ROY COOPER
ATTORNEY GENERAL

State of North Carolina

Department of Justice
PO Box 629
Raleigh, North Carolina
27602

Phone: (919) 716-6400
Fax: (919) 716-6750

September 2016

Senator Stan Bingham
Senator Buck Newton
Senator Shirley B. Randleman
Representative Jamie Boles
Representative N. Leo Daughtry
Representative John Faircloth
Representative Pat Hurley
Co-Chairs, Appropriations Subcommittees on Justice and Public Safety

Senator Ralph Hise
Senator Louis Pate
Senator Tommy Tucker
Representative Josh Dobson
Representative Marilyn Avila
Representative William Brisson
Representative Chris Malone
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 Department of Justice to report 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, 2015 through June 30, 2016.

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

Very truly yours,

Kristi Jones
Chief of Staff

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

REPORT TO THE
NORTH CAROLINA GENERAL ASSEMBLY

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

State Fiscal Year July 1, 2015 through June 30, 2016

TABLE OF CONTENTS

I. INTRODUCTION

Pursuant to N.C.G.S. § 114-2.5A 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 report annual activities to the General Assembly. The report covers the activities of the MID for the State Fiscal Year 2015-2016 (FY 15/16), covering July 1, 2015 through June 30, 2016.

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

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

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

II. OVERVIEW

The MID has worked hard to combat Medicaid provider fraud, the physical abuse of patients in Medicaid funded facilities, the misappropriation of patient funds, and fraud in the administration of the Medicaid program during its 37 year history. In that time over 585 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 $800 million in fines, restitution, interest, penalties, and costs.

The MID continues to maintain strong relationships with the North Carolina Department of Health and Human Services (NC DHHS), the state agency that administers the North Carolina Medicaid Program, and with other law enforcement and prosecutorial agencies. Throughout FY 15/16, the MID continued joint investigations of fraud and patient abuse cases with a number of law enforcement and investigatory agencies, including the United States Department of Health and Human Services Office of Inspector General (OIG), Office of Investigations District Office in Greensboro, N.C.; the Federal Bureau of Investigation (FBI); the Internal Revenue

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

Medicaid Fraud Control Units from other states seek advice and guidance in the areas of administration, investigation, and prosecution from the MID. The MID strives to maintain and build on this reputation and to assist other units directly and through participation with the National Association of Medicaid Fraud Control Units (NAMFCU). During FY 15/16, MID Director Charlie Hobgood served as a member of the NAMFCU Executive Committee and chaired a NAMFCU working group. 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 Global Case Committee and *Qui Tam* Subcommittee. The MID continues to be actively involved in national global cases being coordinated through NAMFCU with the United States Department of Justice and other federal and state agencies. Civil Chief Eddie Kirby, Financial Investigator Camille Carrion and Assistant Attorney Generals Steve McCallister, Stacy Race, Mike Berger, and Lareena Phillips served on NAMFCU global intake groups and teams appointed by NAMFCU's Global Case Committee.

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

The MID has a strong relationship with the North Carolina Division of Health Service Regulation (NC DHSR), the primary agency designated to receive patient physical abuse complaints from or involving long-term care providers in North Carolina. 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 360 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 15-16 the MID continued to provide an extensive training program for its staff through NAMFCU courses. Classes range from multi-level fraud investigation techniques to technical skills training. The MID and Division of Medical Assistance held their yearly joint training to inform all staff of various policies of both agencies and investigative best practices to further our common mission. The MID also attended and presented at training programs for Managed Care Organizations.

The North Carolina General Assembly enacted the North Carolina False Claims Act, G.S. §§ 1-605 through 1-618, effective January 1, 2010. This act established a state *qui tam* law that

has improved the MID's ability to prosecute and investigate Medicaid provider fraud and abuse. Since the North Carolina False Claims Act became effective, the MID received information from and filings by whistleblowers alleging approximately 490 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 facilitating *qui tam* actions by relators (whistleblowers), the state is allowed to retain an additional ten percent of the Federal share of recoveries. However, **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 N.C. False Claims Act should be amended by the legislature. Our staff has shared information on compliance with the legislature and remains available to pursue compliance.

The MID enjoys the full support of Attorney General Roy Cooper who has worked to enhance cooperation between government agencies in fighting health care fraud and abuse of the elderly.

In summary, the MID's activities over the past year in both the criminal and non-criminal areas have proven productive. Our successful investigation and prosecution of a variety of Medicaid providers during FY 15/16 enhanced 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 336 referrals made to the MID during the State FY 15/16; an increase from FY 14/15. The referrals came from varied sources. Referral sources include citizens, *qui tam* relators, the Program Integrity Section of the Division of Medical Assistance of the NC DHHS, Managed Care Organizations (MCO) in connection with behavioral health services, the Division of Health Service Regulation, local departments of Social Services, former employees, the National Association of Medicaid Fraud Control Units, United States Attorney's Offices, and other law enforcement agencies such as FBI, OIG, IRS, DEA, and SBI.

Of those 336 new referrals, the MID opened new case files on 145 matters. The remaining 191 were referred to another agency for review, declined for insufficiency of the evidence, or rolled into existing MID investigations. In many instances it is appropriate to refer a matter to the North Carolina Division of Medical Assistance for further review or administrative action. DMA can compare the allegation to its history of the provider and conduct billing analysis and reviews to determine whether further investigation is appropriate. DMA may then refer the matter back to the MID with the additional data and analysis. In that case, the MID can reconsider whether to open an investigation. Alternatively, DMA may decide to apply one of the administrative remedies or sanctions it has at its disposal. It is also possible that the matter could be referred to another appropriate investigatory agency for action.

A number of referrals were declined on the grounds that the referral did not sufficiently allege Medicaid provider fraud, were not substantiated by a preliminary review, or the potential for successful criminal prosecution was low. Some of the allegations pertained to Medicaid recipient fraud, but the MID's federal grant does not allow the MID to use funding to investigate Medicaid recipient fraud. Therefore, the MID refers recipient fraud allegations to the Division of Medical Assistance and the county Department of Social Services. Please note that allegations of Medicaid recipient fraud should be referred to the Recipient Services Section of the Division of Medical Assistance, 919-855-4000, 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 15/16 the MID staff investigated 594 cases; an increase from FY 14/15. 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 15/16. The subjects of current investigations include counselors and psychologists; physicians; dentists; psychiatrists; pharmacies; pharmaceutical manufacturers; durable medical equipment suppliers; transportation providers; home health care providers and aides; labs; nursing facilities; hospice; mental health facilities; managed care organizations; and hospitals. The MID is also investigating caregivers 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 15/16, the MID successfully convicted 27 providers; an increase from FY 14/15. These criminal convictions resulted in the recovery of $13,354,250.86 in restitution, fines, courts costs, supervision fees, and community services fees. Details of these convictions are set forth in Section IV of this report.

Of particular note was the federal criminal conviction and 240 month sentence of Terry Lamont Speller. Terry Lamont Speller was the owner and/or operator of several outpatient behavioral health providers including, but not limited to, Carter Behavior Health Services and Superior Living, LLC. These providers were located in several places in and around Greenville, NC. Through these providers, Speller recruited hundreds of Medicaid beneficiaries, mostly children, from various communities in Eastern North Carolina to receive alleged services compensable by Medicaid.

This case was initially referred to the Medicaid Investigations Division by the Division of Medical Assistance, Program Integrity (DMA-PI). Starting in 2010, DMA-PI began an investigation of one of Speller's companies based upon allegations that the company was billing

for services that were not actually rendered. When requested, Speller failed to provide records to support the services that were billed. As such, the company was suspended from further participation in Medicaid programs.

The MID investigated this case jointly with the Office of Inspector General (OIG) and the Internal Revenue Service.

Although Speller had been excluded from the Medicaid program, over the next several years he concocted various schemes to continue getting paid. The investigation revealed that from approximately September 2, 2010 through May 15, 2015, Speller was responsible for submitting fraudulent claims for reimbursement totaling $5,839,569.77. The schemes included getting various other providers to bill the Medicaid program on his behalf and submitting a forged document to Medicaid in order for payments to be wired into a bank account controlled by Speller. In regards to these claims, no services were provided. Speller and others used the Medicaid identification numbers of thousands of individuals, mostly children, and the signatures of doctors to submit these claims without their consent. Through this scheme, he caused one of the doctors to have her provider number suspended, which caused her to incur legal costs and other damages. Analysis of records showed that the millions of dollars obtained by Speller was split amongst various co-conspirators and converted, mostly, to cash. Prior to pleading guilty, Speller was arrested and detained for threatening to kill a witness if she spoke to law enforcement.

On November 4, 2015, Terry Lamont Speller pled guilty in the United States District Court for the Eastern District of NC to Health Care Fraud and Engaging in Monetary Transactions Involving Criminally Derived Property. On March 21, 2016, Speller was sentenced to 120 months imprisonment on both Counts to run consecutively producing a total term of imprisonment of 240 months to be followed by three years of supervised release. He was ordered to pay a special assessment of $200.00 and restitution to the Medicaid Program in the amount of $5,839,569.77. He was further ordered to pay restitution in the amount of $122,620.00 to the doctor.

b. Civil Settlements

During this period the MID obtained 29 civil settlements and recovered $80,765,782.60 in damages, interest, civil penalties, and costs; an increase from FY 14-15. Of significance was a civil settlement agreement with Wyeth, LLC and Pfizer, Inc. Wyeth, which is now a wholly-owned subsidiary of Pfizer, distributed pharmaceutical products in the United States including Protonix IV and Protonix Oral. This matter was referred to the Medicaid Investigations Division by NAMFCU.

It was alleged that from July 1, 2001 through December 31, 2006, Wyeth submitted false quarterly statements to the Centers for Medicare and Medicaid Services of its Best Price for Protonix Oral tablets and Protonix IV. Under the Medicaid Drug Rebate Statute, drug makers are required to report to Medicaid the lowest price they charge commercial customers for their drugs and to pay quarterly rebates to Medicaid based on those reported prices. In order to

encourage hospitals to purchase Protonix Oral tablets, Wyeth allegedly sold it in a discounted bundle with Protonix IV, but failed to report the discounted sale price to the Medicaid Drug Rebate Program. As a result, Wyeth avoided paying millions of dollars in drug rebates it owed to Medicaid and other federal health programs. Two *qui tam* complaints were filed in the U.S. District Court for the District of Massachusetts. The U.S., North Carolina and thirty-five other States and the District of Columbia intervened in these cases.

This case was actively litigated from 2010 through February 2016. The litigating States coordinated their efforts through a NAMFCU team. North Carolina was a key member of the Team. MID attorneys F. Edward Kirby, Jr. and Steven K. McCallister were actively involved in all phases of the litigation. Both Kirby and McCallister represented the States in a series of summary judgment and pre-trial hearings in Boston in the fall of 2015.

In 2016 the government and Pfizer/Wyeth entered into a settlement. Under the terms of the settlement, the State of North Carolina recovered $45,338,969.35. Of that amount, the federal government received $28,815,078.93 for North Carolina's federal portion of Medicaid recoveries. The North Carolina State share of the settlement was $16,523,890.42. Of this amount, $11,347,552.24 was paid to the North Carolina Medicaid Program as restitution and interest, $4,992,922.99 was paid to the North Carolina Schools Fund, and $183,415.19 was paid to the North Carolina Department of Justice for cost of investigation and collection.

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

Together, these 27 criminal convictions and 29 civil recoveries represent a total of $94.1 million recovered for the State of North Carolina. Consistent with federal reporting instructions, recoveries are amounts individual and organizational defendants are ordered to pay in criminal cases and must pay in civil judgments and settlements and may not reflect actual collections. A case by case breakdown of the amounts recovered in each case and allocation of recovered funds is shown below in Table A.

Table A Funds Recovered 7/1/2015 - 6/30/2016						
Name	Federal Government	NC Medicaid	Civil Penalty & Forfeiture Fund	NC DOJ Costs	Other	Total
Terry L. Speller / Superior Living, LLC	3,817,910.72	2,021,659.05			122,820.00	5,962,389.77
Eric B. Mitchell	1,338,195.69	711,736.43			200.00	2,050,132.12
Alyia Boss/Boss Counseling	739,762.96	395,539.31			100.00	1,135,402.27 *
Dr. Mark Le	7,811.85	4,198.99			1,032,677.68	1,044,688.52
D'Marcus Antonio White	355,959.49	187,407.15			100.00	543,466.64 *
Sakeenah David Davis	331,005.10	175,118.90			100.00	506,224.00 *
Kino Williams	331,005.10	175,118.90			100.00	506,224.00 *
Jacqueline P. Ford	289,999.62	152,680.30			100.00	442,779.92 *
Tanisha Melvin	256,903.89	135,255.92			100.00	392,259.81 *
Alexander Bass	242,630.94	127,741.43			100.00	370,472.37 *
Torrey D. Moton	242,630.94	127,741.43			100.00	370,472.37 *
Lachanda C. Parks	230,965.78	121,599.91			100.00	352,665.69 *
Anthony Marc Hailey	203,378.86	108,695.50			200.00	312,274.36
Zaria Davis Humphries	145,456.44	76,580.56			100.00	222,137.00
Dr. Wayne V. Wilson	135,169.12	72,943.46			2,348.08	210,460.66
Shaconda Simmons	88,815.54	47,237.67			25.00	136,078.21
Wanda Marie Webb					79,438.74	79,438.74
Sarah Gewanter	46,063.03	24,499.21			354.50	70,916.74
PACE, Inc. /Harriett Reid-Bell	14,223.73	7,565.07			80.00	21,868.80
Rebecca Derwin	13,946.04	7,338.04			240.00	21,524.08
Ieshia Watkins	12,745.22	6,865.84			200.00	19,811.06 *
Marlon R. Cooks	9,253.34	4,982.57			810.00	15,045.91
Lashaun Lloyd	1,151.63	596.44			2,527.70	4,275.77
Victoria White / Miracle Restoration					1,464.50	1,464.50
Alvin Barnes					607.50	607.50
Yvette Francine McLean	172.39	87.86			78.87	339.12
Drema Kincaid					305.00	305.00
Total Criminal Recoveries	7,914,718.46	4,194,154.83	0.00	0.00	1,245,377.57	13,354,250.86 *
Wyeth, Inc.	28,815,078.93	11,347,552.24	4,992,922.99	183,415.19		45,338,969.35
Millennium, LLC.	4,425,574.33	1,408,404.85	1,357,181.87	30,467.62	484,382.00	7,706,010.67
Country Lane	5,796,381.80	778,473.20				6,574,855.00
Physicians Pharmacy Alliance	3,860,876.17	297,174.76	805,724.93	36,224.14		5,000,000.00
Novartis Pharmaceuticals	1,819,415.73	253,699.82	374,855.99	7,012.68	234,559.53	2,689,543.75
Olympus Corporation	1,416,692.53	350,117.20	338,595.01	7,601.18	135,318.02	2,248,323.94
Dr. Won	1,541,625.87	421,446.99	230,041.48	6,885.66		2,200,000.00
Spencer Howard, DDS/Howard Surgery Cnt.	1,305,600.00	411,455.26	343,346.08	7,707.84		2,068,109.18
Astrazeneca, LP	1,335,859.36	456,302.00		5,077.34	144,447.69	1,941,686.39
Accredo Health Group, Inc.	723,996.68	98,224.94	114,233.14	6,926.64	80,563.04	1,023,944.44
Carolina Apothecary	442,076.40	56,329.52	56,329.52	1,264.56		556,000.00
Cape Fear Regional Urological Clinic	467,861.43	720.66	1,349.90	68.01		470,000.00
Warner Chilcott	288,563.26	43,149.91	56,935.32	1,102.54	33,109.05	422,860.08
Qualitest Pharmaceuticals	275,766.69	46,136.04	50,134.77	1,074.32	25,727.96	398,839.78
Cephalon, Inc. (Streck v. Allergan)	264,400.00	91,137.87		1,004.93	28,589.81	385,132.61
Genetech Corp.	239,036.10	55,397.11	54,294.02	1,218.86	22,490.57	372,436.66
Dr. James Sowell	292,718.82	64,393.26		4,387.92		361,500.00
Adventist Health System-Sunbelt, Inc.		105,975.49	52,987.75	1,784.30	37,706.21	198,453.75
Millennium, LLC.	112,519.10	34,654.31	33,340.90	748.48	13,324.55	194,587.34
Pharmerica Corporation (Depakote)	77,927.45	19,253.03	18,281.57	410.40	6,524.74	122,397.19
Pediatric Services of America, Inc.	69,673.72	12,736.58	13,337.47	850.63	5,095.16	101,693.56
Stephen Wilkins	62,688.88	32,623.93		366.19		95,679.00
Biogen, IDEC, Inc	51,854.42	16,885.47		554.59	6,450.43	75,744.91
Deguzman V. Inspire Pharmaceuticals, Inc.	44,167.33	8,233.62	5,940.45	455.24	3,579.07	62,375.71
Nuvasive, Inc. (Coroent)	41,113.79	7,550.54	7,554.24	168.33	3,216.86	59,603.76
Pharmerica Corporation (Aranesp)	19,564.38	6,800.05		75.86	2,928.86	29,369.15
Respironics, Inc.	18,697.85	8,467.80		95.05	1,600.77	28,861.47
Janice Brown	13,647.81	7,413.61		243.49		21,304.91
Genesis Family Healthcare	11,352.25	1,949.42	4,130.09	68.24		17,500.00
Total Civil Recoveries	53,834,731.08	16,442,659.48	8,911,517.49	307,260.23	1,269,614.32	80,765,782.60
Total Recoveries	61,749,449.54	20,636,814.31	8,911,517.49	307,260.23	2,514,991.89	94,120,033.46 *

* These defendants were ordered to repay $1,439,474.07 joint and severally. The Criminal Recoveries totals have been adjusted to reflect these joint and several judgments.

IV. CRIMINAL CONVICTIONS

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

U.S. v. Terry Lamont Speller

Terry Lamont Speller was the owner and/or operator of several outpatient behavioral health providers including, but not limited to, Carter Behavior Health Services and Superior Living, LLC. These providers were located in several places in and around Greenville, NC. This case was initially referred to the Medicaid Investigations Division (MID) by the Division of Medical Assistance, Program Integrity. This case became a joint investigation with Office of Inspector General (OIG) and the Internal Revenue Service (IRS). Details of the investigation are above.

As required by law, the MID reported Speller's conviction to the OIG for the purpose of program exclusion and to the National Practitioner Data Bank (NPDB).

U.S. v. Eric Bernard Mitchell

Eric Mitchell created an unincorporated company, Mitchell Connor & Associates (MCA) in 2006 and also owned and operated Angelic Community and Family Services, L.P. from 2007 to 2009. In 2009, Angelic went defunct, and Mitchell assisted in establishing Wee Care Services, Inc., located in Charlotte, NC. Both Angelic and Wee Care were approved by Medicaid to provide services for recipients with Intellectual/Developmental Disabilities. MCA provided operational services to Wee Care, including handling the submission of claims for Medicaid reimbursement and company payroll.

This case was referred to the MID by the United States Attorney's Office of the Western District of NC (USAO – WDNC) and was jointly investigated by the MID and the OIG.

The investigation revealed that from October 2009 to June 2014, Mitchell, through MCA, submitted fraudulent claims to Medicaid claiming Wee Care had provided services when they had not been provided. Mitchell controlled all of Wee Care's bank accounts and received all Medicaid payments, including the payments for the fraudulent claims. Mitchell used his access and control of the Medicaid reimbursements to launder the proceeds of his fraudulent gains and use those funds for payments to a Mercedes dealership and to support his motorsports business and hobby.

On October 27, 2015, Mitchell pled guilty in the United States District Court for the Western District of NC to one count of Health Care Fraud in violation of 18 U.S.C. 1347 and one count of Money Laundering in violation of 18 U.S.C. 1957. On March 15, 2016, Mitchell was sentenced to 37 months in the U.S. Bureau of Prisons. Following his release, Mitchell will serve one year on supervised release. Mitchell was ordered to pay a $200 assessment and was ordered to pay $2,049,932.12 in restitution to the NC Fund for Medical Assistance.

As required by law, the MID reported Mitchell's conviction to the OIG for the purpose of program exclusion and to the NPDB.

U.S. v. Alyia Boss

Alyia Boss was a licensed clinical social worker and a NC Medicaid behavioral health provider who owned and operated Boss Counseling and Consulting (BCC) in Charlotte, NC. This case was referred to the MID by the Division of Medical Assistance, Program Integrity. This case was jointly investigated by the MID and FBI.

The investigation revealed that from 2010 through July 2013, Boss engaged in various schemes to receive fraudulent reimbursements from the Medicaid program. Boss used others as recruiters for BCC whose role was to collect Medicaid recipient information which Boss later used to fraudulently bill Medicaid. Additionally, Boss allowed at least two other mental health companies to use her number so those companies could falsely bill Medicaid for services which were not actually provided by Boss. Boss received a percentage of Medicaid reimbursements paid to those companies as a result of those false billings.

On November 26, 2014, Boss pled guilty in the United States District Court for the Western District of NC to one count of Health Care Fraud Conspiracy. On August 18, 2015, Boss was sentenced to 44 months of imprisonment. Upon release, she will serve three years supervised release. She was fined $100 and ordered to pay $1,135,302.27 in restitution to the N.C Fund for Medical Assistance. The Court noted that this restitution may be joint and several with other defendants who may be identified and ordered to pay in the future.

As required by law, the MID reported Boss's conviction to the OIG for the purpose of program exclusion and to the NPDB.

U.S. v. Alexander Bass

Alexander Bass was a Medicaid provider of mental and behavioral health services at United Rehabilitation Services, Inc. in Erwin, NC. This case was developed by the Western District Task Force as part of an investigation of a scheme involving multiple providers. The MID provided assistance to the investigation of this scheme by the Western District Task Force.

The investigation revealed that, from January 2013 to July 2013, Bass conspired to defraud Medicaid by submitting claims for behavioral health services not actually rendered. Bass and others would gather Medicaid identification numbers from recipients which were eventually used to fraudulently bill Medicaid for services that were not provided. Bass received payment for the fraudulent claims and divided the proceeds with co-conspirators.

On June 4, 2015, Bass pled guilty in the United States District Court for the Western District of NC to one count of Conspiracy to Commit Health Care Fraud. On January 20, 2016, Bass was sentenced to 32 months imprisonment, to be followed by three years supervised release. Bass was ordered to pay a $100 assessment and to pay $370,372.37 in restitution to the NC Fund for Medical Assistance, joint and severally liable with Torrey Darnell Moton.

As required by law, the MID reported Bass's conviction to the OIG for the purpose of program exclusion and to the NPDB.

U.S. v. Torrey Darnell Moton

Torrey Darnell Moton was the co-owner of a Medicaid behavioral health provider, United Rehabilitation Services, Inc., in Erwin, NC. This case was developed by the Western District Task Force as part of an investigation of a scheme involving multiple providers. The MID provided assistance to the investigation of this scheme by the Western District Task Force.

The investigation revealed that, from January 2013 to July 2013, Moton conspired to defraud Medicaid by submitting claims for behavioral health services not actually rendered. Moton and others would gather Medicaid identification numbers from recipients which were eventually used to fraudulently bill Medicaid for services that were not provided. Moton received payment for the fraudulent claims and divided the proceeds with co-conspirators.

On May 26, 2015, Moton pled guilty in the United States District Court for the Western District of NC to one count of Conspiracy to Commit Health Care Fraud. On January 20, 2016, Moton was sentenced to 25 months imprisonment, to be followed with three years supervised release. Moton was ordered to pay a $100 assessment and to pay $370,372.37 in restitution to the NC Fund for Medical Assistance, joint and severally liable with Alexander Bass.

As required by law, the MID reported Moton's conviction to the OIG for the purpose of program exclusion and to the NPDB.

U.S. v. Jacqueline P. Ford

Jacqueline P. Ford was an employee of Cynthia Harlan and Heartland Consulting and Marketing, LLC, of Charlotte, NC. This case was developed by the Western District Task Force as part of an investigation of a scheme involving multiple Medicaid behavioral health providers. The MID provided assistance to the investigation of this scheme by the Western District Task Force.

The investigation revealed that Jacqueline Ford was hired to create false notes to support fraudulent billings to Medicaid on behalf of various Medicaid behavioral health providers and that from October 2012 through August 2013, she participated in the creation of false notes. Ford and others generated fake supporting documentation for the fraudulent claims to Medicaid in case Medicaid ever audited the providers for the services they claimed to have performed. Ford and others invented non-existent mental health problems and treatment in that supporting documentation.

On June 5, 2015, Ford pled guilty in the United States District Court for the Western District of NC to one count of Conspiracy to Commit Health Care Fraud. On November 2, 2015, Ford was sentenced to 21 months imprisonment to be followed by three years supervised release. Ford was ordered to pay a $100 assessment and ordered to pay $442,679.92 in restitution to the NC Fund for Medical Assistance, joint and severally liable with Aliya Boss, Alexander Bass and Torrey Moton.

As required by law, the MID reported Ford's conviction to the OIG for the purpose of program exclusion and to the NPDB.

U.S. v. Tanisha Melvin

Tanisha Melvin was an employee of Cynthia Harlan and Heartland Consulting and Marketing, LLC, of Charlotte, NC. This case was developed by the Western District Task Force as part of an investigation of a scheme involving multiple Medicaid behavioral health providers. The MID provided assistance to the investigation of this scheme by the Western District Task Force.

The investigation revealed that from October 2012 to August 2013, Melvin and her co-conspirators attempted to obtain over $1.6 million in fraudulent Medicaid claims through the conspirators' provider companies. Melvin created false documentation to support claims for services not rendered. Melvin was responsible for organizing the fraudulent documentation in order to deceive Medicaid in the event of an audit of either of two companies for whom Harlan submitted fraudulent billings, Medicaid behavioral health providers, Carolina Care One or United Rehabilitation Services.

On December 21, 2015, Melvin pled guilty in the United States District Court for the Western District of NC to one count of Conspiracy to Commit Health Care Fraud. On April 18, 2016, Melvin was sentenced to 33 months imprisonment. Melvin was also ordered to pay a $100 assessment fee and restitution in the amount of $392,159.81 and to be held joint and severally liable with co-conspirators.

As required by law, the MID reported Melvin's conviction to the OIG for the purpose of program exclusion and to the NPDB.

U.S. v. Lachanda Clotiel Parks

Lachanda Clotiel Parks was an employee of Cynthia Harlan and Heartland Consulting and Marketing, LLC, of Charlotte, NC. This case was developed by the Western District Task Force as part of an investigation of a scheme involving multiple Medicaid behavioral health providers. The MID provided assistance to the investigation of this scheme by the Western District Task Force.

The investigation revealed that Parks has never held full licensure or been qualified to be a Medicaid provider in NC. Parks held provisional licensure from the NC Social Work Certification and Licensure Board from 2003 to 2009. Parks also held provisional licensure with the NC Substance Abuse Professional Practice Board from April 2013. Starting in at least 2012, Parks was employed to fabricate documentation to support the fraudulent billings submitted on behalf of Medicaid behavioral health providers, New Choices Youth and Family Services and Kings of the Carolinas/Carolina Care One. Parks was hired as part of a team of employees to support fraudulent billings of these companies. This documentation included fictitious assessments, treatment plans and notes of services. During her participation in creating false documentation to support fraudulent billings, from January 2013 to August 2013, New Choices and Kings of the Carolinas attempted to obtain over $1.5 million in fraudulent claims.

On May 26, 2015, Parks pled guilty in the United State District Court for the Western District of NC to one count of Conspiracy to Commit Health Care Fraud. On January 13, 2016, Parks was sentenced to 28 months imprisonment, to be followed by three years supervised release. She was ordered to pay a $100 assessment and to pay $352,565.69 in restitution to the NC Fund for Medical Assistance, joint and severally liable with Sakeenah Davis, Kino Williams, Cynthia Harlan, Tyree Jones and Claude McRae.

As required by law, the MID reported Parks' conviction to the OIG for the purpose of program exclusion and to the NPDB.

U.S. v. D 'Marcus Antonio White

D 'Marcus Antonio White was an employee of Cynthia Harlan and Heartland Consulting and Marketing, LLC, of Charlotte, NC. This case was developed by the Western District Task Force as part of an investigation of a scheme involving multiple Medicaid behavioral health providers. The MID provided assistance to the investigation of this scheme by the Western District Task Force.

The investigation revealed that from April 2013 to August 2013, White was hired to create false notes to support fraudulent billings to Medicaid on behalf of various Medicaid behavioral health providers and to organize information into spreadsheets to reflect fraudulent services not rendered to Medicaid recipients. White manufactured intake notes, clinical assessments and therapy notes to support the fraudulent billings for non-existent services. This documentation was to be used in the event Medicaid ever audited the records of the providers and requested documentation to support Medicaid billed reimbursements. During his participation in this scheme, the companies White manufactured records for were reimbursed at least $543,366.64.

On May 28, 2015, White pled guilty in the United States District Court for the Western District of NC. On December 1, 2015, White was sentenced in the United States District Court for the Western District of NC on one count of Conspiracy to Commit Health Care Fraud and received two years' probation. While on probation, he will be on home detention for eight months. He was ordered to pay a $100 assessment and to pay $543,366.64 in restitution to the NC Fund for Medical Assistance, joint and severally liable with Aliya Boss, Sakeenah David Davis, and Kino Williams.

As required by law, the MID reported White's conviction to the OIG for the purpose of program exclusion and to the NPDB.

U.S. v. Sakeenah Davis

Sakeenah David Davis was a co-owner and co-operator of New Choices Youth and Family Services, a Medicaid behavioral health provider located in Charlotte, NC. This case was referred to the MID by the FBI. The MID provided assistance to the FBI in this investigation.

The investigation revealed that Davis was not licensed to provide any mental or behavioral health services. Rather, Davis started New Choices and turned over operations to other individuals. New Choices fabricated notes for non-existent therapy sessions. Davis never inquired about therapists' qualifications or services, and all proceeds were deposited into the New Choices bank account. From September 2012 through at least July 2013, New Choices submitted fraudulent billings in the amount of $1,696,225.00 resulting in payments of $506,124.00 to Davis and her co-owner, Kino Williams.

On December 4, 2014, Davis pled guilty in the United States District Court for the Western District of NC to one count of Health Care Fraud Conspiracy. Davis was sentenced to 42 months of imprisonment to be followed by three years supervised release. She was ordered to pay a $100.00 assessment and ordered to pay $506,124.00 restitution to the NC Fund for Medical Assistance, jointly and severally liable with Kino Williams.

As required by law, the MID reported Davis's conviction to the OIG for the purpose of program exclusion and to the NPDB.

U.S. v. Kino Legette Williams

Kino Legette Williams was an owner and operator of New Choices Youth and Family Services, a Medicaid behavioral health provider located in Charlotte, NC. This case was referred to the MID the FBI. The MID provided assistance to the FBI in this investigation.

The investigation revealed that Williams was not licensed to provide any mental or behavioral health services. Rather, Williams started New Choices and turned over operations to other individuals. New Choices fabricated notes for non-existent therapy sessions. Williams never inquired about therapists' qualifications or services, and all proceeds were deposited into the New Choices bank account. From September 2012 through at least July 2013, New Choices submitted fraudulent billings in the amount of $1,696,225.00 resulting in payments of $506,124.00 to Williams and her co-owner, Sakeenah Davis.

On December 4, 2014, Williams pled guilty in the United States District Court for the Western District of NC to one count of Health Care Fraud Conspiracy. Williams was sentenced to 42 months of imprisonment to be followed by three years supervised release. She was ordered to pay a $100.00 assessment and ordered to pay $506,124.00 restitution to the NC Fund for Medical Assistance, jointly and severally liable with Sakeenah Davis.

As required by law, the MID reported Williams' conviction to the OIG for the purpose of program exclusion and to the NPDB.

U.S. v. Anthony Marc Hailey

Anthony Marc Hailey was the sole owner and operator of A&R Therapeutic Services in Charlotte, NC, a Medicaid group provider of mental and behavioral health services. This case was investigated by the Western District Task Force. The MID opened a case to provide support as needed.

The investigation revealed that Hailey recruited a Licensed Professional Counselor (A.F.) to provide services on his company's behalf. From August 2011 to June 2013, Hailey submitted fraudulent claims to Medicaid falsely listing A.F. as an attending clinician on claimed services when, in fact, any services provided were provided by unqualified or unapproved providers.

On November 13, 2015, Hailey pled guilty in the United States District Court for the Western District of NC to one count Health Care Fraud and one count Aggravated Identity Theft. On March 7, 2016, Hailey was sentenced to 30 months on count one and 24 months, to be served consecutively, on count two for a total of 54 months of imprisonment. Upon his release, Hailey will be on supervised release for a total of one year. Hailey was ordered to pay a $200 assessment and ordered to pay $312,074.36 in restitution to the Division of Medical Assistance.

As required by law, the MID reported Hailey's conviction to the OIG for the purpose of program exclusion and to the NPDB.

U.S. v. Mark Tuan Le, MD

Mark Tuan Le was a physician practicing through his business, Northcross Medical Center in Huntersville, NC. Mark Le was enrolled as a Medicaid Provider and was linked to multiple Medicaid provider numbers. This case was referred to the MID from the USAO/WDNC. This case was jointly investigated by the MID and OIG.

The investigation revealed that from 2009 through 2012, Le falsely claimed that Northcross Medical provided Enhanced External Counterpulsation (EECP) therapy and provided thousands of dollars of services that were not necessary or were not provided. Many of the fraudulent claims were for EECP services Le claimed to have provided to recipients who were relatives of Le or other employees of Northcross Medical Center. Additionally, Le submitted fraudulent claims to Medicare and private insurance companies for hemorrhoidectomies which did not occur. During part of the period where Le was committing this fraud in 2009 and 2010, Le was constructing a new 8,000 square foot residence on Lake Norman in Cornelius, NC. Le gave his accountant false information listing his house expenditures as Northcross Medical "business expenses." He used monies from the Northcross Medical bank accounts to pay for his construction activities. Le made these representations to evade the assessment of federal income tax on the funds. As result of Le's misrepresentations, his accountant classified Le's construction expenses as business, rather than personal, expenses. Le reported $40,142 income to the Internal Revenue Service, resulting in a tax liability of $832. In reality, Le's income for those two years was approximately $2.4 million. Le had evaded a tax liability of $844,367 through his scheme.

On September 14, 2015, Le pled guilty in the United States District Court for the Western District of NC to one count Health Care Fraud Conspiracy, seven counts Health Care Fraud, Aid, and Abet, and one count Tax Evasion and was sentenced to 18 months of imprisonment on each count, to run concurrently. Upon release, Le will be on supervised release for three years. Le was ordered to pay a $900 assessment, a $7,500 fine, and $1,036,288.52 in criminal restitution for all charges at sentencing. Of this restitution total, $12,010.84 was a direct result of his fraudulent conduct related to the Medicaid program.

As required by law, the MID reported Le's conviction to the OIG for the purpose of program exclusion and to the NPDB.

U.S. v. Zaria Humphries

Zaria Davis Humphries was a licensed clinical social worker since 2009, a Medicaid behavioral health provider, and the sole owner and operator of Life Impact Solutions, LLC, which she created in October 2012. Life Impact Solutions was not a Medicaid approved provider. This case was referred to the MID by the FBI as part of the Western District Task Force. The MID provided assistance to the FBI.

The investigation revealed that Humphries hired a director at Life Impact Solutions who was in charge of coordinating claims to be submitted on behalf of Humphries and Life Impact Solutions. All reimbursements would be made to accounts controlled by Humphries. Humphries learned that the director submitted false claims to Medicaid for services that were not rendered. Nevertheless, Humphries and her co-conspirators continued to cause multiple false claims to be submitted and reimbursed. As a result of Humphries fraudulent billings to Medicaid from January 2013 to June 2013, she was directly reimbursed $222,037.00.

On November 24, 2014, Humphries pled guilty in the United States District Court for the Western District of NC to one count Conspiracy to Commit Health Care Fraud. On September 21, 2015, Humphries was sentenced to 24 months imprisonment, to be followed by three years supervised release. She was given a $100 assessment and ordered to pay $222,037 in restitution to the NC Fund for Medical Assistance.

As required by law, the MID reported Humphries' conviction to the OIG for the purpose of program exclusion and to the NPDB.

U.S. v. Wayne Vincent Wilson, MD

Wayne Vincent Wilson, M.D. was a Medicaid provider and the owner/operator of Wilson Family Practice, a family medical practice located in Hickory, NC. This case was predicated upon a citizen complaint to the MID.

This investigation revealed that from 2007 to June 2014 Wilson billed Medicaid and Medicare $467,376.00 for fraudulent services, and he received reimbursements of at least $210,260.00. Wilson would add fraudulent claims for services not rendered to claims for actual patient office visits. These claims included nerve conduction studies, strep tests, stress tests, ultrasounds, smoking cessation counseling, lesion destruction and other items. In other instances, Wilson billed for fabricated claims for dates where patients did not visit the practice. Wilson provided an oral statement, later supplemented by a written letter, in which he stated he had submitted false billings because he believed Medicaid did not pay him enough for his services.

On October 5, 2015, Wilson pled guilty in the United States District Court for the Western District of NC to two counts of Health Care Fraud. On May 2, 2016, Wilson was sentenced to 18 months imprisonment. He was ordered to serve one year of supervised release upon his release and was ordered to pay a $200 assessment and $210,260.66 in restitution.

As required by law, the MID reported Wilson's conviction to the OIG for the purpose of program exclusion and to the NPDB.

U.S. v. Shaconda Simmons

Shaconda Simmons was co-owner of Unlimited Possibilities (UP), a Medicaid provider of mental and behavioral health services located in Shelby, NC. Simmons operated UP with Ebony Phillips Beam. This case was initiated from evidence developed during another MID investigation.

The investigation revealed that from November 2011 through September 2012, Simmons had falsely claimed that a licensed provider had rendered services through UP that were submitted to Medicaid for reimbursement when, in fact, those services had not been provided and UP was not entitled to reimbursement.

On January 26, 2016, Simmons pled guilty in the United States District Court for the Western District of NC to a single count of False Statements in Health Care Program from December 13, 2011. On May 3, 2016, Simmons was sentenced to one year of probation. Simmons was also ordered to pay a $25 assessment fee and restitution in the amount of $136,053.21 to the NC Fund for Medical Assistance.

As required by law, the MID reported Simmons' conviction to the OIG for the purpose of program exclusion and to the NPDB.

U.S. v. Wanda Marie Webb

Wanda Marie Webb was a psychologist and a Medicaid provider who was also the sole owner of Cornerstone Counseling and Consulting located in Charlotte, NC. This case was referred to the MID by the FBI. The MID provided assistance to the FBI.

The investigation revealed that in August 2013, Webb agreed to allow her Medicaid number to be used to submit $239,175 in fraudulent claims to Medicaid, with Webb sharing the reimbursements with others. Webb personally received $79,338.74, 68% of the total fraudulent reimbursements.

On June 5, 2015, Webb pled guilty in the United States District Court for the Western District of NC to one count of Conspiracy to Commit Health Care Fraud. On December 15, 2015, Webb was sentenced to two years' probation and 200 hours of community service in the. Webb was ordered to pay a $100 assessment fee and $79,338.74 in restitution to Mecklenburg County.

As required by law, the MID reported Webb's conviction to the OIG for the purpose of program exclusion and to the NPDB.

U.S. v. Ieshia Hicks Watkins

Ieshia Hicks Watkins was an employee of the Mecklenburg County Department of Social Services located in Charlotte, NC. This case was predicated upon information obtained during an investigation by the Western District Task Force of Medicaid provider, Ronnie Lorenzo Robinson, Jr., the owner of a behavioral health company, Peaceful Alternative Resources, located in Charlotte, NC. The MID provided assistance to the FBI.

The investigation revealed that Watkins, in her position as a social worker at Department of Social Services (DSS), solicited and received kickbacks from Ronnie Lorenzo Robinson. Watkins had access to names and identification information of DSS clients from her caseload and those of her co-workers. From October 2010 to February 2012, Watkins gathered Medicaid recipient information and passed that information to Robinson. Robinson then used that information to fraudulently bill Medicaid for services not rendered, and Watkins received payment for each recipient that she provided information on.

Watkins pled guilty on October 14, 2014 in the United States District Court for the Western District of NC to two counts of Illegal Remunerations involving Federal Health Care Programs and one count of Health Care Fraud Conspiracy. On July 27, 2015, Watkins was sentenced to three months home detention, two years' probation, and ordered to pay a $200 assessment, to complete 50 hours of community service, and to pay $19,611.06 in restitution to the NC Fund for Medical Assistance, joint and severally liable with Ronnie Robinson.

As required by law, the MID reported Watkins' conviction to the OIG for the purpose of program exclusion and to the NPDB.

State v. Sarah Emily Gewanter

Sarah Gewanter was a licensed clinical social worker and owner of Berard Auditory Integration Therapy in Leicester, NC. This case was referred to the MID by the Division of Medical Assistance, Program Integrity.

The investigation revealed that from January 2010 through December 2013, Gewanter billed Medicaid for psychotherapy services that were not rendered.

On March 21, 2016, Gewanter pled guilty in Wake County Superior Court to one count of felony Obtaining Property by False Pretenses and one count of felony Fraud by Medical Assistance Provider. On March 21, 2016, Gewanter was sentenced to six to 17 months in prison for count one followed by six to 17 months in prison for count two, suspended for 60 months on supervised probation. The court ordered Sarah Gewanter to pay $354.50 in court costs and $70,562.24 in restitution to cover the loss to the Medicaid program. The court ordered that Sarah Gewanter be excluded as a medical assistance provider for NC Medicaid Program and any managed-care-organization working within the NC Medicaid Program. After 18 months of supervised probation, Gewanter may be transferred to unsupervised probation if all monies have been repaid and if Gewanter has complied with all the terms of supervised probation. As part of the plea agreement, Sarah Gewanter paid $20,000.00 toward the restitution on the day of sentencing.

As required by law, the MID reported Gewanter's conviction to the OIG for the purpose of program exclusion and to the NPDB.

State v. Harriett Reid-Bell

Harriett Reid-Bell was the owner of Preparing Adults and Children to Excel (PACE), Inc., a Medicaid behavioral health provider located in Jamestown and Greensboro, NC. This case was referred to the MID by the N.C. Department of Insurance.

The investigation revealed that from 2008 through 2012, multiple recipients had not received the treatment for which the Medicaid program was billed and that Bell was the responsible party.

On October 21, 2015, Bell pled guilty in Wake County District Court to two counts of misdemeanor attempted medical provider fraud and was sentenced to two consecutive 45-day sentences, suspended for 60 months of supervised probation. Bell was ordered to pay restitution in the amount of $21,788.80 to the Medicaid program. The court waived all other costs, fines and fees aside from the $80.00 attorney appointment fee.

As required by law, the MID reported Bell's conviction to the OIG for the purpose of program exclusion and to the NPDB.

State v. Rebecca Smith Derwin

Rebecca Derwin was a licensed professional counselor and the owner and operator of Heartland Family Counseling Services, LLC, a Medicaid provider of mental and behavioral health services, located in Oxford, NC. This case was referred to the MID from the Division of Medical Assistance, Program Integrity.

The investigation revealed that from January 2012 through December 2013, Derwin submitted back-dated and falsified claims and billed for services not rendered.

On July 30, 2015, Derwin pled guilty in Granville County Superior Court to one count of felony Obtaining Property by False Pretenses and was sentenced to six to 17 months in prison, suspended for five years on supervised probation. The court ordered Derwin to pay $240.00 in court costs and to pay restitution of $21,284.08 to cover the loss to the Medicaid program. The court ordered that Derwin be excluded as a medical assistance provider for NC Medicaid Program and any managed-care-organization working within the NC Medicaid Program. After two years of supervised probation, Derwin may be transferred to unsupervised probation if all monies have been repaid and if Derwin has complied with all the terms of supervised probation.

As required by law, the MID reported Derwin's conviction to the OIG for the purpose of program exclusion and to the NPDB.

State v. Marlon Cooks

Marlon Cooks was hired as a Qualified Professional under the name and identity of "Gary Lawrence" by three Wake County Medicaid providers: Turning Point Family, LLC, where he worked from approximately June 24, 2011 through November 3, 2011; The Bruson Group, Inc., where he worked from approximately September 16, 2011 through December 21, 2011; and Life Changez, Inc., where he worked from approximately January 6, 2012 through July 16, 2012. This case was referred to the MID by the Division of Medical Assistance, Program Integrity.

The investigation revealed that Cooks used the social security number and other information of Gary Lawrence in obtaining employment. Although Cooks was a convicted felon, he represented that he did not have a felony conviction. Cooks submitted fraudulent documents showing degrees from two separate colleges to gain employment as a Qualified Professional when, in fact, Cooks did not have the educational qualifications to be a Qualified Professional. His total net pay from these companies was $14,235.91. All of Cook's time worked was billed to the Medicaid program.

On April 12, 2016, Cooks pled guilty in Wake County District Court to the three counts of Obtaining Property by False Pretenses. Cooks was sentenced to a minimum term of eight months and a maximum term of 19 months of imprisonment. This sentence was suspended and Cooks was placed on supervised probation for 60 months. After 24 months, Cooks may be transferred to unsupervised probation provided he has paid the full restitution amount. Cooks was given credit for the 55 days he spent in confinement prior to the judgment. Cooks was ordered to pay court costs of $750.00, restitution to the NC Fund for Medical Assistance of $14,235.91, and a fee of $60.

As required by law, the MID reported Cooks' conviction to the OIG for the purpose of program exclusion and to the NPDB.

State v. Lashaun Lloyd

Lashaun Lloyd was an employee at Care Providers Network II, Inc., a Medicaid personal care service provider located in Rocky Mount, NC. This case was referred to the MID by the Division of Health Service Regulation.

The investigation revealed that from December 2014 through February 2015, Lloyd turned in false time sheets to Care Providers Network II, Inc., indicating that she had provided services to two Medicaid recipients when, in fact, she had not. One of the recipients was deceased at the time Lloyd claimed to have provided services to the recipient. When questioned, Lloyd admitted she had turned in the fraudulent timesheets. Lloyd was paid by Care Providers Network based on her timesheets, and, in turn, Care Providers Network billed Medicaid based on the timesheets. Lloyd's fraudulent timesheets resulted in Medicaid paying for services that were not provided.

On August 25, 2015, Lloyd pled guilty in Nash County Superior Court to four misdemeanor counts of attempted medical assistance provider fraud and was sentenced to two 120 day sentences which were to run consecutively. The active sentences were suspended and Lloyd was placed on supervised probation for 24 months. As part of her probation, she was ordered to complete 12 months of electronic house arrest. Lloyd was ordered to pay court costs of $364.50, a fine of $500, restitution of $1,748.07, and an electronic house arrest fee of $1,663.20. The restitution was ordered to be paid to the NC Fund for Medical Assistance.

As required by law, the MID reported Lloyd's conviction to the OIG for the purpose of program exclusion and to the NPDB.

State v. Victoria White

Ms. Victoria Diane White, also known as Victoria Diane McNair, was the owner of Miracle Restoration, Inc., a Medicaid assisted living facility in Fayetteville, NC. This case was referred to the MID by the Division of Medical Assistance, Program Integrity.

White was under investigation by the Cumberland County Sheriff's Department due to complaints that she had stolen money and medication from elderly patients in her care. White was described as a drug user who had allegedly utilized the bank card of one of the facility residents to purchase drugs. White also traded patient medication in exchange for illegal drugs and altered the residents' medical logs to indicate that the medications had been administered to the residents.

On September 1, 2015, White pled guilty in Cumberland County Superior Court to two counts of felony Financial Card Theft, two counts of misdemeanor Financial Card Fraud, one count of felony Obtaining Controlled Substances by Fraud/Forgery and one count of felony Sale of Oxycodone and was sentenced to concurrent judgements of six to 17 months in prison and 13 to 25 months in prison, suspended for three years on supervised probation. The court ordered White to pay $1,464.50 in court costs, fees and fines. The court ordered that White not own, operate or work at any family care home center or any facility that provides assisted living care for people, including no home health care jobs.

As required by law, the MID reported White's conviction to the OIG for the purpose of program exclusion and to the NPDB.

State v. Alvin Barnes

Alvin Barnes was a health care worker for Cherry Hospital, a NC Medicaid provider. This case was predicated upon a referral received from Cherry Hospital Police Department.

The investigation revealed that on or about November 15, 2014, Barnes assaulted a resident of Cherry Hospital by grabbing the resident's throat and forcefully pushing the resident against a wall and onto a table.

On July 20, 2015, Barnes pled guilty in Wayne County Superior Court to one count of misdemeanor assault on a handicapped person and was sentenced to 150 days in jail, suspended for 24 months on supervised probation. The court ordered Barnes to comply with any treatment programs that his probation officer deemed appropriate. Barnes was ordered to pay $607.50 in fines, fees, and the cost of court. The court stated that Barnes may be transferred to unsupervised probation after six months if Barnes has met all requirements of his probation.

As required by law, the MID reported Barnes' conviction to the OIG for the purpose of program exclusion and to the NPDB.

State v. Yvette McLean

Yvette McLean was a certified nursing assistant working for Bryant's Family Home Care (BFHC) in Maxton, NC, a Medicaid provider. This case was predicated upon a referral received from the NC Division of Health Service Regulation.

The investigation revealed that McLean submitted several fraudulent timesheets for services that McLean did not render for the months of November 2015, December 2015, and January 2016. A confession was obtained from McLean during a custodial interrogation.

On 17 May 2016, McLean entered a plea of guilty in Robeson County District Criminal Court to one count of misdemeanor Attempted Medical Provider Fraud and was sentenced to 120 day of imprisonment. The sentence was suspended for six months of supervised probation under the usual terms and conditions of probation and the special conditions that she pays restitution to BFHC in the amount of $78.87 and to the NC Medicaid Program in the amount of $260.25 for a total restitution order of $339.12. McLean received credit for two days of time served and was not ordered to pay any other fees.

As required by law, the MID reported McLean's conviction to the OIG for the purpose of program exclusion and to the NPDB.

State v. Drema Kincaid

Drema Kincaid was a Resident Care Specialist at the Brian Center Health and Rehabilitation, a long term care and rehabilitation facility and Medicaid provider, in Hickory, NC. This case was referred to the MID by the Division of Health Service Regulation.

The investigation revealed that on or about May 22, 2015, Kincaid verbally and physically abused a resident of the Brian Center.

On December 9, 2015, Kincaid was convicted in Catawba County District Criminal Court on the charge of Assault on a Handicapped Person and sentenced to 30 days suspended for 12 months of unsupervised probation. Kincaid was ordered to pay a $300.00 fine plus costs and to not to have any contact with the victim or the victim's family.

As required by law, the MID reported Kincaid's conviction to the OIG for the purpose of program exclusion and to the NPDB.

V. CIVIL RECOVERIES

WYETH, INC.

Wyeth, Inc. was a Delaware corporation with its headquarters in Madison, New Jersey. Pfizer, Inc. is a Delaware corporation with its principal executive offices in New York, New York. In October 2009, Pfizer acquired Wyeth. Wyeth distributed, marketed and/or sold pharmaceutical products in the United States, including drugs sold under the trade names Protonix IV and Protonix Oral tablets. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units, and details of the litigation are summarized above

On June 3, 2016, in conjunction with a national settlement, a settlement agreement was executed between Wyeth and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $45,338,969.35. Of that amount, the federal government received $28,815,078.93 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 $16,523,890.42. Of this amount, $11,347,552.24 was paid to the North Carolina Medicaid Program as restitution, $4,992,922.99 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $183,415.19 was paid to the North Carolina Department of Justice for costs of collection and investigation.

MILLENNIUM HEALTH, LLC

Millennium Health, LLC is a limited liability company organized under the laws of California with its principal place of business in San Diego, California. Millennium marketed and performed laboratory testing services in the United States, including urine drug testing. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2008 through May 20, 2015, Millennium knowingly submitted or caused to be submitted claims to the Medicaid program by excessive and unnecessary urine drug testing ordered by physicians without an individualized assessment of patient need.

On November 6, 2015, in conjunction with a national settlement, a settlement agreement was executed between Millennium and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $7,706,010.67. Of that amount, the federal government received $4,425,574.33 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 $3,280,436.34. Of this amount, $1,408,404.85 was paid to the North Carolina Medicaid Program as restitution and interest, $1,357,181.87 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $484,382.00 was paid to the *qui tam* plaintiff, and $30,467.62 was paid to the North Carolina Department of Justice for costs of collection and investigation.

COUNTRY LAYNE DAY TREATMENT

Country Layne was a Medicaid Day Treatment Services provider located in Pembroke, North Carolina. A joint MID and HHS-OIG investigation revealed that from 2006 through 2010, Country Layne billed the Medicaid Program for services not rendered. In January 2013, Andetra Sampson, owner of Country Layne, was sentenced to prison and ordered to pay restitution to the Medicaid Program in the amount of $2,187,951.65. This criminal judgment was reported in the Annual Report for SFY 2013.

On March 30, 2011, the United States Attorney's Office, Eastern District of North Carolina filed an intervention complaint in a civil *qui tam* case venued in the United States District Court for the Eastern District of North Carolina alleging False Claims Act violations against Country Layne Day Treatment, LLC, Country Layne, LLC, Andetra Sampson and Lynn Sampson. The United States Attorney's Office, Eastern District of North Carolina, HHS-OIG, and MID jointly investigated the matter.

On March 6, 2014, the United States District Court for the Eastern District of North Carolina entered a summary judgment against Country Layne Day Treatment, LLC, Country Layne, LLC, Andetra Sampson and Lynn Sampson in the amount of $6,574,855.00. The summary judgment amount of $6,574,855.00 allowed for treble damages. Of that amount, the federal government is owed $5,796,381.80. The North Carolina State share of the judgment would be $778,473.20.

PHYSICIANS PHARMACY ALLIANCE

Physicians Pharmacy Alliance is a North Carolina corporation that provided pharmacy services. This matter was referred to the MID by OIG.

It was alleged that from January 1, 2008 through January 4, 2011, Physicians Pharmacy Alliance provided gift cards to patients, physician office employees, and community health center employees in order to induce them to enroll or refer patients to Physicians Pharmacy Alliance. This matter was worked jointly with OIG and the United States Attorney's Office, Eastern District of North Carolina. The settlement was negotiated by the United States Attorney's Office, Eastern District of North Carolina and the Medicaid Investigations Division.

On May 6, 2015, a settlement agreement was executed between Physicians Pharmacy Alliance and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $5,000,000.00. Of that amount, the federal government received $3,860,876.17 for federal health care programs 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 $1,139,123.83. Of this amount, $297,174.76 was paid to the North Carolina Medicaid Program as restitution, $805,724.93 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $36,224.14 was paid to the North Carolina Department of Justice for costs of collection and investigation.

NOVARTIS PHARMACEUTICALS CORPORATION

Novartis Pharmaceuticals is a corporation with its principal place of business in East Hanover, New Jersey. Novartis distributed, marketed and/or sold pharmaceutical products in the United States, including a drug sold under the trade name Exjade. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from February 2007 through May 2012, Novartis paid kickbacks to Accredo Health Group, BioScrip, Inc. and U.S. Bioservices to induce these pharmacies to recommend to patients that they order Exjade refills.

On December 18, 2015, in conjunction with a national settlement, a settlement agreement was executed between Novartis and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $2,689,543.75. Of that amount, the federal government received $1,819,415.73 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 $870,128.02. Of this amount, $253,699.82 was paid to the North Carolina Medicaid Program as restitution and interest, $374,855.99 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $234,559.53 was paid to the *qui tam* plaintiff, and $7,012.68 was paid to the North Carolina Department of Justice for costs of collection and investigation.

OLYMPUS CORPORATION

Olympus Corporation is a New York corporation with its principal place of business in Center Valley, Pennsylvania. Olympus sold and distributed medical optics and imaging equipment, including endoscopes, ultrasound systems, and clinical microscopes. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2006 through December 31, 2011, Olympus paid kickbacks to physicians and hospital employees to induce them to purchase Olympus endoscopes and other Olympus medical and surgical equipment.

On May 2, 2016, in conjunction with a national settlement, a settlement agreement was executed between Olympus and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $2,248,323.94. Of that amount, the federal government received $1,416,692.53 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 $831,631.41. Of this amount, $350,117.20 was paid to the North Carolina Medicaid Program as restitution and interest, $338,595.01 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $135,318.02 was paid to the *qui tam* plaintiff, and $7,601.18 was paid to the North Carolina Department of Justice for costs of collection and investigation.

DR. JON WON, D.D.S., MD

Dr. Won is a North Carolina dental provider that provided dental and oral surgical services to clients within the Eastern District of North Carolina. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2008 through December 31, 2011, Dr. Won submitted claims for Detailed and Extensive Oral Evaluations, Deep Sedation/general anesthesia, Alveoloplasty in conjunction with extractions – four or more tooth spaces, per quadrant, and Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant that were not medically necessary. This matter was worked jointly with the United States Attorney's Office, Eastern District of North Carolina. The settlement was negotiated by the United States Attorney's Office, Eastern District of North Carolina and the Medicaid Investigations Division.

On August 21, 2015, a settlement agreement was executed between Dr. Won and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $2,200,000.00. Of that amount, the federal government received $1,541,625.87 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $658,374.13. Of this amount, $421,446.99 was paid to the North Carolina Medicaid Program as restitution and interest, $230,041.48 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $6,885.66 was paid to the North Carolina Department of Justice for costs of collection and investigation.

SPENCER HOWARD, D.D.S.

Spencer Howard is a North Carolina dental provider that provided dental and oral surgical services to clients within the Middle District of North Carolina. This matter was referred to the MID by an in house investigation on another provider.

It was alleged that from January 1, 2010 through December 31, 2013, Howard billed for Program for Deep Sedation/general anesthesia – each additional 15 minutes, which was not medically necessary. Howard also submitted claims alleging performance as attending provider when in fact it was a shared service Howard provided with another provider.

On March 28, 2016, a settlement agreement was executed between Spencer Howard, D.D.S and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $2,068,109.18. Of that amount, the federal government received $1,305,600.00 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $762,509.18. Of this amount, $411,455.26 was paid to the North Carolina Medicaid Program as restitution and interest, $343,346.08 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $7,707.84 was paid to the North Carolina Department of Justice for costs of collection and investigation.

ASTRAZENECA

AstraZeneca is a Delaware limited partnership with its principal place of business in Wilmington, Delaware. AstraZeneca distributed and sold pharmaceutical products in the United States. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from October 1, 2007 through June 30, 2014, AstraZeneca falsely under-reported its Average Manufacturer's Price to the Centers for Medicare and Medicaid Services, improperly decreasing the amounts AstraZeneca rebated to the states under the Medicaid Drug Rebate Program.

On October 22, 2015, in conjunction with a national settlement, a settlement agreement was executed between AstraZeneca and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $1,941,686.39. Of that amount, the federal government received $1,335,859.36 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 $605,827.03. Of this amount, $456,302.00 was paid to the North Carolina

Medicaid Program as restitution and interest, $144,447.69 was paid to the *qui tam* plaintiff, and $5,077.34 was paid to the North Carolina Department of Justice for costs of investigation.

ACCREDO HEALTH GROUP, INC.

Accredo is a specialty pharmacy headquartered in Memphis, Tennessee. Accredo filled patients' prescriptions for Exjade, a drug manufactured and distributed by Novartis Pharmaceuticals. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from March 2008 through March 2012, Accredo participated in an Exjade patient referral allocation scheme under which Novartis and Accredo agreed that Accredo would receive additional patient referrals and related benefits in return for achieving the highest refill percentage for Exjade patients as compared to the refill percentages among Exjade patients at other pharmacies.

On July 14, 2015, in conjunction with a national settlement, a settlement agreement was executed between Accredo and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $1,023,944.44. Of that amount, the federal government received $723,996.68 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 $299,947.76. Of this amount, $98,224.94 was paid to the North Carolina Medicaid Program as restitution and interest, $114,233.14 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $80,563.04 was paid to the *qui tam* plaintiff, and $6,926.64 was paid to the North Carolina Department of Justice for costs of collection and investigation.

CAROLINA APOTHECARY

Carolina Apothecary is a pharmacy located in Rockingham, North Carolina. This matter was referred to the MID by the United States Attorney General's Office in the Middle District of North Carolina.

It was alleged that from January 1, 2008 through December 31, 2011, Carolina Apothecary billed Medicaid pharmacy prescriptions which were filled but never picked up by the recipient. Carolina Apothecary then restocked the prescriptions for subsequent billing to Medicaid.

On October 29, 2015, a settlement agreement was executed between Carolina Apothecary and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $556,000.00. Of that amount, the federal government received $442,076.40 to satisfy North Carolina's obligation to return the federal portion of Medicaid and Medicare recoveries to the federal government. The North Carolina State share of the settlement was $113,923.60. Of this amount, $56,329.52 was paid to the North Carolina Medicaid Program as restitution, $56,329.52 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $1,264.56 was paid to the North Carolina Department of Justice for costs of collection and investigation.

CAPE FEAR REGIONAL UROLOGICAL CLINIC

Cape Fear Regional Urological Clinic is a North Carolina Medicaid provider located in Fayetteville, North Carolina. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from December 31, 2009 through December 31, 2014, Cape Fear billed improperly, including billing for services without the required direct physician supervision or without the requisite medical professional providing the services.

On May 6, 2015, a settlement agreement was executed between Cape Fear Regional Urological Clinic and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $470,000.00. Of that amount, the federal government received $467,861.43 for federal health care programs 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 $2,138.57. Of this amount, $720.66 was paid to the North Carolina Medicaid Program as restitution, $1,349.90 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $68.01 was paid to the North Carolina Department of Justice for costs of collection and investigation

WARNER CHILCOTT

Warner Chilcott is a for-profit limited liability company in Delaware with its principal place of business in Parsippany, New Jersey. Warner Chilcott distributed, marketed and sold pharmaceutical products in the United States, including drugs sold under the following names: Actonel, Asacol, Asacol HD, Atelvia, Doryx, Enablex, Estrace, Loestrin 24 FE, and Lo Loestrin. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2009 through March 31, 2013, Warner Chilcott paid kickbacks to physicians to induce them to prescribe Actonel, Asacol, Asacol HS, Atelvia, Doryx, Enablex, Estrace, Loestrin 24 FE, and Lo Loestrin.

On October 29, 2015, in conjunction with a national settlement, a settlement agreement was executed between Warner Chilcott and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $422,860.08. Of that amount, the federal government received $288,563.26 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 $134,296.82. Of this amount, $43,149.91 was paid to the North Carolina Medicaid Program as restitution and interest, $56,935.32 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $33,109.05 was paid to the *qui tam* plaintiff, and $1,102.54 was paid to the North Carolina Department of Justice for costs of collection and investigation.

QUALITEST PHARMACEUTICALS

Qualitest Pharmaceuticals distributed, marketed and sold pharmaceutical products in the United States, including chewable multivitamin fluoride supplement tablets. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from October 1, 2007 through August 31, 2013, Qualitest marketed, sold and distributed Qualitest Fluoride Tablets that contained less than 50% of the fluoride ion indicated on the labels.

On February 8, 2016, in conjunction with a national settlement, a settlement agreement was executed between Qualitest and the State of North Carolina in settlement of these allegations. Under

the terms of North Carolina's settlement, the State of North Carolina recovered $398,839.78. Of that amount, the federal government received $275,766.69 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 $123,073.09. Of this amount, $46,136.04 was paid to the North Carolina Medicaid Program as restitution and interest, $50,134.77 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $25,727.96 was paid to the *qui tam* plaintiff, and $1,074.32 was paid to the North Carolina Department of Justice for costs of collection and investigation.

CEPHALON, INC.

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

It was alleged that from January 1, 2007 through March 31, 2012, Cephalon falsely under-reported its Average Manufacturer's Price to the Centers for Medicare and Medicaid Services, improperly decreasing the amounts Cephalon rebated to the states under the Medicaid Drug Rebate Program.

On September 22, 2015, in conjunction with a national settlement, a settlement agreement was executed between Cephalon and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $385,132.61. Of that amount, the federal government received $264,400.00 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $120,732.61. Of this amount, $91,137.87 was paid to the North Carolina Medicaid Program as restitution and interest, $28,589.81 was paid to the *qui tam* plaintiff, and $1,004.93 was paid to the North Carolina Department of Justice for costs of investigation.

GENENTECH/OSI PHARMACEUTICALS

Genentech is a Delaware corporation with its principal place of business in California. OSI Pharmaceuticals is a Delaware limited liability corporation. The defendants manufactured, distributed, marketed and promoted an oncology drug sold under the trade name Tarceva. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2006 through December 31, 2011, Genentech/OSI off-label marketed the drug Tarceva.

On June 6, 2016, in conjunction with a national settlement, a settlement agreement was executed between Genentech/OSI and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $372,436.66. Of that amount, the federal government received $239,036.10 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 $133,400.56. Of this amount, $55,397.11 was paid to the North Carolina Medicaid Program as restitution and interest, $54,294.02 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $22,490.57 was paid to the *qui tam* plaintiff, and $1,218.86 was paid to the North Carolina Department of Justice for costs of collection and investigation

DR. JAMES SOWELL/HEALTH-PRO MENTAL HEALTH SERVICES

Dr. James Sowell owns and operates Health-Pro Mental Health Services, PLLC. This matter was referred to the MID by the United States Attorney General's Office in the Western District of North Carolina.

It was alleged that from January 1, 2007 through December 31, 2013, Dr. Sowell submitted claims to the Medicaid program that identified Sowell as the attending provider for psychotherapy services when the services were performed by non-physician therapists. Dr. Sowell did not provide the direct supervision of the therapists that was required by Medicaid policies for Sowell to bill these therapists' services under Sowell's Medicaid provider numbers. This matter was worked jointly with OIG and the United States Attorney's Office, Western District of North Carolina. The settlement was negotiated by the United States Attorney's Office, United States District Court for the Western District of North Carolina and the Medicaid Investigations Division.

On September 8, 2015, a settlement agreement was executed between Dr. Sowell/Health-Pro Mental Health Services and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $361,500.00. Of that amount, the federal government received $292,718.82 for federal health care programs 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 $68,781.18. Of this amount, $64,393.26 was paid to the North Carolina Medicaid Program as restitution and $4,387.92 was paid to the North Carolina Department of Justice for costs of investigation.

ADVENTIST HEALTH SYSTEM

Adventist Health System is a Florida non-profit corporation with its principal place of business in Florida. Adventist owns numerous hospitals and medical practices throughout the southeastern United States, including Fletcher Hospital, Inc., d/b/a Park Ridge Health and Park Ridge Medical Associates in North Carolina. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2007 through December 31, 2012, Adventist paid improper compensation to physicians to induce them to illegally refer patients to Defendants' hospitals for inpatient and ancillary services.

On September 19, 2015, a settlement agreement was executed between Adventist and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $198,453.75. Of this amount, $105,975.49 was paid to the North Carolina Medicaid Program as restitution and interest, $52,987.75 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $37,706.21 was paid to the *qui tam* plaintiff, and $1,784.30 was paid to the North Carolina Department of Justice for costs of collection and investigation. The United States released the federal portion of the state Medicaid funds in their settlement agreement with Adventist to allow for the global resolution of the federal and state claims.

MILLENNIUM

Millennium Health, LLC is a limited liability company organized under the laws of California with its principal place of business in San Diego, California. Millennium marketed and performed laboratory

testing services in the United States, including pharmacogenetic testing ("PGT"). This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2012 through May 20, 2015, Millennium knowingly submitted or caused to be submitted claims to the Medicaid program by performing unnecessary PGT because it was performed on a routine or preemptive basis without an assessment of individual patient needs.

On November 6, 2015, in conjunction with a national settlement, a settlement agreement was executed between Millennium and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $194,587.34. Of that amount, the federal government received $112,519.10 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 $82,068.24. Of this amount, $34,654.31 was paid to the North Carolina Medicaid Program as restitution and interest, $33,340.90 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $13,324.55 was paid to the *qui tam* plaintiff, and $748.48 was paid to the North Carolina Department of Justice for costs of collection and investigation.

PHARMERICA CORPORATION (DEPAKOTE)

Pharmerica Corporation is a Delaware corporation with its principal place of business in Louisville, Kentucky. Pharmerica operated pharmacies in the United States, providing pharmacy services to residents in long-term care and other facilities. This matter was referred to the MID by the *qui tam* plaintiff and the National Association of Medicaid Fraud Control Units.

It was alleged that from January 1, 2001 through December 31, 2008, Pharmerica knowingly solicited and received illegal remuneration from drug manufacturer Abbott Laboratories in the form of rebate agreements that required Pharmerica to engage in certain promotional programs, grants, and other financial support influencing the utilization of Depakote.

On October 5, 2015, in conjunction with a national settlement, a settlement agreement was executed between Pharmerica and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $122,397.19. Of that amount, the federal government received $77,927.45 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $44,469.74. Of this amount, $19,253.03 was paid to the North Carolina Medicaid Program as restitution and interest, $18,281.57 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $6,524.74 was paid to the *qui tam* plaintiff, and $410.40 was paid to the North Carolina Department of Justice for costs of investigation.

PHARMERICA CORPORATION (ARANESP)

Pharmerica Corporation is a Delaware corporation with its principal place of business in Louisville, Kentucky. Pharmerica operated pharmacies in the United States, providing pharmacy services to residents in long-term care and other facilities. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from June 14, 2005 through March 31, 2010, Pharmerica solicited and received remuneration from Amgen, Inc. in the form of purported discounts, purported market-share rebates, grants, honoraria, speaker fees, consulting services, dinners, travel, or fees for the purchase of data, and that this remuneration was solicited and received in exchange for Pharmerica's influencing health care providers' selection and utilization of Aranesp in long-term care settings.

On November 12, 2015, in conjunction with a national settlement, a settlement agreement was executed between Pharmerica and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $29,369.15. Of that amount, the federal government received $19,564.38 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 $9,804.77. Of this amount, $6,800.05 was paid to the North Carolina Medicaid Program as restitution and interest, $2,928.86 was paid to the *qui tam* plaintiff, and $75.86 was paid to the North Carolina Department of Justice for costs of investigation.

PEDIATRIC SERVICES OF AMERICA, INC.

Pediatric Services of America, Inc. is a Delaware corporation with its principal place of business in Georgia. Pediatric Services of America marketed and provided nursing and caregiver home care services for medically fragile children and adults in the United States. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2007 through October 31, 2014, Pediatric Services of America knowingly failed to return overpayments that it received from Medicaid and upcoded by billing one whole hour for home nursing services performed in 30 minutes or less when such a whole hour "rounding up" is only permitted for services that were rendered for 31 minutes or more.

On July 20, 2015, in conjunction with a national settlement, a settlement agreement was executed between Pediatric Services of America and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $101,693.56. Of that amount, the federal government received $69,673.72 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $32,019.84. Of this amount, $12,736.58 was paid to the North Carolina Medicaid Program as restitution and interest, $13,337.47 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $5,095.16 was paid to the *qui tam* plaintiff, and $850.63 was paid to the North Carolina Department of Justice for costs of collection and investigation.

STEPHEN WILKINS

Stephen Wilkins is a licensed clinical social worker and operates his private therapy and counseling practice in Caldwell County, North Carolina. This matter was referred to the MID by the Division of Medical Assistance.

It was alleged that from July 12, 2012 through May 24, 2014, Wilkins knowingly billed Medicaid for multiple family members for participating in the same family therapy session on the same date of service and billed Medicaid for a family therapy session as family therapy for one or more participating members of the same family and also as an individual therapy session or psychotherapy with patient

and/or family member session for one or more participating members of the same family on the same date of service.

On January 19, 2016, a settlement agreement was executed between Stephen Wilkins and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $95,679.00. Of that amount, the federal government received $62,688.88 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 $32,990.12. Of this amount, $32,623.93 was paid to the North Carolina Medicaid Program as restitution and $366.19 was paid to the North Carolina Department of Justice for costs of investigation.

BIOGEN IDEC, INC.

Biogen IDEC, Inc. is a Delaware corporation with its principal place of business in Cambridge, Massachusetts. Biogen developed, manufactured, distributed, marketed and sold drugs in the United States. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

It was alleged that from January 1, 2007 through July 31, 2015, Biogen improperly underpaid its Medicaid Rebate obligations by falsely under-reporting Average Manufacturer Price to the Center for Medicare and Medicaid Services.

On August 3, 2015 Biogen IDEC and the State of North Carolina entered into a settlement to resolve these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $75,744.91. Of that amount, the federal government received $51,854.42 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 $23,890.49. Of this amount, $16,885.47 was paid to the North Carolina Medicaid Program as restitution, $6,450.43 was paid to the *qui tam* plaintiff, and $554.59 was paid to the North Carolina Department of Justice for costs of investigation.

INSPIRE PHARMACEUTICALS, INC.

Inspire Pharmaceuticals, Inc. is a Delaware corporation with its principal place of business in Lake Forest, Illinois. Inspire developed, distributed, and sold drugs in the United States. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2008 through September 30, 2011, Inspire off-label marketed AzaSite for the treatment of blepharitis, a use which was not approved by the Food and Drug Administration.

On June 11, 2015, in conjunction with a national settlement, a settlement agreement was executed between Inspire Pharmaceuticals and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $62,375.71. Of that amount, the federal government received $44,167.33 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 $18,208.38. Of this amount, $8,233.62 was paid to the North Carolina Medicaid Program as restitution and interest, $5,940.45 was paid to the Civil Penalty Forfeiture

Fund for the support of public schools, $3,579.07 was paid to the *qui tam* plaintiff, and $455.24 was paid to the North Carolina Department of Justice for costs of collection and investigation.

NUVASIVE, INC.

Nuvasive, Inc. is a Delaware corporation with its principal place of business in San Diego, California. Nuvasive distributed, marketed and/or sold medical devices, including minimally invasive surgical products for the spine, in the United States, including CoRoent spinal fusion devices. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2008 through December 31, 2013, Nuvasive knowingly marketed the CoRoent for uses that were not approved or cleared by the Food and Drug Administration and knowingly offered and paid illegal remuneration to physicians to induce them to use CoRoent in spinal fusion surgeries.

On October 2, 2015, in conjunction with a national settlement, a settlement agreement was executed between Nuvasive and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $59,603.76. Of that amount, the federal government received $41,113.79 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 $18,489.97. Of this amount, $7,550.54 was paid to the North Carolina Medicaid Program as restitution and interest, $7,554.24 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $3,216.86 was paid to the *qui tam* plaintiff, and $168.33 was paid to the North Carolina Department of Justice for costs of collection and investigation.

RESPIRONICS, INC.

Respironics, Inc. is a Delaware corporation with its principal place of business in Murrysville, Pennsylvania. Respironics provided various healthcare goods and services, including manufacturing and selling continuous pressure airway pressure ("CPAP") therapy device masks and related equipment used to treat sleep apnea. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from April 1, 2012 through November 30, 2015, Respironics provided kickbacks to DME suppliers in order to induce them to sell Respironics products.

On May 20, 2016, in conjunction with a national settlement, a settlement agreement was executed between Respironics and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $28,861.47. Of that amount, the federal government received $18,697.85 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 $10,163.62. Of this amount, $8,467.80 was paid to the North Carolina Medicaid Program as restitution, $1,600.77 was paid to the *qui tam* plaintiff, and $95.05 was paid to the North Carolina Department of Justice for costs of investigation.

JANICE BROWN

Janice Brown was a Registered Nurse who owned and operated Personal Compassionate Care Services, Inc., Helping Hands Home Care, and Heaven Scent Home Healthcare, Inc. with locations in eastern North Carolina. This matter was referred to the MID by an anonymous informant.

Janice Brown and her companies were alleged to have submitted false claims to the Medicaid Program from 2004 through 2009 for personal care services that were not rendered. The state obtained a default judgment against Ms. Brown and her companies. After significant effort by the MID, Ms. Brown agreed to sell several of her properties and vehicles to pay on the judgment. A private auction company sold the properties and vehicles. The North Carolina Department of Revenue maintained liens on several of Ms. Brown's properties and were paid from the sale of the assets. The Board of Nursing also began an investigation into Ms. Brown's fraudulent activities based on the allegations against her.

On September 23, 2015 the State of North Carolina agreed to settle for $21,304.91. This amount was recovered from Brown from the sale of properties, vehicles, and assets. Of that amount, the federal government received $13,647.81 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 $7,657.10. Of this amount, $7,413.61 was paid to the North Carolina Medicaid Program as restitution and $243.49 was paid to the North Carolina Department of Justice for costs of investigation.

GENESIS FAMILY HEALTH CARE, INC.

Genesis Family Health Care, Inc. is a North Carolina personal care services company with its principal place of business in Jamestown, North Carolina. This matter was referred to the MID by a private citizen.

Genesis was alleged to have submitted false claims to the Medicaid Program from August 23, 2009 through April 10, 2010 for continuing to bill personal care services for a recipient that died.

On October 29, 2015, a settlement agreement was executed between Genesis Family Health Care and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $17,500.00. Of that amount, the federal government received $11,352.25 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 $6,147.75. Of this amount, $1,949.42 was paid to the North Carolina Medicaid Program as restitution, $4,130.09 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $68.24 was paid to the North Carolina Department of Justice for costs of collection and investigation.

VI. PROSPECTUS

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

- ✓ We continue to have a reliable exchange with our Medicaid single-state agency, DMA, especially the DMA/Program Integrity Section, as well as other state and federal investigative and prosecutorial agencies. These relationships have played an important role in the MID's success to date and should significantly contribute to the MID's accomplishments in future fiscal years.
- ✓ MID investigators continue to uncover and obtain evidence showing complex fraud schemes. MID criminal enforcement attorneys continue to make a significant impact by prosecuting felony cases resulting in active time. MID civil enforcement attorneys continue to be actively involved in numerous state cases and national global/multi-state civil cases which have potential for successful conclusions and the recovery of funds for the state in future fiscal years.
- ✓ Each of the Managed Care Organizations (MCOs) managing North Carolina's Behavioral Health Managed Care 1915(b)(c) Waiver program has appointed a Compliance Officer and Committee whose duties include implementing an effective system for identifying and reporting fraud. DMA and MID have provided training to the MCOs on identifying and reporting fraud. DMA and MID have been meeting on a quarterly basis with the MCO compliance staff. MCO compliance staff has shown serious interest in the training and meetings and an understanding of the importance of reporting fraud. MCO compliance staff members have become an important source of fraud referrals in connection with the Medicaid behavioral health program, and we are optimistic that this collaboration will increase.
- ✓ MID continues to have a robust and creative training program that will increase the skill and abilities of MID staff and increase proficiency in investigating and prosecuting fraud and abuse. The Office of Inspector General recently highlighted our best practice of partnering with another state agency to create a Financial Investigator Academy.
- ✓ Utilization of the latest technology for data analytics allow attorneys and investigators to obtain necessary information expeditiously and efficiently in complex fraud investigations. Newly acquired software has significantly improved the speed with which MID investigators can import and analyze bank records.
- ✓ The Affordable Care Act (ACA), Title 42 C.F.R. 455.23, requires DMA to suspend payments to any Medicaid provider where there is a credible allegation of fraud unless the MFCU requests that suspension not be imposed if suspension would jeopardize an ongoing investigation. Consistent with procedures established by MFCUs nationwide, the MID and DMA have created a process whereby when DMA refers a provider to the MID, the MID may not object to the suspension of the provider or MID may request that DMA not suspend the provider consistent with the regulation. As a result of this

regulation, DMA has been able to suspend Medicaid providers when appropriate in order to prevent further losses of taxpayer money to fraud, and in appropriate cases MID has been able to request that suspension not be imposed if suspension might compromise or jeopardize an investigation. For a full description of the regulation, please see 42 C.F.R. 455.23.

Our optimism must be tempered by identified challenges for the MID as follows: (1) the lingering effect of the loss of reliable data in 2013 and 2014; (2) a change in the nature of civil actions and the resulting effect on the stability of MID state funding and operations; and (3) the recommendation to upgrade and enhance our case management system.

In our 2014 and 2015 Annual Reports we described the history and the challenges of not having access to reliable data. The MID relies on the Medicaid data repository and access systems to efficiently and effectively prosecute fraud and recover monies. We noted that in 2013 the MID lost access to current data that was sufficiently reliable to be admissible in court which required MID to develop work around plans to obtain reliable data on a case by case basis. We are pleased to report that as of September 23, 2015, the issue of access to reliable data was substantially resolved for the MID. While the loss of data during 2013 and 2014 continues to have an impact on current conviction and recovery levels due to the decrease in case referrals before the resolution of this issue, as we go forward access to reliable data will allow us to continue the successful prosecution and recovery of funds lost due to fraud.

The nature of civil actions is changing. In past years the MID obtained significant civil recoveries in civil False Claims Act cases against pharmaceutical manufacturers that were alleged to have engaged in improper off-label marketing and pricing schemes. However, there has been a shift in the landscape of national civil Medicaid fraud cases. The MID has increased the number of state and regional settlements, but the number and size of national settlements has decreased. In prior years the MID settlements included multi-million dollar recoveries from large pharmaceutical manufacturers that allegedly engaged in off-label marketing of drugs with substantial utilization of those drugs in North Carolina. Most of these recoveries resulted from joint actions taken by the federal government, North Carolina, and other participating states. These significant recoveries by the federal government and states have substantially and uniformly decreased due to a number of market factors including the following:

- As a positive change, prior year cases have changed the behavior of the industry. Enforcement efforts may have decreased the off-label marketing business practices of pharmaceutical companies which we count as a success consistent with our ultimate goal of eliminating fraud in the Medicaid program. The decrease may also be explained in part by the federally mandated higher transparency that now exists in the financial relationships between pharmaceutical companies and the physicians with whom they do business. In addition, as a condition of these settlements, pharmaceutical companies were required to adopt corporate integrity agreements that were designed to prevent future abusive practices. Other corporations have adopted voluntary compliance programs, promoted by OIG, which may have further reduced the incidence of fraud allegations.

- A significant shift in prescription drug spending from Medicaid to Medicare occurred in 2006 with the inception of Medicare Part D. The period of covered conduct in False Claims Act cases can go back 10 years. We have been transitioning into a period of time in which a larger portion of the covered conduct in prescription drug False Claims Act settlements will have occurred after the inception of Medicare Part D. Therefore, a larger portion of the payments being recovered in future settlements will be allocated to repay Medicare Part D as opposed to Medicaid. We have requested that CMS and the U.S. DOJ accept a clawback theory whereby, consistent with the ACA, a state's Medicaid program may share proportionally in recovered Medicare Part D funds.
- North Carolina and other states are transitioning their Medicaid programs to managed care. State Medicaid Agencies and MFCUs are developing policies to allocate, and strategies to recover, Medicaid damages in the context of managed care. This is an ongoing process. How recoveries occur in a managed care context is still under review.
- Named defendants in pending False Claims Act actions have shifted from being primarily national pharmaceutical companies to being state and regional hospitals, nursing homes, dental, and similar providers. We are bringing more actions and settlements than ever, but more of these involve state and regional providers. Pursuing actions against this type of defendant is important, but can be resource-intensive, may raise ability-to-pay issues, may result in smaller per-settlement monetary recoveries, and may result in the need to collect more payments over time. Actions against larger companies are typically settled with one lump-sum payment made at the time of settlement. Actions against smaller providers with a more limited ability to pay may need to be settled with payments over time with interest, resulting in a delay in receipt of full costs.

These trends could affect the current MID operations model. By way of background, the MID is funded 75% by a federal grant and 25% by state matching funds. <u>These trends warrant careful monitoring to ensure a stable source of the State's required matching funds</u>. We want to emphasize that the MID civil and criminal operations continue to recover funds resulting in a positive return on investment for North Carolina. In state fiscal year 2016, the MID obtained $13,354,250.86 in criminal judgments and $80,765,782.60 in civil recoveries for a total of $94,120,033.46. These MID civil and criminal operations resulted in a positive return on investment of $55.32 in SFY 2016 for every state dollar invested in MID. In addition, MID operations save state funds by deterring potential fraudsters.

Our final challenge is to modernize the current case management system. The Office of Inspector General, our federal oversight agency, recommended that MID replace its current case management system and we concur. The MID has researched potential enhancements of our system and is working with the Department of Justice IT and Fiscal staff to develop a business plan for future migration.

In conclusion, we remain optimistic as to the long term success of the MID. We are 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.