JOSH STEIN
ATTORNEY GENERAL

STATE OF NORTH CAROLINA
DEPARTMENT OF JUSTICE

SETH DEARMIN
CHIEF OF STAFF

September 1, 2019

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Co-Chairs, Appropriations Subcommittees on Health and Human Services
North Carolina General Assembly
Raleigh, North Carolina 27601-1096

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

Dear Members:

G.S. §114-2.5A requires the Attorney General to report by September 1 on the activities of the Medicaid Fraud Control Unit of the Department of Justice, which is the Medicaid Investigations Division, during the previous fiscal year to the Chairs of the Appropriations Subcommittees on Justice and Public Safety and Health and Human Services of the Senate and House of Representatives and the Fiscal Research Division of the Legislative Services Office. Pursuant to that statute, I have enclosed the Medicaid Investigations Division Activities Report for July 1, 2018 through June 30, 2019.

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

Sincerely,

Seth Dearmin
Chief of Staff

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

REPORT TO THE
NORTH CAROLINA GENERAL ASSEMBLY

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

State Fiscal Year July 1, 2018 through June 30, 2019

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I. INTRODUCTION

Pursuant to N.C.G.S. § 114-2.5A "each year the Medicaid Fraud Control Unit of the Department of Justice," which is the Medicaid Investigations Division (MID), "shall file a written report about its annual activities" with the General Assembly. This report covers the activities of the MID for the State Fiscal Year 2018-2019 (FY 18/19), covering the period of July 1, 2018, through June 30, 2019.

G.S. § 114-2.5A requires the report on the MID's activities during the previous state fiscal year 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 40 year history. In that time over 635 providers have been convicted of crimes spanning the above-mentioned categories, and the MID has recovered over $879 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 18/19, 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 (HHS-OIG), Office of Investigations District Office in Greensboro, N.C.; the Federal Bureau of Investigation (FBI); the Internal Revenue Service (IRS); the United States Department of Justice (USDOJ); N.C. State Bureau of Investigation (SBI); 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 North Carolina 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 18/19, former MID Special Deputy Attorney General Charlie Hobgood served as a member of the NAMFCU Executive Committee and NAMFCU working groups. MID Director Eddie Kirby served on the NAMFCU Global Case Committee. Former MID Criminal Chief Doug Thoren served as a member of the NAMFCU Training Committee and a working group. MID Civil Chief Steve McCallister served on the Global Case Committee, Qui Tam Subcommittee, and NAMFCU working groups. The MID continues to be actively involved in national global cases being coordinated through NAMFCU with the United States Department of Justice and other federal and state agencies. Civil Chief Steve McCallister and Special Deputy Attorneys General Stacy Race, Mike Berger, and Lareena Phillips, and Financial Investigator Jennifer Brock served on NAMFCU global teams appointed by NAMFCU's Global Case Committee.

The United States Attorney's Offices for the Eastern, Middle, and Western Districts have appointed a number of MID attorneys as Special Assistant United States Attorneys (SAUSAs) 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. Special Deputy Attorney General Tim Rodgers is embedded in the Western District U.S. Attorney's Office in Charlotte and serves there as a SAUSA.

The MID has a strong relationship with the North Carolina Division of Health Benefits, and particularly with its Office of Compliance and Program Integrity (OCPI). In May 2019, MID and OCPI 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 has a strong relationship with the North Carolina Division of Health Service Regulation (NC DHSR), the primary agency designated to receive patient physical abuse complaints from or involving long-term care providers in North Carolina.

During FY 18-19 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 North Carolina General Assembly enacted the North Carolina False Claims Act, G.S. §§ 1-605 through 1-618, effective January 1, 2010. This act established a state *qui tam* law that has improved the MID's ability to prosecute and investigate Medicaid provider fraud and abuse. Since the North Carolina False Claims Act became effective, the MID has received information from and filings by whistleblowers alleging approximately 712 cases of Medicaid fraud and abuse.

During the 2017-2018 session of the North Carolina General Assembly, SB 368, "Update False Claims Act," was enacted effective June 22, 2018. This bill amended the North Carolina False Claims Act (NCFCA). On October 26, 2018, the United States Department of Health and Human Services, Office of Inspector General certified that after these recent amendments, the NCFCA is at least as effective in rewarding and facilitating *qui tam* actions for false and fraudulent claims as those described in the federal False Claims Act. As a result, North Carolina now qualifies under the Deficit Reduction Act to receive a 10% "bump" in civil healthcare fraud recoveries. We have submitted the bill to the Inspector General and have requested that it be certified. The State now will be able to retain approximately 43 cents of every dollar recovered instead of 33 cents. This effectively results in a 30% increase in the State's recovery. North Carolina is already receiving these increased recoveries, because the 10% "bump" applies in settlements and judgments obtained after the amendments' June 22, 2018 effective date.

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 18/19 enhanced our reputation as an effective and professional Medicaid Fraud Control Unit that vigorously, but fairly, pursues and prosecutes fraud and abuse.

III. INFORMATION REQUIRED ON MID ACTIVITIES

1. The number of matters referred to the MID.

There were 384 referrals made to the MID during the State FY 18/19; an increase from FY 17/18. The referrals came from varied sources. Referral sources include private citizens, *qui tam* relators, the Office of Compliance and Program Integrity (OCPI) of the Division of Health Benefits, Managed Care Organizations (MCO) in connection with behavioral health services, the Division of Health Service Regulation, local departments of Social Services, former employees, State Survey and Certification agencies, Licensing Boards, the National Association of Medicaid Fraud Control Units, United States Attorney's Offices, and other law enforcement agencies such as Office of Inspector General.

Of those 384 new referrals, the MID opened new case files on 120 matters. The remaining 264 were referred to another agency for review, rolled into existing MID investigations, or declined for various reasons. In many instances, it is appropriate to refer a matter to the North Carolina Division of Health Benefits for further review or administrative action. DHB can compare the allegation to its history of the provider and conduct billing analysis and reviews to determine whether further investigation is appropriate. DHB 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, DHB 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 referrals 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 Health Benefits and the county Departments of Social Services. Please note that allegations of Medicaid recipient fraud should be referred to the Recipient Services Section of the Division of Health Benefits, 919-527-7749, 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 18/19 the MID staff investigated 505 cases. Due to the length of time required to properly investigate a case, a number of these cases were referred and/or opened prior to FY 18/19. The subjects of investigations included ambulance transportation providers, dentists, durable medical equipment providers, home care providers, laboratories, medical doctors, mental health providers, pain management centers, pharmaceutical manufacturers, pharmacies, and psychiatrists. The MID also investigated caregivers accused of patient physical abuse at Medicaid funded facilities, and the misappropriation of patient personal funds.

3. The number of Criminal Convictions and Civil Settlements.

a. Criminal Convictions

During FY 18/19, the MID successfully convicted 10 providers. These criminal convictions resulted in more than 369 months of incarceration and in the recovery of $9,661,434.46 in restitution, fines, courts costs, supervision fees, and community services fees. A number of the convicted defendants were connected to each other in some fashion. The various types of connections included family relationships, selling Medicaid patient information to each other, loaning their provider numbers to each other, use of the same billing company, and teaching fraud techniques to each other. While these judgments ordered the repayment of over $14 million in restitution, fines, court costs, and fees, because many of the crimes were related, many of the judgments were "joint and several." We adjusted our report of the total recoveries to reflect these joint and several judgments; therefore, we are reporting $9.6 million in recoveries rather than $14 million. Details of these convictions are set forth in Section IV of this report.

Of particular note was the criminal conviction of Catinia Farrington and Haydn Thomas. Farrington owned Durham County Mental & Behavioral Health Services, LLC ("DCMBHS") located in Durham, North Carolina. This case was prosecuted in federal court in the Middle District of North Carolina. It illustrates the effectiveness of joint investigations and prosecutions with our federal partners as it was jointly investigated by MID, HHS-OIG, and IRS and prosecuted by attorneys from MID, the USAO-MDNC, and the US DOJ Tax Division.

Farrington owned DCMBHS. From 2011 through 2015, DCMBHS submitted thousands of false claims to Medicaid for services that were not performed, resulting in approximately $4 million in wrongful payments to the company. During the relevant period, Haydn Thomas worked as an office manager for an oral surgeon and provided Farrington with the names and Medicaid identification numbers of dental patients. The patient information was used to submit the false claims to Medicaid.

Farrington and Thomas diverted millions of dollars from DCMBHS for their own personal use and evaded income taxes by, among other things, transferring money to various business bank accounts and paying personal expenses from the business bank accounts.

Farrington earned more than $1.1 million from DCMBHS and evaded income taxes on this money by transferring funds to various business bank accounts and paying personal expenses from the business bank accounts while failing to file tax returns. The resulting tax loss is approximately $391,747. Likewise, Thomas evaded tax on the more than $1.4 million he earned from DCMBHS, resulting in approximately $518,997 in tax loss.

Both defendants pled guilty in September 2018. Farrington pleaded guilty to one count of health care fraud conspiracy and one count of tax evasion. Thomas pleaded guilty to one count of making a false statement relating to health care matters and one count of tax evasion.

On March 1, 2019, Farrington was sentenced to 60 months in prison followed by three years of supervised release. Farrington was also ordered to make restitution payments of $3,950,656.01 to the Medicaid program (jointly and severally liable with Haydn Patrick Thomas) and $391,747 to the Internal Revenue Service. There was a $100 special assessment in each count ($200 total).

On May 24, 2019, Thomas was sentenced to 78 months in prison followed by three years of supervised release. Thomas was also ordered to make restitution payments of $3,950,656.01 to the Medicaid program (jointly and severally liable with Farrington) and $518,997 to the Internal Revenue Service. There was a $100 special assessment in each count ($200 total).

b. Civil Settlements

During FY 18/19, the MID successfully obtained 15 civil settlements and recovered $13,445,021.43 in damages, interest, civil penalties, and costs.

Of significance was a civil jury verdict in favor of the government in the matter of *United States of America and the State of North Carolina v. Compassionate Home Care Services, Inc., Carol Anders, and Ryan Santiago*. Compassionate Home Care Services, Inc. is a Robeson County company founded in 2003 and owned by Carol Anders. Ryan Santiago is Anders's son. Compassionate provided in-home assistance to Medicaid patients who needed help with daily living tasks.

Defendants participated in an extensive Medicaid fraud scheme in which they knowingly billed Medicaid for services not rendered and for services not provided in compliance with Medicaid regulations. Specifically, Defendants submitted documents indicating that they

provided services to Medicaid recipients when they did not provide the services. Defendants used unlicensed aides when licensed aides were required by Medicaid regulations. Defendants also allowed aides to provide services to their close family members in violation of Medicaid regulations. When the State issued subpoenas during the investigation, defendants falsified hundreds of documents in an effort to conceal the fraud.

Chief United States District Judge James C. Dever, III granted summary judgment on liability finding that the defendants violated the federal and North Carolina False Claims Acts. The case went to trial on damages in June, 2018.

The evidence at trial showed that between 2008 and 2013, Compassionate Home Care Services, Inc. billed the North Carolina Medicaid program $585,082.73 in fraudulent claims, including not only claims for services provided in violation of Medicaid policies, but also claims for services that were never provided at all. The jury determined that the defendants submitted 1,713 false claims to the government as part of the scheme. The federal and North Carolina False Claims Acts mandate that the government recover three times the damages caused by the fraud, plus civil penalties for every false or fraudulent claim. Applying those provisions and other applicable law, Judge Dever awarded the government a judgment of $2,921,248.19.

The jury verdict was obtained by Special Deputy A.G. Stacy Race and then Assistant A.G. Lareena Phillips of the N.C. Medicaid Investigations Division, with support from MID staff (including Financial Investigations Supervisor David Haire, who testified at trial) and the U.S. Attorney's Office for the Eastern District of N.C. Details of this case are set forth in Section V of this report.

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

Together, these 10 criminal convictions and 15 civil recoveries represent a total of $23,106,455.89 recovered for the State of North Carolina. Consistent with federal reporting instructions, recoveries are amounts individual and organizational defendants are ordered to pay in criminal cases and must pay in civil judgments and settlements and may not reflect actual collections. A case by case breakdown of the amounts recovered in each case and allocation of recovered funds is shown below in Table A.

Table A Funds Recovered 07/01/2018 - 06/30/2019						
Name	**Federal Government**	**NC Medicaid**	**Civil Penalty & Forfeiture Fund**	**NC DOJ Costs**	**Other**	**Total**
Catina Farrington	2,584,124.10	1,366,531.91			391,947.00	4,342,603.01
Haydn Thomas	2,584,124.10	1,366,531.91			519,197.00	4,469,853.01 *
Tamara McCaffity	344,924.20	178,858.80			100.00	523,883.00 *
Natures Reflection / Eric Leak	274,881.24	145,233.76			200.00	420,315.00
Antoinette Green	3,351.74	1,722.04			250.00	5,323.78
Renee Borunda / Skeen Personal Care	147,951.96	77,447.12			200.00	225,599.08
Robert Harrington					550.00	550.00
Lisa Raymond					2,069,192.15	2,069,192.15
Robert Maglicic, Jr					2,069,192.15	2,069,192.15
Michael Smith	2,330.55	1,154.13			5,877.61	9,362.29
Total Criminal Recoveries	5,941,687.89	3,137,479.67	0.00	0.00	5,056,705.91	$ 9,661,434.46
Groat v. Boston Heart Diagnostics, et al	0.00	7,009.79	6,675.63	1,265.60	0.00	14,951.02
Miksell-Branch v. Astrazeneca Pharmaceuticals (Seroquel)	205,202.94	59,995.75	0.00	3,986.06	24,063.03	293,247.78
Bandy v. Medical Park Pharmacy, Inc., et al	120,000.00	0.00	0.00	0.00	0.00	120,000.00
McGraw v. Healogics, Inc.	2,783.33	472.53	890.39	42.30	351.31	4,539.86
Lily Guo, DDS, MS / Complete Dental Care of Mebane	483,982.18	114,618.74	109,154.88	20,694.20	0.00	728,450.00
AngioDynamics, Inc. (Bliss v. AngioDynamics, Inc., et al) (Drug-Eluting Beads)	29,832.53	145.24	9,418.01	1,128.47	2,888.52	43,412.77
Omni Healthcare, Inc. v. AmerisourceBergen, Inc., et al	1,899,576.23	439,444.96	346,347.07	69,762.10	160,285.43	2,915,415.79
Rahimi v. Walgreen Boots Alliance, Inc.	1,327,388.55	375,815.79	355,770.65	67,449.01	189,948.93	2,316,372.93
Folstad, et al v. Health Management Associates, et al	18,144.20	2,781.89	2,535.91	480.79	2,047.25	25,990.04
Wu v. Alere San Diego, Inc., et al	312,185.17	85,883.81	26,287.81	5,848.19	28,828.24	459,033.22
Compassionate Home Care	1,899,061.72	191,974.21	800,291.05	29,921.21	0.00	2,921,248.19
Abbott Pharmaceuticals (Tricor)	109,330.28	29,064.35	26,445.93	5,013.77	0.00	169,854.33
Baker v. Walgreens Co. (U&C)	1,964,370.08	529,059.31	498,298.53	94,470.26	296,660.93	3,382,859.11
Gary Newsome (Meyer & Cowling v. HMA, et al)	225.11	38.38	36.53	6.92	27.29	334.23
Foothills Prosthetics	32,703.82	7,786.82	7,415.62	1,405.90	0.00	49,312.16
Total Civil Recoveries	8,404,786.14	1,844,091.57	2,189,568.01	301,474.78	705,100.93	$13,445,021.43
Total Recoveries	14,346,474.03	4,981,571.24	2,189,568.01	301,474.78	5,761,806.84	$ 23,106,455.89

* These defendants were ordered to repay $4,474,439.01 joint and severally. The Criminal Recoveries totals have been adjusted to reflect these joint and several judgments.

IV. CRIMINAL CONVICTIONS

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

State v. Antoinette Green

Antoinette Green was a support specialist working for ACI Support Specialists Inc., a Medicaid behavioral health provider located in Garner, NC. This matter was referred to the MID by Ella Peebles with the Program Integrity Section of DHB. The case was referred to DHB by Alliance MCO.

The referral alleged that Antoinette Green billed for services that were not provided. Interviews and investigative techniques substantiated the allegations.

On July 2, 2018, in Wake County District Court, Green pleaded guilty to one count of misdemeanor Attempted Medicaid Provider Fraud in violation of N.C.G.S. 108A-63. Green received a 45 day suspended sentence and was placed on 24 months of supervised probation. Green was ordered to pay $50 fine, $200 in court costs, and $5073.78 in restitution.

State v. Robert Harrington

Robert Lee Harrington was a paraprofessional and a life skills residential coach employed at Trotter's Bluff Group Home, an intermediate care facility for persons with intellectual disabilities located in Holly Springs, North Carolina. This matter was referred to the MID by the mother of a Medicaid recipient.

The investigation revealed that on July 20, 2017, Harrington assaulted a resident of Trotter's Bluff Group Home. Harrington hit the victim, wrestled him to the ground and restrained him until another staff member intervened. The victim was taken to the ER and diagnosed with a fracture to the nasal bones.

On September 27, 2018, in Wake County District Court, Powell pleaded guilty to one count of misdemeanor Assault on a Handicapped Person in violation of N.C.G.S. 14-32.1(F). Harrington received a 60 day suspended sentence and was placed on supervised probation. He was ordered to pay a $100 fine, $200 in court costs and a $250 community service fee. He was furthered ordered to perform 24 hours of community service and successfully complete anger management.

US v. Renee Borunda

Renee Borunda was the Medicaid biller for multiple Medicaid providers including Skeen Personal Care Services and Skeen Behavior Services, LLC. While working at Skeen Services, Inc.,

Borunda also managed a company, which was owned by her parents. Skeen Services, Inc. and her parents' company offered behavioral health services to Medicaid recipients in eastern North Carolina. This case was a spin-off investigation from another MID case.

The investigation revealed that from May 9, 2013, to September 12, 2014, Borunda used a therapist's personal information to submit fraudulent electronic claims to Medicaid from Skeen Services, Inc. and her parents' company.

On March 13, 2018, in the United States District Court for the Eastern District of North Carolina, pursuant to a waiver of indictment and a written plea agreement, Borunda pleaded guilty to Conspiracy to Commit Health Care Fraud in violation of 18 U.S.C. § 1349 and Aggravated Identity Theft in violation of 18 U.S.C. § 1028A. She was sentenced on November 7, 2018, to 37 months in federal prison, required to make restitution of $225,399.08 to the North Carolina Medicaid Program, and given a $200 special assessment.

US v. Eric Leak

Eric Leak was executive director and co-signor of Nature's Reflections, LLC, a Medicaid outpatient behavioral health provider with several offices located in North Carolina. Nature's Reflections, LLC was headquartered in Durham, North Carolina. This matter was referred to MID by the Internal Revenue Service.

The investigation revealed that Nature's Reflections, LLC submitted falsified medical documents and fraudulent claims to the Medicaid Program for behavioral services not rendered during October 27, 2011, through December 19, 2013. This investigation was a joint federal investigation with the IRS, DHHS, and OIG.

On March 8, 2018, Leak pleaded guilty in the United States District Court for the Eastern District of North Carolina to one count of felony Illegal Health Care Remunerations in violation of 42 USC § 1320(a)-7b(b)(2)(A) and one count of felony Money Laundering in violation of 18 USC § 1957(a). He was sentenced on December 8, 2018, to 18 months in prison followed by 3 years of supervised release. He was ordered to pay a $5000 fine, $200 special assessment fee, and restitution of $420,115.00 to the North Carolina Medicaid Program.

US v. Tamara McCaffity

Tamara McCaffity was the owner/operator of three Medicaid providers, Dreamworks II, in Durham, Prominence Consulting & Therapeutic Services, in Raleigh and 1st Choice Health Services in High Point, North Carolina. This matter was referred to the MID by the Federal Bureau of Investigation.

The investigation revealed that in or about January 2013, through May 2016, McCaffity entered into a scheme with Chris Brown to purchase Health Choice and Medicaid beneficiary numbers and bill for services not rendered.

On October 19, 2018, McCaffity pleaded guilty in the United States District Court for the Eastern District of North Carolina to one count of Conspiracy to Commit Healthcare Fraud in violation of 18 USC § 1349. On February 15, 2019, McCaffity was sentenced to 46 months in federal prison followed by 3 years of supervised release. She was given a special assessment of $100 and ordered to pay restitution to the North Carolina Medicaid Program in the amount of $523,783. She was also ordered to forfeit $771,269 in proceeds from the offense which included three tracts of real property located in North Carolina and Florida.

US v. Michael Smith

Michael Smith was a MD who owned and operated Mt. Holly Family Practice, Inc. located in Mount Holly, North Carolina. This matter was referred to the MID by the DHB Director of Pharmacy.

The investigation revealed that between January 2017, and October 2017, Dr. Smith illegally distributed controlled substances to female patients in exchange for sex acts. During that time period, Smith submitted fraudulent claims to, and received payment from, North Carolina Medicaid and Medicare for non-existent medical services for the office visits in which he performed and received sex acts from female patients.

On June 1, 2018, Smith pleaded guilty in the United States District Court for the Western District of North Carolina to one count of Drug Distribution in violation of 21 U.S.C. § 841, one count of Health Care Fraud in violation of 18 U.S.C. § 1347, and one count of Aggravated Identity Theft in violation of 18 U.S.C. § 1028A. On February 21, 2019, he was sentenced to 36 months in federal prison followed by 2 years of supervised release. Smith was ordered to pay a $300 assessment, a $5,500 fine, and restitution in the amount of $3,562.29.

US v. Catinia Farrington

Catinia Farrington owned Durham County Mental & Behavioral Health Services, an outpatient behavioral health provider located in Durham, North Carolina. While investigating and prosecuting another case, MID learned of allegations regarding DCMBHS.

The investigation revealed that during January 2011, through April 2015, DCMBHS submitted fraudulent claims to Medicaid and Farrington failed to file tax returns and evaded incomes taxes. The investigation was a joint investigation with the IRS and US DHHS-OIG.

On September 4, 2018, Farrington pleaded guilty in the United States District Court for the Middle District of North Carolina to one count of Conspiracy to Commit Health Care Fraud in violation of 18 USC § 1349 and one count of Tax Evasion in violation of 26 USC § 7201. On March 1, 2019, she was sentenced to 60 months in federal prison followed by 3 years of supervised

release. Farrington was ordered to pay a $200 assessment, $391,747 to the IRS, and restitution in the amount of $3,950,656.01 to the North Carolina Medicaid Program.

US v. Robert Paul Maglicic, Jr.

Robert Maglicic was the regional manager for Southern Support Services as well as other entities owned and operated by Lee Shepard Spruill in North and South Carolina. This referral arose out of another MID investigation.

The investigation revealed that Maglicic participated in a scheme to defraud the South Carolina Medicaid Program. Maglicic committed portions of the scheme in Greenville, North Carolina, using stolen names and identifiers of North Carolina employees. The investigation was a joint investigation with the IRS, US DHHS-OIG, and the FBI.

On December 6, 2018, Maglicic pleaded guilty in the United States District Court for the Eastern District of North Carolina to one count of Conspiracy to Commit Healthcare Fraud in violation of 18 USC § 1349. On April 11, 2019, Maglicic was sentenced to 42 months in federal prison followed by 3 years of supervised release. He was ordered to pay a $100 special assessment and restitution in the amount of $2,069,092.15 to the South Carolina Department of Health and Human Services.

US v. Lisa Raymond

Lisa Raymond was the corporate office manager for Southern Support Services and Carolina Support Services owned and operated by Lee Shepard Spruill in North and South Carolina. This referral arose out of another MID investigation.

The investigation revealed that Raymond participated in a scheme to defraud the South Carolina Medicaid Program. Raymond committed portions of the scheme in Greenville, North Carolina, using stolen names and identifiers of North Carolina employees. The investigation was a joint investigation with the IRS, US DHHS-OIG, and the FBI.

On December 6, 2018, Raymond pleaded guilty in the United States District Court for the Eastern District of North Carolina to one count of Conspiracy to Commit Healthcare Fraud in violation of 18 USC § 1349. On April 11, 2019, Raymond was sentenced to 7 months in federal prison followed by 3 years of supervised release. She was ordered to pay a $100 special assessment and restitution in the amount of $2,069,092.15 to the South Carolina Department of Health and Human Services.

US v. Haydn Thomas

Haydn Thomas was an office manager for an oral surgeon and lived in Durham, North Carolina. This referral arose out of another MID investigation.

The investigation revealed that from January 2011, to April 2015, Thomas submitted thousands of false claims to Medicaid. Thomas was obtaining the Medicaid numbers of dental patients and then submitting false claims to Medicaid for mental health services that were not provided. Thomas also evaded income tax regulations. The investigation was a joint investigation with the IRS and US DHHS-OIG.

On September 5, 2018, Thomas pleaded guilty in the United States District Court for the Middle District of North Carolina to one count of making a false statement related to a health care matter in violation of 18 USC § 1035 and one count of tax evasion in violation of 26 USC § 7201. On May 24, 2019, Thomas was sentenced to 78 months in federal prison followed by 3 years of supervised release. Thomas was ordered to pay $200 special assessment, $518,997 to the IRS, and restitution in the amount of $3,950,656.01 to the North Carolina Medicaid Program.

V. CIVIL RECOVERIES

Walgreen Company (Usual and Customary)

Walgreen Company is a Delaware corporation with its principal place of business in Deerfield, Illinois. Walgreens owns a series of retail pharmacies throughout the United States. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2008, through December 31, 2017, Walgreens submitted claims in which the prices identified as the usual and customary prices for certain prescription drugs that it sold through the Prescription Savings Club ("PSC") program were substantially higher than the prices it charged for those drugs pursuant to the PSC program.

On January 24, 2019, in conjunction with a national settlement, a settlement agreement was executed between Walgreens and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $3,382,859.11. Of that amount, the federal government received $1,964,370.08 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 $1,418,489.03. Of this amount, $529,059.31 was paid to the North Carolina Medicaid Program as restitution and interest, $498,298.53 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $296,660.93 was paid to the *qui tam* plaintiff, and $94,470.26 was paid to the North Carolina Department of Justice for costs of collection and investigation.

Compassionate Home Care Services (Carol Anders, Anthony Anders & Ryan Santiago)

Compassionate Home Care Services was a Medicaid provider that provided personal care services in and around Robeson County, North Carolina. A joint MID and HHS-OIG investigation revealed that from 2008 through 2013, Compassionate Home Care Services and its owner, Carol Anders, her son, Ryan Santiago, and Anthony Anders falsified records for services that were not performed.

On May 29, 2014, the United States Attorney's Office, Eastern District of North Carolina and MID filed a complaint alleging False Claims Act violations against Compassionate Home Care Services, Carol Anders, Anthony Anders and Ryan Santiago. The United States Attorney's Office, Eastern District of North Carolina, HHS-OIG, and MID jointly investigated the matter.

On August 8, 2018, the United States District Court for the Eastern District of North Carolina entered a judgment against Compassionate Home Care Services, Carol Anders, Anthony Anders and Ryan Santiago in the amount of $2,921,248.19. The judgment amount of $2,921,248.19 allowed for treble damages and penalties. Of that amount, the federal government is owed $1,899,061.72. The North Carolina State share of the judgment is $1,022,186.47.

AmerisourceBergen Corporation

AmerisourceBergen Corporation is a Delaware corporation with its corporate headquarters in Conshohocken, Pennsylvania. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from October 21, 2001, through January 31, 2014, AmerisourceBergen adulterated the cancer drugs Procrit, Aloxi, Kytril, Anzemet, and Neupogen by "breaking the seal" and supplying the drugs in pre-filled syringes without FDA oversight.

On November 27, 2018, in conjunction with a national settlement, a settlement agreement was executed between AmerisourceBergen 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 $2,915,415.79. Of that amount, the federal government received $1,899,576.23 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 $1,015,839.56. Of this amount, $439,444.96 was paid to the North Carolina Medicaid Program as restitution and interest, $346,347.07 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $160,285.43 was paid to the *qui tam* plaintiff, and $69,762.10 was paid to the North Carolina Department of Justice for costs of collection and investigation.

Walgreen Company (Insulin Pens)

Walgreen Company (Walgreens) is a Delaware corporation with its principal place of business in Deerfield, Illinois. Walgreens owns a series of retail pharmacies throughout the United States. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2006, through December 31, 2017, Walgreens under-reported the days of supply (*i.e.,* the number of days that insulin pens should last if the patient used insulin strictly according to the prescriber's directions for use); and that, due to this under-reporting, the federal government and State Medicaid programs paid for more insulin than certain patients needed.

On January 24, 2019, in conjunction with a national settlement, a settlement agreement was executed between Walgreens 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 $2,316,372.93. Of that amount, the federal government received $1,327,388.55 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 $988,984.38. Of this amount, $375,815.79 was paid to the North Carolina Medicaid Program as restitution and interest, $355,770.65 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $189,948.93 was paid to the *qui tam* plaintiff, and $67,449.01 was paid to the North Carolina Department of Justice for costs of collection and investigation.

Zhanying Guo, D.D.S.

Zhanying Guo, D.D.S., is a North Carolina Medicaid provider that provides general dentistry services in and around Alamance County, North Carolina. This matter was discovered during the course of an investigation of another MID case.

It was alleged that from January 1, 2013, through December 31, 2018, Guo billed for Palliative [emergency] treatment of dental pain – minor procedure, full mouth debridement to enable comprehensive evaluation and diagnosis, limited oral evaluation – problem focused, and comprehensive oral evaluation – new or established patient in which there was no supporting clinical documentation, were medically unnecessary and were performed in violation of clinical coverage policy.

On May 21, 2019, a settlement agreement was executed between Zhanying Guo 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 $728,425.00. Of that amount, the federal government received $483,982.18 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 $244,467.82. Of this amount, $114,618.74 was paid to the North Carolina Medicaid Program as restitution, $109,154.88 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $20,694.20 was paid to the North Carolina Department of Justice for costs of collection and investigation.

Alere San Diego

Alere San Diego is a Delaware corporation with its principal place of business in San Diego, California. Alere develops, manufactures and sells in vitro diagnostic devices used for rapid point-of-care testing, including the testing devices marketed under the trade name "Triage." This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2006, through March 31, 2012, Alere manufactured and distributed triage devices for use in rapid point-of-care testing, whose precision varied significantly from the precisions stated in the tests' package inserts and FDA approval documents.

On June 15, 2018, in conjunction with a national settlement, a settlement agreement was executed between Alere 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 $459,033.22. Of that amount, the federal government received $312,185.17 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $146,848.05. Of this amount, $85,883.81 was paid to the North Carolina Medicaid Program as restitution and interest, $26,287.81 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $28,828.24 was paid to the *qui tam* plaintiff, and $5,848.19 was paid to the North Carolina Department of Justice for costs of collection and investigation.

AstraZeneca

Astrazeneca is a Delaware Limited Partnership with its headquarters in Wilmington, Delaware. Astrazeneca designs, produces, markets and promotes Seroquel and Seroquel XR. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from 1997 through 2012, Astrazeneca off-label marketed Seroquel and Seroquel XR and concealed safety information from regulators.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $293,247.78. Of that amount, the federal government received $205,202.94 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $88,044.84. Of this amount, $59,995.75 was paid to the North Carolina Medicaid Program as restitution, $24,053.03 was paid to the *qui tam* plaintiff, $10 mailing fee, and $3,986.06 was paid to the North Carolina Department of Justice for costs of investigation.

Abbott Laboratories

Abbott Laboratories is an Illinois corporation with its principal place of business in Abbott Park, Illinois. Abbott markets the drug TriCor as part of its research based pharmaceutical business. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

It was alleged that from January 1, 2006, through December 31, 2008, Abbott off-label marketed TriCor for uses not approved by the FDA and paid kickbacks to physicians to induce them to prescribe TriCor.

On December 21, 2018, in conjunction with a national settlement, a settlement agreement was executed between Abbott 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 $169,854.33. Of that amount, the federal government received $109,330.28 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $60,524.05. Of this amount, $29,064.35 was paid to the North Carolina Medicaid Program as restitution and interest, $26,445.93 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $5,013.77 was paid to the North Carolina Department of Justice for costs of collection and investigation.

Medical Park Pharmacy

Medical Park Pharmacy dispenses prescription medication and pharmaceutical services to clients in 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, 2013, through December 31, 2018, Medical Park Pharmacy utilized discount coupons to reduce or eliminate the co-payment or co-insurance liability for customers.

On May 3, 2019, a settlement agreement was executed between Medical Park Pharmacy 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 $120,000.00. Of that amount, the federal government received $120,000.00 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government.

Foothills Prosthetics, LLC

Foothills Prosthetics provides durable medical equipment to Medicaid beneficiaries in and around Burke County, North Carolina. This matter was referred to the MID by a Medicaid recipient.

It was alleged that from January 1, 2013, through October 31, 2017, Foothills billed for durable medical equipment in which there was no supporting clinical documentation, were medically unnecessary and were performed in violation of clinical coverage policy.

On June 13, 2019, a settlement agreement was executed between Foothills 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 $49,312.16. Of that amount, the federal government received $32,703.82 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 $16,608.34. Of this amount, $7,786.82 was paid to the North Carolina Medicaid Program as restitution, $7,415.62 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $1,405.90 was paid to the North Carolina Department of Justice for costs of collection and investigation.

AngioDynamics, Inc.

AngioDynamics, Inc. is a medical device company based in Latham, New York. AngioDynamics designs, manufactures and sells various medical, surgical, and diagnostic devices in the United States. This matter was referred to MID by the *qui tam* plaintiff.

It was alleged that from May 1, 2006, through December 31, 2011, AngioDynamics off-label marketed its LC Bead medical device.

On July 9, 2018, in conjunction with a national settlement, a settlement agreement was executed between AngioDynamics and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $43,412.77. Of that amount, the federal government received $29,832.53 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 $13,580.24. Of this amount, $9,563.25 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $2,888.52 was paid to the *qui tam* plaintiff, and $1,128.47 was paid to the North Carolina Department of Justice for costs of collection.

Health Management Associates, LLC

Health Management Associates ("HMA") is a for-profit health care system that through its subsidiaries, indirectly owned and/or operated hospitals throughout the United States. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2008, through December 31, 2012, HMA billed for certain inpatient admissions that were medically unnecessary and should have been billed as outpatient or observation services. It was also alleged that HMA offered and provided remuneration to Emcare, a physician staffing company, in the form of service contracts and payments, in return for Emergency Department physician inpatient admission recommendations of Medicaid Program beneficiaries and for falsely inflating Emergency Department facility charges.

On February 1, 2019, in conjunction with a national settlement, a settlement agreement was executed between HMA and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $25,990.04. Of that amount, the federal government received $18,144.20 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $7,845.84. Of this amount,

$2,781.89 was paid to the North Carolina Medicaid Program as restitution and interest, $2,535.91 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $2,047.25 was paid to the *qui tam* plaintiff, and $480.79 was paid to the North Carolina Department of Justice for costs of collection and investigation.

Boston Heart Diagnostics

Boston Heart Diagnostics is a Delaware Corporation with its principal place of business in Framingham, Massachusetts. Boston Heart is a clinical diagnostic laboratory that performs cardiovascular disease-focused laboratory testing services. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2009, through December 31, 2014, Boston Heart engaged in a scheme to encourage physicians to order medically unnecessary clinical laboratory testing services.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $14,951.02. Of this amount, $7,009.79 was paid to the North Carolina Medicaid Program as restitution, $6,675.63 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $1,265.60 was paid to the North Carolina Department of Justice for costs of collection and investigation.

Healogics, Inc.

Healogics, Inc. is a Delaware corporation headquartered in Jacksonville, Florida. Healogics owns and/or manages wound care centers nationwide. This matter was referred to MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2012, through June 30, 2017, Healogics submitted CPT codes for "Evaluation and Management" services when they should have used a lower reimbursement code.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $4,539.86. Of that amount, the federal government received $2,783.33 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 $1,756.53. Of this amount, $472.53 was paid to the North Carolina Medicaid Program as restitution, $890.39 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $351.31 was paid to the *qui tam* plaintiff, and $42.30 was paid to the North Carolina Department of Justice for costs of collection and investigation.

Gary Newsome (Health Management Associates, LLC)

Gary Newsome was the President and CEO of Health Management Associates. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2008, through December 31, 2012, Newsome in his capacity as President and CEO of HMA developed and implemented a systematic practice of pressuring physicians into inpatient admissions of Government Healthcare Program beneficiaries that were medically unnecessary and should have been billed as outpatient or observation services.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $334.23. Of that amount, the federal government received $225.11 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 $109.12. Of this amount, $38.38 was paid to the North Carolina Medicaid Program as restitution, $36.53 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $27.29 was paid to the *qui tam* plaintiff, and $6.92 was paid to the North Carolina Department of Justice for costs of collection and investigation.

VI. PROSPECTUS

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

- ✓ MID investigators continue to uncover and obtain evidence of complex fraud schemes. MID criminal enforcement attorneys continue to make a significant impact by prosecuting felony cases resulting in active jail 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.
- ✓ The MID continues to work as part of the United States Department of Justice "Operation Synthetic Opioid Surge" on the Opioid Task Force of the U.S. Attorney for the Middle District. The MID is currently investigating a number of providers for fraudulent activities related to their opioid prescribing practices, in addition to actual patient harm caused by those practices. The MID has also participated in Attorney General Stein's opioid roundtable and provided assistance in the development of the "Stop Act" and the "HOPE Act."
- ✓ MID continues to work to address the opioid crisis in other ways, too. For example, in August 2018, MID filed a complaint against drug manufacturer Insys Therapeutics, Inc., alleging violations of the N.C. False Claims Act. We were joined in the filing by several other *qui tam* states. Insys produces and sells Subsys, a highly potent and addictive fentanyl pain killer that is sprayed under the tongue and used to treat breakthrough cancer pain. MID alleges that Insys paid kickbacks to entice doctors and nurse practitioners to prescribe Subsys to patients. These kickbacks ranged from speaker payments for phony speeches to lavish meals and entertainment. The complaint also alleges that Insys employees pushed prescribers to prescribe Subsys for patients who

were not diagnosed with cancer, and lied to insurance companies about patient diagnoses to obtain Medicaid reimbursements for Subsys prescriptions. Insys executed a settlement agreement with the federal government to pay a total of $195 million over five years. Insys paid the first installment delineated in the settlement agreement of $5 million dollars, $185,000.00 of which was paid to the states. However, Insys filed for bankruptcy on June 10, 2019, only days after the federal settlement agreement was executed. Insys moved for an order approving bidding procedures for the sale of assets, including Subsys and its other drug products. The bankruptcy case is ongoing. The MID is actively monitoring the Insys bankruptcy and will continue to pursue an appropriate resolution in light of the company's unsettled financial and operational future.

- ✓ MID continues to have a reliable exchange with the North Carolina Medicaid Agency, as well as with other state, local and federal investigative, licensing, law enforcement and prosecutorial agencies. These relationships have played an important role in MID's success and will continue to contribute to our accomplishments in future fiscal years.
- ✓ HHS-OIG granted MID permission to engage in data mining in November 2017. In February 2018, NC DHHS agreed to an amendment to the Memorandum of Understanding between MID and DHHS to establish procedures for coordination with respect to MID's data mining activities. In FY 2019 MID and OCPI met regularly to coordinate on data mining. MID will continue to coordinate with OCPI and to engage in data mining. We expect data mining will allow us to broaden our case mix in future years, and will help MID to execute its healthcare oversight responsibilities. We have already opened several healthcare fraud investigations based upon our data mining efforts
- ✓ MID is currently engaged in the replacement of its document management system. MID's document management system was identified in our FY 2018 annual report as a "challenge." This year we are glad to report that, with substantial assistance from the NCDOJ IT Department, we are now in the process of transitioning to the new document and case management system. We expect the new system to improve our productivity.
- ✓ As mentioned above, MID continues to conduct joint training with OCPI. In the FY 2019 joint training, a large number of managed care organization representatives also attended. Each of the managed care organizations in North Carolina's Behavioral Health Managed Care 1915(b)(c) Waiver program has a Compliance Officer and Committee, whose duties include implementing a fraud and abuse detection and reporting system. We see that MCOs are making referrals to OCPI, which evaluates these referrals and identifies the matters that should be referred to MID. MID has continued to meet regularly with OCPI to discuss referrals, initiatives and other matters of significance to both of our organizations.

MID also continues to face challenges. We see our primary challenge in the coming year to be the current transition of the North Carolina Medicaid Program to a managed care model of care delivery. We have concern that the managed care organizations may not prioritize fraud and abuse in the Program and will not make appropriate referrals to us.

MID is coordinating with NC DHHS on this. MID has provided proposed managed care contract language to NC DHHS with respect to fraud and abuse. We also have been working with

DHHS to ensure that MID will have access to the data stream for the encounter data associated with the provision of care in the managed care system, while continuing to receive the fee-for-service data stream to the extent areas of the Program remain in a fee-for-service delivery model. Finally, we have been working with OCPI with respect to planning outreach to the managed care organizations' Special Investigation Units (SIUs). We expect to develop effective working relationships with the SIUs and to receive fraud referrals from them.

MID's criminal and civil operations continue to recover funds resulting in a positive return on investment for every state dollar invested in MID. Our operations also continue to save state funds by deterring potential fraudulent activity.

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