $100.00.

U.S. v. SASSAN BASSIRI, DDS

Sassan Bassiri was a dentist in an individual practice located in King, North Carolina. This matter was referred to the MID by the North Carolina Division of Medical Assistance – Program Integrity.

A MID investigation revealed that between August 2007 and January 2011, Bassiri was billing the Medicaid Program for cast metal partials, but delivering acrylic or non-reimbursable interim partials instead, as well as billing for office visits not actually rendered.

On January 2, 2013, Sassan Bassiri (Bassiri) pled guilty to three (3) counts of Health Care Fraud. On May 3, 2013, the United States District Court for the Middle District of North Carolina sentenced Bassiri. The Court sentenced Bassiri to a term of five (5) months incarceration for each count to run concurrently. Upon release from prison, Bassiri was ordered to serve an additional five (5) month term of house arrest as part of his two (2) years supervised probation. Bassiri was further ordered to pay a $300.00 assessment fee, a $10,000.00 fine, and a total of $68,795.65 in restitution to the Medicaid Program. The full restitution amount was deposited with the Clerk of Court on the day of sentencing.

U.S. v. CRYSTAL DELEON-EVANS

Crystal Deleon-Evans 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, HHS-OIG, and IRS investigation revealed that between December 2006 and October 2010, Evans participated in criminal activity while she was an employee of FFHHC by signing blank time sheets for personal care services not actually rendered, and participating in a fee-splitting arrangement whereby she would share her wages with the assigned recipient in lieu of providing services.

On March 5, 2012, Crystal Deleon-Evans 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 Evans to a term of twelve (12) months supervised probation, imposing the

standard conditions of probation. Evans was further ordered to pay a $100.00 assessment fee and a total of $33,006.00 in restitution to the Medicaid Program, which she is jointly and severally liable for the total amount along with co-conspirator Betty Cook.

STATE vs. SARINA HOTKA (SOUTHERN HOME HEALTHCARE)

Sarina Hotka was the owner of Southern Home Healthcare ("Southern"), a Medicaid Personal Care Services provider located in Fayetteville, NC. This matter was initiated based upon information provided to the MID by a former employee of Southern Home Healthcare.

The MID investigation revealed that from 2006 to 2008, Southern did not have a registered nurse employed to perform patient evaluations and prepare plans of care. Hotka had a rubber stamp made bearing the signature of a registered nurse and used it to sign patient evaluations and plans of care. The registered nurse had applied for a job with Southern and had signed the job application but was never employed by Southern and did not authorize the use of her signature. Hotka had fraudulently completed plans of care for multiple recipients using the forged signature stamp to improperly bill for Personal Care Services.

On March 7, 2013, Hotka pled guilty to eight (8) counts of Medical Assistance Provider Fraud in Cumberland County Superior Court in Fayetteville, NC. The court ordered that Hotka receive three (3) consecutive six (6) to eight (8) month sentences in the custody of the North Carolina Department of Corrections and suspended those sentences for 60 months of supervised probation. Hotka was also ordered not to be employed in any position that receives funds from or results in billing to the North Carolina Medicaid Program and pay $70,000.00 in restitution to the Medicaid, court costs and attorney's fees.

STATE v. BOBBY FAISON

Bobby Faison was a licensed mental health counselor in Henderson, North Carolina. Faison was the primary owner and operator of Prodigious Health Services, LLC, which provided mental health counseling in and around Vance County, North Carolina. This investigation was initiated by MID after a hotline call from a citizen.

The MID investigation uncovered a fraud scheme involving the use of kickbacks by Faison to obtain Medicaid recipient identification numbers of children from parents and guardians. Faison would then bill Medicaid for services through Prodigious Health Services, LLC without providing any counseling services to those children. From January 2010 through October 2011, Faison defrauded $56,179.68 from Medicaid.

On March 25, 2013, Faison pled guilty to one (1) count of Felony Medical Provider Fraud and one (1) count of Felony Offering/Paying Kickbacks by a Medicaid provider. The Wake County District Court sentenced Faison to serve six (6) to eight (8) months in prison, suspended for twenty-four (24) months of supervised probation. Faison was ordered to pay restitution of $56,179.68 and court costs of $200.00. Faison was ordered to complete fifty (50) hours of

community service and pay the community service fee of $250.00. Faison was ordered not to be employed in any job that may result in billings, for goods or services, to Medicaid, directly or indirectly. As a special condition required by the plea agreement, Faison paid full restitution at the time of his sentencing.

STATE v. GLORIA ROGERS

Gloria Rogers had solicited work as a speech pathologist, in Fayetteville, North Carolina, after her license to practice speech and language therapy had been suspended by the North Carolina Board of Examiners for Speech and Language Pathologists. It was discovered during the investigation that Rogers was the owner of Theracomm Speech Therapy. This matter was referred to the MID by the North Carolina Board of Examiners for Speech and Language Pathologists.

A MID Investigation revealed that, between July 2010 through March 2011, Rogers was providing SLP services to Medicaid recipients in local child care centers and at the Theracomm address during the period that her license was suspended, in violation of her Medicaid provider agreement.

On July 11, 2012, Gloria Rogers appeared in Cumberland County Superior Court and pled guilty to seven (7) counts of Felony Medical Assistance Provider Fraud. The charges were consolidated for two (2) judgments and sentenced Rogers to two (2) consecutive six (6) to eight (8) month sentences in the custody of North Carolina Department of Corrections. Those sentences were suspended and Rogers was placed on supervised probation for a period of sixty (60) months on the condition that she pay restitution to the Medicaid program in the amount of $53,371.50 and that she not be employed in any position that receives funds from or results in billing to Medicaid.

STATE v. DEBORAH AROCHE

Deborah Aroche was an employee of Living Waters Home Health, LLC (Living Waters), 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 2010 and August 2011, Aroche participated in criminal activity while she was an employee of Living Waters by submitting time sheets for personal care services not actually rendered.

On March 26, 2013, Deborah Aroche pled no contest to one (1) count of misdemeanor attempted Medicaid fraud. The Alleghany County District Court sentenced Aroche to forty-five (45) days, suspended for sixty (60) months of supervised probation, and ordered Aroche to pay restitution to the Medicaid program in the amount of $8,018.10, pay court costs of $215.00, Attorney's fees of $275.00, and a Miscellaneous fee of $60.00. The Court withheld any order of

community service, finding Aroche unable to perform community service hours due to health issues.

STATE v. APRII FULLER

Aprii Dominique Fuller, worked for A Small Miracle Inc., a Medicaid provider. This matter was referred to the MID by the Department of Health Service Regulation.

The investigation revealed that A Small Miracle reported to the Department of Health Services Regulations and the Cary Police Department that Aprii Fuller was submitting timesheets for work not performed. The Cary Police Department issued a warrant on November 1, 2011. MID interviews and investigative techniques substantiated the allegations that Fuller was submitting timesheets for work not performed.

On March 30, 2012 Aprii Dominique Fuller plead to one (1) count of obtaining property by false pretenses. Aprii Dominique Fuller received a five (5) to six (6) month sentence suspended and thirty-six (36) months' probation. Aprii Dominique Fuller was further ordered to pay restitution in the amount of $8,298.88.

STATE v. DEBRA WRIGHT-BROWER (LOVING WAY ADULT CARE HOME, INC.)

Debra Wright-Brower was an administrator of two adult home care homes located in Clyde, North Carolina. The matter was referred to the MID by the Division of Health Service Regulation.

The investigation revealed that in January 2011, Debra Brower assumed administrative responsibilities at two adult care homes in Clyde, NC, Hospitality Retreat and Mountain Hart Retirement. These homes were previously owned and operated by Gail Reece and Mary Allen. There were no formal contracts signed related to the transfer of ownership to Brower, nor did Brower apply to become a Medicaid provider. Brower registered the homes with the NC Secretary of State as "Loving Way Adult Care Home, Inc." Brower ran the business under the previously existing Hospitality Retreat and Mountain Hart provider numbers, and was paid by Reece and Allen from Medicaid reimbursements to their accounts.

Included among the monies provided to Brower were $66/month in patient personal funds. These funds were to be used for personal items such as hair appointments, dinners outside the facility, or prescription medications for facility residents. Brower had contracted PSA Pharmacy for the pharmacy needs of Loving Way. During the time Brower was the administrator of Loving Way, she did not pay any co-pays to PSA for prescriptions filled for residents of Loving Way from patient personal funds, rather she used those funds to cover other facility expenses.

On November 14, 2012, Brower was charged in Haywood County District Court with two (2) counts of Commingling Patient Personal Funds in violation of G.S. 108A-60. Brower pled guilty and was sentenced to two (2) consecutive forty-five (45) day sentences. Those sentences

were suspended for eighteen (18) months, and Brower was to pay $4,936.23 in restitution to PSA Pharmacy, complete twenty-four (24) hours of community service, not violate any laws, and not own or manage any health care facility during her period of probation.

STATE v. TAMMY ATKINS

Tammy Atkins 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 December 2007 and February 2008, Atkins participated in criminal activity while she was an employee of FFHHC by submitting time sheets for personal care services not actually rendered.

On March 26, 2013, Tammy Atkins pled guilty to two (2) counts of misdemeanor attempted Medicaid fraud. The Alleghany County District Court consolidated the cases for judgment, and sentenced Atkins to forty-five (45) days, suspended for thirty-six (36) months of supervised probation, and ordered Atkins to perform twenty-four (24) hours of community service, pay restitution to the Medicaid program in the amount of $3,997.68, pay court costs of $215.00, Attorney's fees of $137.50, Community Service fees of $250.00, and a Miscellaneous fee of $60.00.

STATE v. AMY LYALL

Amy Lyall was an employee of Cook's Home Care (CHC), 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 December 2010 and July 2011, Lyall participated in criminal activity while she was an employee of CHC by submitting time sheets for personal care services not actually rendered.

On March 26, 2013, Amy Lyall pled no contest to one (1) count of misdemeanor attempted Medicaid fraud. The Alleghany County District Court sentenced Lyall to one-hundred twenty (120) days with one (1) day credited for time served. The remaining sentence was suspended for thirty-six (36) months of supervised probation. The Court further ordered Lyall to perform forty-eight (48) hours of community service, pay restitution to the Medicaid program in the amount of $3,667.44, pay court costs of $230.00, Attorney's fees of $165.00, Community Service fees of $250.00, and a Miscellaneous fee of $60.00.

STATE v. DIETRA MICHELLE BOTTOMLEY

Dietra Michelle Bottomley 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 August 2008 and December 2008, Bottomely participated in criminal activity while she was an employee of FFHHC by submitting time sheets for personal care services not actually rendered.

On April 23, 2013, Michelle Bottomley pled guilty to one (1) count of misdemeanor attempted Medicaid fraud. The Alleghany County District Court sentenced Bottomley to forty-five (45) days, suspended for eighteen (18) months of supervised probation, and ordered Bottomley to pay restitution to the Medicaid program in the amount of $3,281.04 (of which $1,941.84 is jointly and severally liable with Billie Jo Castillo-Bingman), pay a fine of $50.00, pay court costs of $210.00, Attorney's fees of $247.50, and a Miscellaneous fee of $60.00.

STATE v. KELLIE HICKMAN

Kellie Hickman was an in-home aide working for United Home Care, Inc. Hickman provided in-home series for Medicaid recipients in Sampson County, North Carolina. This matter was referred to the MID by the Health Care Personnel Registry (DHSR).

The MID investigation determined that Hickman had submitted hourly billing to her employer for in-home services that she had not provided to two Medicaid recipients from March 1, 2012 to July 5, 2012. Hickman's actions caused United Home Care, Inc. to bill Medicaid for $2,904.90 in services not rendered. United Home Care, Inc. repaid Medicaid for the loss.

On March 7, 2013, Hickman pled guilty to two (2) counts of Attempted Medical Assistance Provider Fraud. The Sampson County District Court sentenced Hickman to a term of forty-five (45) days in jail which was suspended for twelve (12) months of supervised probation. Hickman was ordered to pay restitution of $2,904.90 to United Home Care, Inc. Hickman was ordered to complete forty-eight (48) hours of community service and pay fee of $250.00. Hickman was ordered to pay two costs of court totaling $370.00. As a special condition of probation, Hickman shall not be employed in any position that results in billing to the North Carolina Medicaid Program.

STATE v. APRIL L. DYER

April L. Dyer was an employee of Easter Seals UCP North Carolina & Virginia, Inc., a Medicaid provider. This case was referred to the MID by the Health Care Personnel Registry Section ("HCPR") of the Division of Health Service Regulation (DHSR).

The investigation revealed that Easter Seals UCP North Carolina & Virginia, Inc. had reported to HCPR that April Dyer had turned in fraudulent timesheets which overstated the numbers of hours of service she provided to a Medicaid recipient. Easter Seals UCP North Carolina & Virginia had then billed Medicaid based on those timesheets. The fraudulent activity occurred from January 20, 2012 through June 12, 2012.

On May 17, 2013, Dyer pled guilty in Randolph County District Court to the misdemeanor of attempted medical provider fraud in violation of N.C.G.S. § 108A-63. The District Court sentenced Dyer to a forty-five (45) day suspended sentence and placed her on supervised probation for eighteen (18) months. Dyer was ordered to pay court costs of $210.00, a fine of $100.00, and restitution of $2,962.50 to the North Carolina Fund for Medical Assistance. The court also ordered that Dyer not work for providers who receive funds from the Medicaid Program.

STATE v. JESSICA COOK

Jessica Cook 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 June 2008 and July 2008, Cook participated in criminal activity while she was an employee of FFHHC by submitting time sheets for personal care services not actually rendered.

On February 26, 2013, Jessica Cook pled guilty to two (2) counts of misdemeanor attempted Medicaid fraud. The Alleghany County District Court consolidated the cases for judgment, and sentenced Cook to forty-five (45) days, suspended for twenty-four (24) months of supervised probation, and ordered Cook to perform twenty-four (24) hours of community service, pay restitution to the Medicaid program in the amount of $2,280.36, pay court costs of $210.00, Attorney's fees of $220.00, Community Service fees of $250.00, and a Miscellaneous fee of $60.00.

STATE v. KAWAINS JORDAN

Kawains Jordan was a home health aide working for Right Choice Home Care and Staffing, LLC located in Wendell, North Carolina. This matter was discovered during the course of another MID investigation.

The investigation revealed that Kawains submitted timesheets indicating she performed 658 units of personal care services for Medicaid recipient, A.W from December 1, 2011 through March 19, 2012. She did not perform those services.

On September 12, 2012, Jordan pled guilty to one (1) count of Attempt Medicaid Fraud, a Class 1 Misdemeanor. The Wake County District Court sentenced her to forty-five (45) days,

county jail, suspended sentence and two (2) years' probation. The Court ordered her to pay $300 in restitution, due immediately, and the remaining $1,970.10 to be paid over the course of the probation. The Court assessed fines and costs in the amount of $442.50.

STATE V. LAKETHA EBRAHIM

Laketha Ebrahim was healthcare practitioner for Maxim Healthcare Services, a home care agency located in Winterville, North Carolina. This matter was referred to MID by the Health Care Personnel Registry.

The investigation revealed that Laketha Ebrahim, submitted timesheets indicating she provided respite home and community services to Medicaid recipients, M.F. and C.M. from September 4, 2009 through November 14, 2009. She did not perform those services.

On January 11, 2013, Ebrahim pled guilty to two (2) counts of Attempt Medicaid Fraud, a Class 1 Misdemeanor, in Pitt County District Court. The District Court sentenced her to forty-five (45) days, county jail, suspended sentence, and two (2) years supervised probation. The Court ordered her to pay $1420.62 in restitution over the course of the probation. The Court assessed fines and costs in the amount of $415.00. Upon payment of the total amount due, the probation office may transfer the defendant to unsupervised status.

STATE v. DONALD DAVIS

Donald Davis was an employee of Pine Valley Adult Care Home, located in Fayetteville, North Carolina. This matter was predicated upon a referral from Hon. Edward W. Grannis, Jr., District Attorney 12th Judicial District.

The MID investigation revealed that Davis had obtained and used the Medicaid card of a resident to obtain dental services and prescriptions from Anna T. Goodrich, DDS on June 12, 2008.

On July 24, 2012 Davis pled guilty to one (1) count of Misdemeanor Possession of Stolen Goods. The Cumberland County District Court sentenced Davis to forty-five (45) days in the custody of the Cumberland County Sheriff's Department and suspended that sentence, placing Davis on supervised probation for twelve (12) months. Davis was ordered to pay restitution to the Medicaid Program in the amount of $958.68 and court costs in the amount of $200.

STATE v. KEDAR MUHAMMAD (HAND TO HAND HEALTH CARE)

Kedar Muhammad was the owner and operator of Hand-To-Hand Home Care, which provided in-home services to Medicaid recipients in Guilford County, North Carolina. This MID investigation was initiated by hotline call from a citizen.

The MID investigation discovered that Muhammad had submitted false billing claims for services rendered to thirteen (13) Medicaid recipients who had been deceased prior to the dates of serviced. Muhammad attempted to defraud Medicaid for $10,424.40 from October 2007 through September 2008. The MID investigation also revealed that Mr. Muhammad had falsified information in his application to become a Medicaid provider.

On September 24, 2012, Muhammad pled guilty to one (1) count of Felony Obtaining Property by False Pretense and three (3) counts of Felony Medical Provider Fraud. The Guilford County Superior Court sentenced Muhammad to serve nine (9) to eleven (11) months in prison. Muhammad was ordered to pay $525.60 in restitution.

STATE v. JAMES GRIMES

James Grimes was a health care tech working for Cherry Hospital in Wayne County, North Carolina. Cherry Hospital provides treatment for patients and Medicaid recipients with mental health issues. The matter was referred to the MID by the Cherry Hospital Police Department.

The investigation revealed that Grimes had assaulted a patient by slapping him on February 13, 2013.

On April 17, 2013, Grimes pled guilty to one (1) count of Misdemeanor Simple Assault. The Wayne County District Court ordered Grimes to pay $185.00 for court costs and granted a Pray for Judgment Continued (PJC) upon payment of the court costs.

V. CIVIL RECOVERIES

GLAXOSMITHKLINE

GSK was a Delaware limited liability company and an indirect subsidiary of GlaxoSmithKline, PLC, a public limited company incorporated under English law with headquarters in Brentford, England. GSK developed, manufactured, distributed, marketed and sold pharmaceutical products in the United States, including drugs sold under the trade names of Paxil, Wellbutrin, Advair, Lamictal, Zofran, Imitrex, Lotronex, Flovent, Valtrex, Avandia, Avandamet, and Avandaryl. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that between January 1, 1994 through December 1, 2010, GSK (1) improperly marketed Paxil, Wellbutrin, Advair, Lamictal, and Zofran for uses not approved by the FDA, and paid illegal remuneration to cause the promotion and prescription of the off-label drugs and four additional products (Imitrex, Lotronex, Flovent, and Valtrex); (2) that GSK failed to report accurate “Best Prices” and underpaid rebates to the state Medicaid Programs; and (3) that GSK promoted Avandia to physicians and providers with false and

misleading representations about the drug's effect on patients' lipid profiles and low-density lipoprotein (LDL) particles when these effects were not supported by adequate scientific data.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $31,897,411.91. Of that amount, the federal government received $19,829,331.37 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $12,068,080.54. Of this amount, $7,001,932.08 was paid to the North Carolina Medicaid Program as restitution and interest, $3,897,354.24 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $722,524.53 was paid to the qui tam plaintiff, and $446,269.69 was paid to the North Carolina Department of Justice for costs of collection and investigation.

MCKESSON CORPORATION

McKesson was a Delaware corporation with its principal place of business in San Francisco, California. McKesson was a wholesaler of pharmaceutical products. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that between August 1, 2001 through March 31, 2005, McKesson knowingly increased, to 25% over Wholesale Acquisition Cost ("WAC") or over Direct Price ("DP"), the markups it reported to First DataBank ("FDB") for all brand-name, self-administered, prescription pharmaceuticals, without regard to the lower markups suggested by drug manufacturers for such drugs, and knowingly reported such 25% markups to FDB, when in fact: (1) prices with such markups did not accurately reflect the prices that McKesson actually charged its customers for such drugs; (2) McKesson knew that reporting such false and inflated markups to FDB would cause FDB to publish false and inflated Average Wholesale Prices ("AWPs") for such drugs; (3) McKesson knew that FDB described its published AWPs as being the product of wholesaler surveys and as reflecting actual prices that wholesalers charged their customers; and (4) McKesson knew that the State would and did use the published AWPs to reimburse providers for such drugs.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $21,842,255.15. Of that amount, the federal government received $14,363,870.79 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 $7,478,384.36. Of this amount, $7,185,176.44 was paid to the North Carolina Medicaid Program as restitution and interest and $293,207.92 was paid to the North Carolina Department of Justice for investigative costs.

ABBOTT PHARMACEUTICALS, INC. (DEPAKOTE)

Abbott was an Illinois corporation headquartered in Abbott Park, Illinois. Abbott distributed, marketed and sold pharmaceutical products in the United States, including a drug

sold under the trade names Depakote DR, Depakote ER, Depacon, and Depakote Sprinkle. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that between January 1, 1998 through December 31, 2008, Abbott knowingly promoted the sale and use of Depakote for uses that were not approved by the Food and Drug Administration as safe and effective, including behavioral disturbances in dementia patients, psychiatric conditions in children and adolescents, schizophrenia, depression, anxiety, conduct disorders, obsessive-compulsive disorder, post-traumatic stress disorder, alcohol and drug withdrawal, attention deficit disorder, autism, and other psychiatric conditions.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $15,940,138.11. Of that amount, the federal government received $10,023,105.25 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 $5,917,032.86. Of this amount, $3,932,919.01 was paid to the North Carolina Medicaid Program as restitution and interest, $917,553.61 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $871,088.08 was paid to the qui tam plaintiff, and $195,472.16 was paid to the North Carolina Department of Justice for costs of collection and investigation.

RANBAXY, INC.

Ranbaxy was a Delaware corporation. Ranbaxy distributed and sold pharmaceutical products in the United States that were manufactured at its facilities in Paonta Sahib, India and Dewas, India. This matter was referred to the MID by the relator's attorney.

This settlement resolves allegations that between April 1, 2003 through September 16, 2010, Ranbaxy knowingly submitted false statements to the Food and Drug Administration and failed to comply with current Good Manufacturing Practices resulting in systematic deficiencies in manufacturing plants located in Paonta, India and Dewas, India.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $8,792,991.10. Of that amount, the federal government received $5,760,106.46 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 $3,032,884.64. Of this amount, $1,180,193.25 was paid to the North Carolina Medicaid Program as restitution and interest, $1,132,429.49 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $626,875.38 was paid to the qui tam plaintiff, and $93,386.52 was paid to the North Carolina Department of Justice for costs of collection and investigation.

BOEHRINGER INGELHEIM PHARMACEUTICALS (MICARDIS, COMBIVENT, ATROVENT, AGGRENOX)

Boehringer Ingelheim Pharmaceuticals, Inc. ("BIPI") was a Delaware corporation headquartered in Ridgefield, Connecticut. BIPI developed, distributed, marketed and sold pharmaceutical products in the United States, including a drugs sold under the trade names Aggrenox, Atrovent, Combivent, and Micardis. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that between January 1, 2000 through December 31, 2008, BIPI knowingly promoted the sale and use of Aggrenox, Combivent and Micardis for uses not approved by the Food and Drug Administration. This settlement also resolves allegations that BIPI offered and provided services and other things of value to health care professionals for participating in programs such as the Ambulatory Blood Pressure Monitoring program and the Inspiring Improvement Program and programs such as advisory boards, speakers' training programs, speaker programs and consultant programs to induce them to promote and prescribe Aggrenox, Atrovent, Combivent, and Micardis.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $1,970,099.84. Of that amount, the federal government received $1,200,980.74 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 $769,119.10. Of this amount, $294,363.15 was paid to the North Carolina Medicaid Program as restitution and interest, $286,242.44 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $164,908.35 was paid to the qui tam plaintiff, and $23,605.16 was paid to the North Carolina Department of Justice for costs of collection and investigation.

AMGEN, INC. (ENBREL)

Amgen was a Delaware corporation with its principal place of business in California. Amgen developed, manufactured, distributed, marketed and sold biologic products in the United States, including Enbrel, Aranesp, Epogen, Neulasta, Neupogen, and Sensipar. This matter was referred to the MID by the relator's attorney.

This settlement resolves allegations that between January 1, 2001 through September 30, 2011, Amgen engaged in various illegal marketing practices to promote sales of the drugs Aranesp, Enbrel, Epogen, Neulasta, Neupogen, and Sensipar and inaccurately reported and manipulated prices for these drugs.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $1,188,697.22. Of that amount, the federal government received $772,519.51 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 $416,177.71. Of this

amount, $225,875.76 was paid to the North Carolina Medicaid Program as restitution and interest, $110,377.76 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $66,270.63 was paid to the qui tam plaintiff, and $13,653.56 was paid to the North Carolina Department of Justice for costs of collection and investigation.

HEALTHPOINT, INC. & DFB PHARMACEUTICALS

Healthpoint was a limited partnership with its principal place of business in Fort Worth, Texas. DFB Pharmaceuticals is the general partner of Healthpoint. Healthpoing distributed, marketed and sold pharmaceutical products in the United States, including Xenaderm. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that between April 2002 through December 31, 2006, Healthpoint marketed its wound-care drug Xenaderm as a pre-1962, unapproved drug despite determinations in the 1970's by the United States Food and Drug Administration that Xenderm's principle ingredient, trypsin, is less than effective for would debridement.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $1,084,720.61. Of that amount, the federal government received $639,334.40 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $445,386.21. Of this amount, $427,792.53 was paid to the North Carolina Medicaid Program as restitution and interest and $17,593.68 was paid to the North Carolina Department of Justice for costs of collection and investigation.

NEXTCARE, INC.

Nextcare, Inc. was a Delaware headquartered in Mesa, Arizona. Nextcare operated a chain of urgent care clinics in seven states in the United States, including North Carolina. This matter was referred to the MID by the relator's attorney.

This settlement resolves allegations that between January 1, 2006 through June 30, 2011, Nextcare submitted false claims to government healthcare reimbursement programs for 1) unnecessary allergy testing, 2) unnecessary respiratory panel and H1N1 flu testing, and 3) up-coded services deliberately designed to obtain higher reimbursement rates than otherwise allowed under the government programs.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $737,945.70. Of that amount, the federal government received $368,792.85 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 $369,152.85. Of this amount, $290,576.45 was paid to the North Carolina Medicaid Program as restitution and

interest, $66,415.11 was paid to the qui tam plaintiff, and $11,981.29 was paid to the North Carolina Department of Justice for costs of collection and investigation.

DR. TUNG NGUYEN

Dr. Tung Nguyen was a Medicaid provider and a dentist licensed to practice dentistry in North Carolina. This matter was referred to the MID by the State Board of Dental Examiners.

This settlement resolves allegations that between January 3, 2005 through January 13, 2009, Dr. Nguyen knowingly submitted claims to the Medicaid program for cast metal partial dentures that are more expensive than the acrylic partial dentures actually delivered and billed for restorative work (fillings) on non-contiguous surfaces of a tooth (requiring more than one drilling) when he actually preformed services on contiguous surfaces (requiring only one drilling).

Under the terms of North Carolina's settlement, the State of North Carolina recovered $400,000.00. Of that amount, the federal government received $255,952.89 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 $144,047.11. Of this amount, $62,316.60 was paid to the North Carolina Medicaid Program as restitution and interest, $76,026.24 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $5,704.27 was paid to the North Carolina Department of Justice for costs of collection and investigation.

AMGEN, INC. (AWP)

Amgen, Inc. was a Delaware corporation with its principal place of business in California. Amgen developed, manufactured, distributed, marketed, and sold biologic products in the United States, including Enbrel, Aranesp, Epogen, Neulasta, Neupogen and Sensipar. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that between 1991 through April 2013, Amgen inaccurately reported and manipulated prices for Aranesp, Enbrel, Epogen, Neulasta, Neupogen and Sensipar.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $370,524.18. Of that amount, the federal government received $248,593.39 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 $121,930.79. Of this amount, $90,247.49 was paid to the North Carolina Medicaid Program as restitution and interest, $26,880.42 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $4,802.88 was paid to the North Carolina Department of Justice for costs of collection and investigation.

AMGEN, INC. (ARANESP)

Amgen, Inc. was a Delaware corporation with its principal place of business in California. Amgen developed, manufactured, distributed, marketed, and sold biologic products in the United States, including a drug sold under the trade name Aranesp. This matter was referred to the MID by the relator's attorney.

This settlement resolves allegations that between September 1, 2003 through December 31, 2011, Amgen offered and paid illegal remuneration to long-term care pharmacy providers Omnicare, PharMerica and Kindred Healthcare in the form of purported market-share rebates, purported volume-based rebates, grants, honoraria, speaker fees, consulting services, dinners, and travel, and that this illegal remuneration was offered and paid for the purpose of inducing Omnicare, PharMerica and Kindred to recommend Aranesp and to influence health care providers' selection and utilization of Aranesp within nursing homes, skilled nursing facilities and long-term care settings. This settlement also resolves allegations that Amgen off-label marketed Aranesp for patients who did not have "amnesia associated with chronic renal failure."

Under the terms of North Carolina's settlement, the State of North Carolina recovered $360,213.08. Of that amount, the federal government received $234,917.14 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 $125,296.66. Of this amount, $50,324.53 was paid to the North Carolina Medicaid Program as restitution and interest, $49,683.02 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $21,191.25 was paid to the qui tam plaintiff, and $4,097.14 was paid to the North Carolina Department of Justice for costs of collection and investigation.

VICTORY PHARMA

Victory Pharma, Inc. was a Delaware corporation headquartered in San Diego, California. Victory acquired, licensed, marketed and developed prescription pharmaceutical products in the United States, including products approved for the treatment of pain and related conditions, such as Naprelan, Xodol, Fexmid and Dolgic. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that between January 1, 2007 through December 31, 2009, Victory offered and paid illegal remuneration in cash and in kind, including but not limited to, payment for preceptorships and speaker fees, meals, gifts, entertainment, event tickets, recreational activities, and other valuable goods and services, to health care professionals, to induce them to promote, prescribe or stock the prescription drugs Naprelan, Xodol, Fexmid and Dolgic.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $294,675.37. Of that amount, the federal government received $195,240.20 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 $99,438.17. Of this amount, $34,206.72 was paid to the North Carolina Medicaid Program as restitution and interest, $61,321.87 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and interest and $3,906.58 was paid to the North Carolina Department of Justice for costs of collection and investigation.

WHITE OAK MEDICAL TRANSPORT SERVICES

White Oak Medical Transport Services was an ambulance transport company 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, 2006 through June 30, 2010, White Oak billed Medicare and Medicaid for non-emergency ambulance transportation which was not medically necessary.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $275,000.00. Of that amount, the federal government received $266,605.52 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 $8,394.48. Of this amount, $8,062.06 was paid to the North Carolina Medicaid Program as restitution and interest and $332.42 was paid to the North Carolina Department of Justice for costs of investigation.

PREFERRED MEDICAL TRANSPORT/OC3

OC3, Inc. was an ambulance transport company doing business as Preferred Medical Transport. Will Outlaw, Norman Cherry, Marshall Cherry and Vanderbill Cherry owned and operated OC3. OC3 provided routine non-emergency ambulance transport in eastern North Carolina. This matter was referred to the MID by a former employee.

This settlement resolves allegations that from January 1, 2004 through August 1, 2010, OC3 knowingly billed the Medicare and Medicaid programs for non-emergency ambulance transport of dialysis patients and others to and from their nursing homes and residences, which were not medically necessary.

There were two settlement agreements in this case. One settlement involved OC3 and Marshall, Vanderbill and Norman Cherry. The other settlement agreement involved Will Outlaw.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $205,000.00. Of that amount, the federal government received $201,194.04 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 $3,805.96. Of this amount, $3,655.24 was paid to the North Carolina Medicaid Program as restitution and interest and $150.72 was paid to the North Carolina Department of Justice for costs of investigation.

PAR PHARMACEUTICALS (MEGACE ES)

Par Pharmaceuticals Companies, Inc. was a Delaware corporation with its principal place of business in Woodcliff Lake, New Jersey. Par developed, manufactured, distributed, marketed, and sold pharmaceutical products in the United States, including a drug sold under the trade name Megace ES. This matter was referred to the MID by the relator's attorney.

This settlement resolves allegations that between 2005 through June 30, 2009, Par promoted the sale and use of Megace ES for uses that were not approved by the Food and Drug Administration as safe and effective, including cachexia or weight loss suffered by elderly patients with no diagnosis of AIDS.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $203,464.31. Of that amount, the federal government received $129,981.09 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 $73,483.22. Of this amount, $41,416.35 was paid to the North Carolina Medicaid Program as restitution and interest, $13,822.19 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $15,998.49 was paid to the qui tam plaintiff, and $2,246.19 was paid to the North Carolina Department of Justice for costs of collection and investigation.

JOHNSTON AMBULANCE

Johnston Ambulance Service, Inc. was an ambulance transport company that provided routine non-emergency ambulance transport in North Carolina. This matter was referred to the MID by the Division of Medical Assistance.

This settlement resolves allegations that from October 2002 through March 2011, Johnston Ambulance knowingly billed the Medicare and Medicaid programs for non-emergency ambulance transport of dialysis patients and others to and from their nursing homes and residences, which were not medically necessary.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $200,000.00. Of that amount, the federal government received $192,703.55 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 $7,296.45. Of this amount, $7,007.51 was paid to the North Carolina Medicaid Program as

restitution and interest and $288.94 was paid to the North Carolina Department of Justice for costs of investigation.

WALGREENS (GIFT CARDS)

Walgreen Co. was an Illinois corporation with its principal place of business in Deerfield, Illinois. Walgreens operated a national retail pharmacy chain with over 7,800 locations throughout the United States and its territories. Walgreens dispensed prescription drugs to beneficiaries of the Medicaid and Medicaid Managed Care Programs and billed the Medicaid and Medicaid Managed Care Programs for those drugs. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

This settlement resolves allegations that between January 1, 2005 through June 11, 2010, Walgreens offered and/or provided improper inducements, in the form of gift cards, gift checks, and similar promotions to the beneficiaries of the Medicaid and Medicaid Managed Care Programs in order to influence their decision to transfer prescriptions to Walgreens pharmacies.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $52,730.44. Of that amount, the federal government received $33,771.61 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 $18,958.83. Of this amount, $9,321.51 was paid to the North Carolina Medicaid Program as restitution and interest, $9,163.54 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $473.78 was paid to the North Carolina Department of Justice for costs of collection and investigation.

CONTINUUM CARE

Continuum Care, Inc. was a corporation headquartered in Richmond County, North Carolina that provided mental health services. This matter was referred to the MID by the Richmond County Department of Social Services.

This settlement resolves allegations that from May 2009 through August 2009, Continuum Care failed to maintain records in regard to certain services allegedly rendered by one of its employees. Additionally, Continuum Care failed to accurately report the time in which its employee allegedly provided services to the Medicaid client. Continuum Care also failed to provide appropriate mental health services to the Medicaid client. The "services" which were to be provided were claimed as intensive in home visits when no such interactions occurred. The "services", when they in fact occurred, took place inside of the employee's vehicle on each occasion as opposed to a more suitable and therapeutic environment.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $23,238.00. Of that amount, the federal government received $15,011.75 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 $8,226.25. Of this amount, $2,633.50 was paid to the North Carolina Medicaid Program as restitution and interest, $5,266.99 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $325.76 was paid to the North Carolina Department of Justice for costs of collection and investigation.

RIGHT CHOICE HOME CARE

Right Choice Home Care was a home care company that provided CAP services in North Carolina. This matter was referred to the MID by an employee.

This settlement resolves allegations that from December 2011 through April 2012, Right Choice submitted false timesheets for one of its employees. The employee turned in timesheets stating she provided Personal Care Services to the Medicaid client when in fact she did not.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $4,540.20. Of that amount, the federal government received $2,963.84 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 $1,576.36. Of this amount, $756.97 was paid to the North Carolina Medicaid Program as restitution and interest, $756.97 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $62.42 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 Medicaid single-state agency, DMA, 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.

By January 2013 eleven Local Management Entity (LME)/Managed Care Organization (MCO) entities became operational with the implementation of North Carolina's new Behavioral Health Managed Care 1915(b)(c) Waiver program. Each LME/MCO has appointed a Compliance Officer and Committee whose duties include implementing an effective system for identifying and reporting fraud. DMA and MID have provided training to the LME/MCOs on identifying and reporting fraud. DMA and MID have been meeting on a periodic basis with the LME/MCO compliance staff. LME/MCO compliance staff have shown serious interest in the trainings and meetings and an understanding of the importance of reporting fraud. For this reason, MID has reason to be optimistic that the LME/MCO compliance staff will be a source of appropriate future referrals in connection with the Medicaid behavioral health program.

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 13/14 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.

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.

The Affordable Care Act (ACA) was enacted March 23, 2010. 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 has been able to suspend Medicaid providers when appropriate in order to prevent further fraudulent expenditures of taxpayer money, and in appropriate cases MID has been able to request that suspension not be imposed if suspension might compromise or jeopardize an investigation. For a full description of the regulation please see 42 C.F.R. 455.23.

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 2011/2012 fiscal year MID 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.

Our optimism must be tempered by the challenges that are inherent with any system changes, and 2013 has been a year of substantial changes to the North Carolina Medicaid

Program. In the past DMA provided MID with quick and easy access to Medicaid data through several data repository and access systems. Federal regulation requires that DMA provide MID with access to Medicaid data. This year DMA ended its contract with its fiscal agent, HP, and on July 1, 2013 the new fiscal agent, Computer Science Corporation (CSC), took over Medicaid claims processing and payment functions and implemented a new Medicaid Management Information System. This year DMA has also been in the process of ending its current data access and repository contracts. New data access and repository contracts with new vendors are in the process of being implemented and are expected to become functional in September and October 2013. MID access to data has been limited during this transition period. DMA has provided MID with some training on the new systems, but the training needs to continue. MID has encouraged DMA to ensure the security and accuracy of the Medicaid data in the new systems. MID has met with DMA and explained the importance of full and easy access to data, training, and secure and accurate data to the ability of MID to continue to conduct successful investigations.

In addition, on April 3, 2013 Governor McCrory announced his "Partnership for a Healthy North Carolina," a plan to overhaul North Carolina's Medicaid system by, in part, creating statewide Comprehensive Care Entities (CCEs) that will oversee the provision of services to Medicaid recipients. This shift from a fee for services model to a managed care model may necessitate changes in some of the North Carolina statutes currently relied on by MID to fight fraud in the Medicaid program. The current statutory framework was written for the fee for services model. Changes to the reimbursement methodology may affect the applicability of some of the statutes, especially in the criminal context. In addition, the new managed care model would shift many of DMA's program integrity functions to the CCEs. In order to continue to successfully investigate fraud, that shift would require that the contracts between the CCEs and DMA include provisions mandating that the CCEs detect and report fraud and maintain and disclose records to DMA and MID. MID met with DMA leadership in May, 2013 to explain the impact of a shift to managed care on MID operations and to request inclusion in the development process. The request was well received, and we anticipate a positive partnership in this area.

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.