

NEW YORK STATE MEDICAID FRAUD CONTROL UNIT

2008 Annual Report



**Submitted to the Secretary of the United States
Department of Health and Human Services**

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MESSAGE FROM THE DIRECTOR

This report constitutes the 2008 Annual Report of the New York State Medicaid Fraud Control Unit (“NYMFCU” or “the Unit”). As required by 42 C.F.R. § 1007.17, the NYMFCU submits this report to the Secretary of the United States Department of Health and Human Services and includes data concerning the number of investigations opened and completed by provider category, the number of cases prosecuted, the number of cases resolved and their outcomes, the number of complaints received and investigations opened regarding abuse and neglect of patients in health care facilities, the number of recovery actions resolved, the amount of recoveries collected, the costs incurred by the Unit, and projections for 2009. In addition, as required by the regulations, the report (in this section) includes an evaluation of the Unit’s 2008 performance.

The NYMFCU was highly productive in calendar year 2008. It obtained 143 convictions, the most in the last five years, filed criminal charges against 166 defendants, 68% more than in 2007, and obtained ordered recoveries totaling \$263,486,903, surpassing the totals in 2006 and 2007. In response to fraudulent practices uncovered by the Unit’s continuing investigation of the home health care industry, the Office of the Attorney General submitted a legislative proposal—signed into law in September 2008—creating the state’s first registry of home health and personal care aides. The Unit reached substantial settlements with a certified home health agency, pharmaceutical companies, the largest Medicaid managed care organization in New York State, and hospitals. Additionally, the NYMFCU expanded its use of hidden cameras to uncover and deter the criminal neglect of nursing home residents.

As shown in more detail in the tables in the Appendix to this report, the NYMFCU opened 439 investigations and completed a total of 347. Of the 347 investigations it closed, the Unit resolved 63 through criminal prosecution and 164 as a result of civil actions. It referred seven cases to other agencies and closed 113 due to insufficient evidence. At year’s end, the Unit’s docket included 628 active investigations. Of the 628, 559 are investigations of provider fraud, including 109 stemming from *qui tam* (whistleblower) actions, asserting claims under the New York State False Claims Act, which went into effect on April 1, 2007.

During 2008, the Unit initiated criminal prosecutions against a total of 166 defendants, the second highest number of filings in the last five years and a 68% increase over the 99 filed last year. Of the 166 defendants, 122 were providers accused of fraud and 44 were individuals charged with patient abuse and neglect or misuse of patient funds. The Unit obtained a total of 143 convictions, of which 115 involved provider fraud and 28 involved patient abuse and neglect or misuse of patient funds. The 143 convictions represented the highest number of convictions the Unit obtained during the last five years. The Unit had an overall conviction rate of 94%.

In 2008, the NYMFCU obtained 257 settlements or court orders requiring the payment of \$263.5 million: \$259.6 million in civil damages and almost \$3.9 million in criminal restitution, exceeding the \$59.3 million achieved in 2006 and \$113.8 million in 2007. The Unit collected a total of \$256.2 million in both civil and criminal recoveries.

The Unit continued to attack systemic fraud and focus resources on civil recoveries. Operation Home Alone, our investigation into the home health industry, has uncovered a variety of fraud around the state. This past year, Operation Home Alone resulted in a \$19.7 million civil settlement with a certified home health agency, whose former owner and president was convicted of a felony. The case involved allegations that the company falsified its cost reports. To address the problem of agencies hiring untrained home health and personal care aides who possess fake certificates sold by corrupt schools, at the request of Attorney General Cuomo the legislature passed and the governor signed into law the “New York Certified Aide Registry and Employment Search Act.” The act creates new protections for care-dependent New Yorkers by establishing a central, internet-based registry of aides that includes background information and sworn proof of proper training.

The Unit has also become a more active participant in the National Association of Medicaid Fraud Control Units (“NAMFCU”), which assigns teams to represent states in nationwide investigations. Of the six national settlements concluded in 2008, the NYMFCU was a member of three of the NAMFCU teams and staffed these teams with attorneys, auditors, investigators, and information technology specialists. New York State’s share of these settlements—with pharmaceutical companies—totaled \$157.5 million.

The NYMFCU obtained a \$35 million settlement with Healthfirst, the largest Medicaid managed care provider in New York State, as a result of the company’s violation of its managed care contracts. It also reached settlements of \$24.8 million and \$4.3 million with two New York City area hospitals that resolved allegations involving unlicensed detoxification services.

To protect our state’s most vulnerable residents from abuse and neglect, the NYMFCU, which leads the nation in its use of covert surveillance in nursing homes, arrested and charged six employees of the Medford Multicare Center for Living in Suffolk County based upon evidence derived from a camera secreted in a resident’s room with the consent of the resident’s family. Medford is the fourth nursing home where the NYMFCU has prosecuted defendants on the basis of hidden camera evidence. As of December 31, 2008, the Unit’s ongoing investigation of Medford resulted in criminal charges against eight defendants.

Our challenge in the year ahead is to effectively handle a rising docket of open investigations—spurred by *qui tam* actions filed pursuant to the state’s new False Claims Act—that are complex and resource-intensive. As of December 31, 2008, 17% of the Unit’s open investigations docket consisted of *qui tam* actions. We plan on continuing to focus on large providers and industry-wide investigations, such as Operation Home Alone, work collaboratively with local, state, and federal agencies and the National Association of

Medicaid Fraud Control Units, and achieve systemic changes that will deter fraud and ensure high quality health care for New Yorkers.

Heidi A. Wendel
Director
New York State Medicaid Fraud Control Unit

OPERATIONS

History

Following widespread abuses in the state's nursing home industry, in January 1975 Governor Hugh L. Carey, at the behest of then-Secretary of State Mario M. Cuomo, created the Office of the New York Special Prosecutor for Nursing Homes, Health and Social Services as an independent state agency. On May 2, 1978, after Congress passed legislation establishing the state Medicaid fraud control unit program, the Office of the New York Special Prosecutor for Nursing Homes, Health and Social Services was renamed and reorganized as New York's Medicaid Fraud Control Unit.

In 1995, the New York Medicaid Fraud Control Unit became part of the Office of the New York State Attorney General. With 335 employees, it is today the largest unit within the Criminal Division of the Office of the New York State Attorney General.

Medicaid, created in 1965, is a federal-state program that pays for medical assistance for certain individuals and families with low incomes and resources. Though the federal government establishes general guidelines for the Medicaid program, each state establishes its own program, including eligibility criteria. The New York State Medicaid program currently costs approximately \$46 billion annually and is funded through federal, state and county monies. While the proportion of costs for which the federal government is responsible differs from state to state, federal monies fund 50% of the New York Medicaid program's annual expenditures.

Under federal law, each state must have a Medicaid fraud control unit unless the state demonstrates to the satisfaction of the secretary of the United States Department of Health and Human Services that: 1) such a unit would not be cost-effective because minimal fraud exists in the state's Medicaid program and 2) Medicaid beneficiaries are protected from abuse and neglect. Currently, 49 states and the District of Columbia have Medicaid fraud control units. The U.S. Department of Health and Human Services has certified each year that the NYMFCU meets all federal requirements governing state Medicaid fraud control units.

Under the state Medicaid fraud control unit program, the federal government funds 75% of the NYMFCU's annual budget and New York State is responsible for funding 25%. The NYMFCU's own monetary recoveries comprise the state's share of the Unit's budget.

Jurisdiction

The NYMFCU's mission is to conduct a statewide program for the investigation and prosecution of health care providers and Medicaid administrators who defraud the Medicaid program. The Unit also has jurisdiction to investigate and prosecute those who abuse, neglect or mistreat residents in facilities paid to provide nursing and/or personal care services to one or more unrelated adults. The Unit's jurisdiction extends to all such facilities—regardless of whether the patient is a Medicaid recipient or the facility receives Medicaid money. When Congress created Medicaid fraud control units in 1977, it did so not only because of the evidence of fraud in the Medicaid program, but also because of the horrendous tales of nursing home abuse and victimization.

The NYMFCU holds accountable individuals or corporations who defraud the Medicaid program or abuse residents of health care facilities through both criminal prosecution and civil litigation. To prevent fraud, the NYMFCU makes regulatory recommendations to the New York State Department of Health, which administers the Medicaid program, and the New York State Office of the Medicaid Inspector General, an independent entity within the New York State Department of Health that works to improve and preserve the integrity of the Medicaid program by conducting and coordinating fraud, waste and abuse control activities for all state agencies responsible for Medicaid funded services. In addition, the Office of the New York State Attorney General submits legislative proposals designed to deter fraud to the state legislature. The NYMFCU also makes referrals to New York State licensing agencies so that they can sanction, when appropriate, licensed health care providers.

Organization

The NYMFCU is comprised of seven statewide regional offices located in Albany, Buffalo, Hauppauge, New York City, Pearl River, Rochester and Syracuse, and five other specialized legal, audit and/or investigative sub-divisions and sections: the New York City Patient Protection Section; the Civil Enforcement Division (based primarily in New York City); the Special Projects Division (based largely in New York City and Pearl River); the False Claims Act Section; and the Electronic Investigative Support Group (based in Rensselaer).

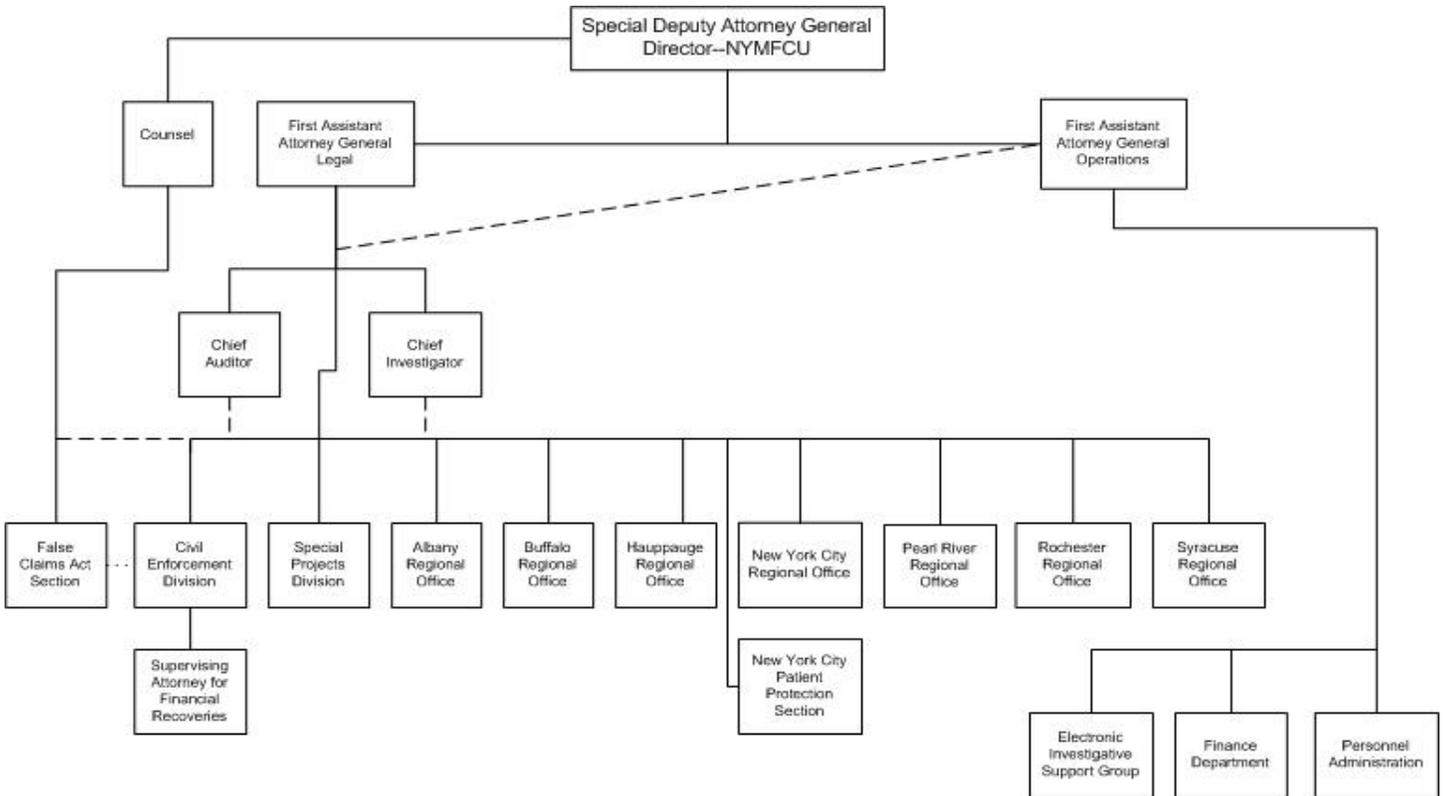
The NYMFCU's regional offices are responsible for criminal investigations involving fraud and patient abuse occurring within the geographic area for which the regional office is responsible. (See map on page 9.) Due to the number of residential care facilities in New York City, however, the NYMFCU established the New York City Patient Protection Section, comprised of attorneys, investigators, and nurse analysts, that focuses exclusively on the investigation and prosecution of patient abuse cases in the five boroughs of New York City.

The Civil Enforcement Division handles complex civil fraud investigations using the New York State False Claims Act, Social Services Law § 145-b, and the Executive Law, and initiates asset forfeiture actions and other actions involving civil remedies. The Special Projects Division, among other responsibilities, joins and takes a leading role in nationwide

teams investigating corporations operating in states across the county. The False Claims Act Section shares responsibility with the Special Projects Division for investigating and, when appropriate, superseding or intervening in *qui tam* (whistleblower) civil actions filed pursuant to the False Claims Act. The Electronic Investigative Support Group (“EISG”) is responsible for housing, organizing, and maintaining state Medicaid claims data required for investigations, conducting complex data queries, coordinating and implementing e-discovery procedures, and managing the Unit’s computer network.

The Unit also includes a Finance Department, which is responsible for the administration of financial recoveries and statewide purchasing, and Personnel Administration, which is responsible for the Unit’s payroll and related functions.

**New York State Medicaid Fraud Control Unit
December 2008**



The Year in Brief

Staffing and Resources

As of December 31, 2008, the Unit employed 335 full-time employees: 55 attorneys, 107 auditors, 95 investigators, five medical analysts, two paralegals, 17 information technology specialists, 36 support staff members assigned to data entry, reception, clerical, and

administrative assistant duties, and 18 employees handling personnel, purchasing, financial collections and inter-governmental affairs. During 2008, the Unit expended a total of \$44,252,612: \$26,706,308 in personal services (salaries), \$9,063,367 in fringe benefits and \$8,482,937 in non-personal services (for example, rent, vehicles, computers and supplies). (Table A-7, Appendix.)

To ensure that the Unit's staff is trained and updated on state-of-the-art investigative and prosecutorial strategies, for the first time in two years the Unit held comprehensive training conferences for its attorneys, auditors, and investigators. Additionally, the Unit sent attorneys, auditors, investigators, medical analysts and information technology specialists to training conferences organized by the National Association of Medicaid Fraud Control Units.

In an effort to recover money from defaulting defendants, in March 2008, the Unit created a Financial Recoveries Department and hired a supervising attorney to organize and oversee the Unit's recovery efforts.

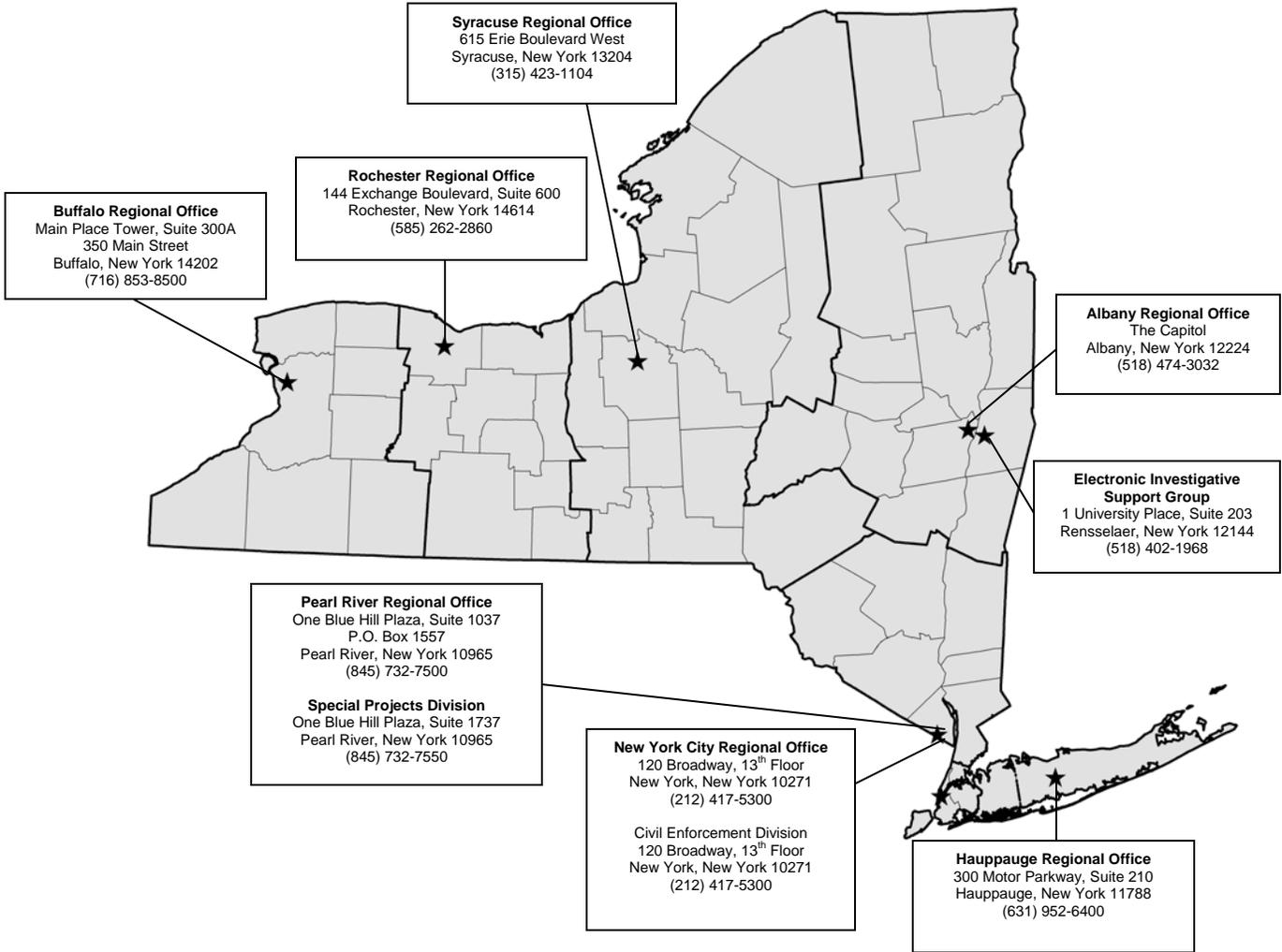
Expanded National Leadership Role in Policing Medicaid Fraud

During 2008, the NYMFCU increased its participation in the activities of the National Association of Medicaid Fraud Control Units (NAMFCU), the professional association of state Medicaid fraud control units. Of the six multi-state and federal global settlements concluded in 2008, the NYMFCU was a member of three of the NAMFCU teams representing the states. New York State's settlements in these six cases resulted in total recoveries of \$157.5 million.¹ As of December 31, 2008, NYMFCU attorneys, auditors, investigators and information technology specialists were assigned to 14 different NAMFCU global case teams and NYMFCU attorneys lead five of these teams.

NYMFCU staffers are also active members of the NAMFCU committees. The NYMFCU's director is a member of the association's executive committee, which manages the association, and two NYMFCU attorneys are members of the association's Global Case Committee, which decides what nationwide cases the NAMFCU pursues. A NYMFCU Special Projects Division attorney is the co-chair of the NAMFCU Qui Tam Subcommittee (whistleblower lawsuits filed pursuant to state and/or federal false claims acts) and the NYMFCU's counsel is also a member of the subcommittee. NYMFCU attorneys, auditors, investigators, medical analysts, and information technology specialists are members of the NAMFCU's Training Committee, Nurse Investigator Working Group, Resident Abuse Committee, and Electronic Systems Working Group. The Unit's staff members also serve as instructors at the NAMFCU's training conferences.

¹ The ordered recovery figures in this report reflect total settlement and restitution amounts. Of the total settlement or restitution amounts, the federal government in most cases is entitled to 50%, which reflects the proportion of New York State Medicaid expenditures it funds. In claims filed pursuant to the New York State False Claims Act, New York State is entitled to an extra 10% of the recovery. In New York State, county governments are partially responsible for the state's share of Medicaid expenditures. As a result, county governments also receive a portion of the state's share of the recovery.

**New York State Medicaid Fraud Control Unit's Statewide Offices
December 2008**



PROVIDER FRAUD PROSECUTIONS AND CIVIL ACTIONS

Statistical Overview²

In 2008, the Unit opened 439 Medicaid fraud investigations and resolved 347. Thirty-six of the cases were resolved through prosecutions and 164 as a result of civil settlements or actions. (See Tables A-1 and A-2, Appendix.) As of December 31, 2008, the Unit had 559 open fraud investigations, of which 109 are *qui tam*, or whistleblower, complaints filed pursuant to the New York State False Claims Act, which went into effect on April 1, 2007. In fraud cases, the NYMFCU filed criminal charges against 122 defendants and obtained convictions against 115, the highest number of fraud convictions during the last five years. Charges against five defendants were dismissed. No defendants were acquitted. (See Table A-4, Appendix.) The Unit obtained orders and settlements of Medicaid restitution totaling \$263.5 million, substantially higher than the \$113.8 million in 2007 and the \$59.3 million achieved in 2006. (See Table A-6.)

This section highlights some of the more significant fraud cases the NYMFCU brought, participated in and/or resolved in 2008.

Home Health Care: Operation Home Alone

During 2008, the NYMFCU continued to aggressively fight fraud in the home health care industry. The Unit's efforts resulted in significant prosecutions and convictions, civil settlements and the passage of the "New York Certified Aide Registry and Employment Search Act," which established the state's first-ever registry of home health and personal care aides. As reflected in the cases described in this section, Operation Home Alone has exposed a range of fraudulent practices and schemes around the state that cost taxpayers millions of dollars and in some cases, compromise patient care.

Medicaid-reimbursed home health care involves a myriad of services, programs, and employment arrangements involving skilled nurses, home health aides, and personal care aides. Operation Home Alone is far-reaching: the NYMFCU has obtained convictions of aides, nurses, schools, and licensed home health care service agencies, and ordered restitution of more than \$14 million. The Unit has also reached civil settlements with certified home health agencies totaling \$27.7 million.

² Prior years' statistical data included in this report may differ slightly from data previously reported due to efforts to present the most up-to-date data available.

Due to state initiatives designed to improve care and reduce costs—by emphasizing home care rather than institutional care—the number of Medicaid patients receiving home health care has grown significantly. Every month, more than 150,000 New Yorkers receive some sort of Medicaid-funded home health services. In 2007, Medicaid spent approximately \$3.8 billion on home health care throughout the state. Because these services are provided outside an institution and therefore are difficult to supervise, home health care is particularly prone to fraud.

Corrupt Training Schools Provided Falsified Certificates to Untrained Aides Employed by Licensed Home Health Care Service Agencies

The NYMFCU's investigation into home health agencies, home health aide training schools and home health aides has uncovered a New York City-based network of aides who possessed bogus certifications, schools that sold certificates without providing adequate training, and licensed home health care service agencies that knowingly hired unqualified aides, resulting in millions of dollars in unlawful Medicaid billings. Thus far, the NYMFCU has charged more than 100 such defendants and obtained convictions against approximately 75, including school owners and administrators, licensed home health care service agencies and their owners, home health and personal care aides, nurses, Medicaid recipients, and intermediaries linking would-be aides and schools and licensed home health care service agencies. In 2008, the Unit obtained convictions of approximately 49 defendants in the industry engaged in fraud involving false certifications.

Under the New York State Medicaid program, physicians must certify that individuals require home health care and the level of care needed. Home health services for Medicaid patients may only be provided by aides who have successfully completed a state-licensed training program. Home health aides, who provide a variety of services that may include catheter and colostomy care, wound care and the administration of certain medications, are required to receive a minimum of 75 hours of training, including 16 hours of supervised practical training conducted by a registered nurse. Personal care aides, who assist patients with personal hygiene care, nutrition and meal preparation, are required to take a 40-hour basic training program and receive three hours of semi-annual in-service training. The Unit's investigation, however, discovered that hundreds of individuals in the New York City area purchased bogus certificates falsely certifying that they had been trained to provide home health services. These false certificates were mass-produced and sold by corrupt school owners and their employees. Armed with fraudulent certificates, the unqualified individuals secured work with licensed home care services agencies as home health aides or personal care aides.³

The NYMFCU's investigation also found examples of unqualified aides causing Medicaid to be billed without ever appearing at the patient's home and splitting their pay with complicit Medicaid recipients.

³ Licensed agencies do not directly bill Medicaid for the aides they employ, but instead contract to supply the aides to certified home health agencies and long-term home health care plans, which bill Medicaid for the services performed by the unqualified workers. Services provided by uncertified aides are not eligible for Medicaid reimbursement.

People v. B & H Health Care Services, Inc.—Licensed Home Health Care Service Agency and Its Part-owner Charged with Knowingly Employing Untrained Aides

During 2008, the NYMFCU obtained an indictment charging Brooklyn-based B & H Health Care Services, Inc., known as Nursing Personnel Home Care, and its part-owner and president, Walter Greenfeld, with grand larceny in the first degree and three counts of offering a false instrument for filing in the first degree. According to the charges, Nursing Personnel, a licensed home health care service agency, and Greenfeld knew that home health aides they employed and for whom they caused Medicaid to be billed had not received the requisite home health aide training.

At the same time, the Unit filed a civil lawsuit against Nursing Personnel, Greenfeld and 16 other Nursing Personnel shareholders seeking money Medicaid paid for untrained aides employed by Nursing Personnel. In related indictments, the NYMFCU filed criminal charges against several Nursing Personnel marketers and coordinators, who actively recruited untrained aides and allegedly arranged for the aides to receive certifications from corrupt training schools without the requisite training. The Unit also obtained indictments against and charged 23 aides.

The criminal charges and civil lawsuit against Nursing Personnel and Greenfeld are pending.

People v. Melody McKnight—Defendant Sold Personal Care Aide Certificates to Undercover Officer

While Operation Home Alone uncovered a network of corrupt home health training schools, aides and licensed home health care service agencies based in New York City, it also resulted this past year in the conviction of Melody McKnight, who sold bogus personal care aide certificates while working for an in-home health care training and services company in Buffalo.

As an employment recruiter with WillCare, Inc., Melody McKnight interviewed an undercover officer who had applied for a job with WillCare. Over the course of two months, McKnight sold the undercover officer a personal care aide certificate, which reported the undercover had successfully completed the personal care aide training program at Staff Builders Health Care Services, a phony medical report indicating the officer was physically fit for work at WillCare, and gave the officer a bogus personal care aide certificate for the officer's "friend." Prior to her arrest, McKnight also agreed to sell the officer two more personal care aide certificates for two other "friends" and to have sex with the officer for \$200 at a Buffalo hotel.

On April 1, 2008, McKnight pleaded guilty to attempted forgery in the second degree, a felony, and commercial bribe receiving in the second degree; on June 10, 2008, she was sentenced to five years' probation and ordered to repay \$950 to the Unit.

At the Request of Attorney General Cuomo, State Legislature Passed and Governor Signed Into Law “New York Certified Aide Registry and Employment Search Act,” Establishing Registry of Home Health and Personal Care Aides

On September 25, 2008, the “New York Certified Aide Registry and Employment Search Act,” which was introduced at the request of Attorney General Cuomo, was signed into law. The act creates new protections for care-dependent New Yorkers by establishing, through the New York State Department of Health, a central internet-based registry of home health and personal care aides that includes background information and sworn proof of proper training. The act will be effective on September 25, 2009.

The New York Certified Aide Registry and Employment Search Act addresses the problem of unqualified aides working with invalid training certifications. It requires senior officials of state-certified training programs to provide proof that they have verified the true identity of each person successfully completing a home health training program and certify to the Department of Health, under penalty of perjury, that the aide completed the required training. The new law also requires home care agencies to review the registry prior to allowing a worker to begin providing home care services. The registry will include the following information regarding the aide:

- The aide’s name, address, sex, and date of birth;
- The name of each state-approved education or training program and the date the aide successfully completed the program;
- The aide’s employment history in home care services;
- Final findings of prior instances of physical abuse, mistreatment, neglect, or misappropriation of a patient’s property;
- Any prior determination by the Department of Health that the person was approved or disapproved for employment in connection with a check of criminal history information.

Subject to federal law regarding dissemination of criminal records, the information in the registry (excluding the aide’s address and date of birth) will be available to members of the public.

The New York Certified Aide Registry and Employment Search Act extends the same protections that exist on behalf of nursing home patients to persons requiring care in their homes. The registry will permit the Department of Health, for the first time, to track the number and identity of home health and personal care aides working in New York. A similar registry already exists for certified nurse aides who work in nursing homes.

Family Aides Home Care Companies Reached \$19.7 Million Settlement to Resolve Allegations of Overbilling; Former Owner and President Convicted of Stealing Medicaid Dollars

Following a multi-year investigation and audit, William C. Schnell, the former owner, president, and sole shareholder of Family Aides, Inc., Family Aides Certified Services of

New York City, Inc., and Family Aides Certified Services of Nassau, Suffolk, Inc., pleaded guilty to grand larceny in the third degree on April 19, 2007. On August 18, 2008, the court sentenced Schnell to a conditional discharge and ordered him to pay restitution of \$212,118 and penalties of \$424,236. Schnell is now barred for life from participating in the Medicaid and Medicare programs. The NYMFCU also obtained from the Family Aides companies, which employ thousands of workers and serve patients in the New York metropolitan area and Long Island, a \$19.7 million settlement that resolved overbilling allegations.

Schnell admitted to giving his ex-wife a no-show job and submitting to the New York State Department of Health a certified home health agency cost report that falsely stated that the costs of his ex-wife's salary were related to the provision of patient care services, causing Medicaid to pay money to which the company was not entitled.

The rates at which Medicaid reimburses certified home health agencies like the Family Aides home care companies—enrolled providers of personal care and nursing services—are based upon annual cost reports filed with the New York State Department of Health. Using allowable costs and statistics regarding number of visits or hours of service, the Department of Health calculates the reimbursement rates (e.g., hourly home health aide rates) providers can bill Medicaid. Allowable costs are defined by regulation and cost reports must be filed in accordance with those regulations and cost report instructions. Inflating allowable costs upon which hourly rates are based can lead to improper Medicaid payments.

Based upon an audit of the cost reports filed by Schnell and the Family Aides home care companies from 1997 through 2004, the NYMFCU concluded that the companies received Medicaid monies to which they were not entitled as a result of cost reports that incorporated non-allowable expenses. The NYMFCU found, for example:

- costs attributed to the salary and fringe benefits of no-show or ghost employees;
- costs attributed to accrued vacation leave that did not exist;
- excessive salary expenses and bonuses for the owner and key employees;
- costs attributed to the owner's investment in the company;
- failure to offset expenses with the revenue received for those expenses; and
- the same costs on different annual cost reports.

In June 2008, the Family Aides home care companies—the stock of which was transferred to blind trusts out of Schnell's control—finalized the \$19.7 settlement to resolve the overbilling allegations raised primarily by their cost reports.⁴

⁴ Although the settlement was signed in June 2008, the Family Aides companies paid \$14.1 million to the New York State Medicaid Fraud Control Unit Restitution Fund and conceded liability for the full \$19.7 million in 2007. As a result, the NYMFCU considered the \$19.7 million as an ordered recovery that occurred in 2007 rather than in 2008.

Holistic Home Care Agency Charged with Stealing More than \$1 Million from Medicaid by Billing for Individuals Not Licensed to Practice as Nurses in New York State

In December 2008, the NYMFCU filed an indictment charging Holistic Home Care Agency, a certified home health agency and licensed home care services agency in New York City, and its owner and administrator, Julianna Nwaogu, with grand larceny in the first degree and 45 counts of offering a false instrument for filing in the first degree. In addition, the indictment charged Nwaogu with aiding and abetting three or more persons with the unauthorized practice of a profession (nursing). At the same time, the Unit arrested and charged 16 others—individuals Holistic employed who allegedly lacked New York State nursing licenses—with unauthorized practice of a profession and grand larceny in either the second or third degree.

The NYMFCU's investigation of Holistic Home Care, whose patients were frequently severely disabled children, revealed that Nwaogu secured employees through advertisements in professional publications and referrals. She interviewed potential employees, questioned them about their professional licensing and allegedly offered individuals employment as licensed practical nurses and registered nurses regardless of whether they were licensed in New York State.⁵

The Unit's investigation discovered that Holistic and Nwaogu billed Medicaid approximately \$1.2 million for 26 individuals not licensed to practice nursing in New York State. More arrests are expected and the criminal charges against Holistic, Nwaogu and other individual defendants are pending.

Home Care Nursing Services Company Agreed to Repay \$2.2 Million in Medicaid Overpayments

On December 1, 2008, Queens-based Harry's Nurses Registry, Inc., which provides skilled nursing services in patients' homes in New York City and Long Island, agreed to repay \$2.2 million in Medicaid overpayments based upon claims the company submitted from December 1, 2002, to December 31, 2006.

The Unit's audit of the company's billing records revealed that Harry's overbilled the Medicaid program in primarily two ways. First, Harry's submitted claims that overstated the rates at which licensed practical nurses ("LPN") and registered nurses ("RN") could be billed pursuant to a program that entitles chronically sick and disabled children under the age of 18 to skilled nursing care. Under this program, the New York State Department of Health fixes hourly rates for LPN and RN services that vary county by county. Rather than

⁵ While some individual defendants had worked as nurses in other countries, were or had been licensed in other states, and/or were in the process of getting New York State licenses, Medicaid regulations do not allow providers to bill for nursing services performed in state by individuals not licensed as nurses in New York State.

bill Medicaid for the pre-established rates for the nursing services provided in the recipients' respective counties, however, Harry's routinely submitted invoices seeking reimbursement at highly inflated rates. Second, Harry's received overpayments as a result of claims submitted on behalf of registered nurses when, in fact, Harry's provided licensed practical nurses, whose hourly rates are lower than RNs. (Physicians approved these patients for LPN services, though Medicaid approved the same patients for RN care.)

The NYMFCU also determined that Harry's received overpayments by billing for services not provided, including services that could not have been rendered because recipients were hospitalized, and by billing for an RN, Jocelyn Louis, whose license was invalid. The Unit's investigation of Harry's Nurses Registry arose from its investigation and successful prosecution of Louis, who in 2005 pleaded guilty to grand larceny in the third degree and was sentenced to two years in prison and ordered to pay restitution in the amount of \$549,811.

People v. Charles Zizi and Ricardo Francois: Defendants, Who Ran Certified Home Health Agency, Convicted of Stealing More than \$314,000 from Taxpayers

The Unit successfully partnered with the Nassau County District Attorney's Office to investigate, prosecute and sue Charles Zizi, the former operator of Always There Homecare, and Ricardo Francois, the home care agency's former billing manager. Zizi and Francois committed a litany of Medicaid-related and other crimes that bankrolled their extravagant lifestyles. Always There provided home care services to children and adults with ailments including cerebral palsy, muscular dystrophy, mental retardation, seizure disorders, quadriplegia, spasms and pulmonary diseases. The Zizi and Francois case, which resulted in convictions during 2008, was the first to be brought by the New York State-Nassau County joint Medicaid fraud task force created in 2007. The task force operates pursuant to an agreement between the Office of the Attorney General and the Nassau County District Attorney's Office. The agreement calls for the cooperative investigation and prosecution of Medicaid provider fraud and provides for the shared administration and supervision of these joint endeavors.

Zizi pleaded guilty on May 14, 2008, and admitted to stealing more than \$314,000 from Medicaid by submitting false claims for services Always There either never provided or provided in areas where it was not licensed to operate. For example, Zizi inflated his nurses' hours of service and billed Medicaid for the maximum price of authorized services rather than for the actual services rendered. In addition, Zizi admitted to using the stolen money to pay various personal expenses, including payments for purchases made with a corporate credit card in the names of Always There and the company's original owner that Zizi had obtained through identity theft. Zizi also admitted to fraudulently obtaining with Francois a home equity line of credit from the Nassau Credit Union. Zizi pleaded guilty to two counts of second-degree grand larceny, one count of third-degree grand larceny, one count of first-degree identity theft and one count of fourth-degree money laundering, all felonies. On January 5, 2009, Zizi was sentenced to six months of incarceration, five years' probation and required to pay restitution of \$381,953.

On December 23, 2008, Francois was sentenced to five years' probation and ordered to pay restitution of \$50,000 following his April 2008 plea to two counts of grand larceny in the second degree. Francois admitted to helping Zizi defraud Medicaid by submitting the falsified claims and to filing fraudulent documents in order to obtain the credit union loan.

People v. Juanita Orji: Licensed Practical Nurse Defrauded Medicaid by Billing for Home Nursing Services 24 Hours a Day for Nearly Two Years

On the eve of trial, Juanita Orji, a licensed practical nurse, pleaded guilty on November 25, 2008, to grand larceny in the third degree, a class D felony. She is scheduled to be sentenced during 2009 to five years' probation and restitution of \$154,135.

From January 2003 through 2007, Orji, an enrolled Medicaid provider, submitted fraudulent claims to Medicaid involving three home-bound patients in her care. For one patient completely disabled by multiple sclerosis, Orji defrauded Medicaid by submitting false home nursing pre-approval forms to the Westchester County Department of Social Services. In these forms, Orji listed the names and provider numbers of other nurses who, along with Orji, would care for the patient. However, these nurses never cared for the patient and were unaware that Orji included their identifying information in the forms. Orji falsified the forms to ensure approval because the local department of social services would not grant approval in the absence of a sufficient number of nurses to provide quality care. In addition, Orji repeatedly submitted claims that she provided skilled nursing services to the patient 24 hours per day, which was not permitted by applicable regulations. The regulations limit home nursing care to 16 hours a day per nurse—a rule intended to ensure quality of care.

With respect to two other patients, Orji also stole from Medicaid by billing for hours she never actually worked and by again billing Medicaid in excess of 16 hours per 24-hour period.

People v. Suzan Sheldon, Anna Reid, Michele Schug and Monica Webster: Nurses Convicted of Lying about Nearly \$250,000 in Billings for a Home-bound Young Adult Patient

During 2008, the NYMFCU obtained convictions of registered nurse Anna Reid and licensed practical nurses Suzan Sheldon, Michele Schug and Monica Webster for falsely billing Medicaid for the care of a home-bound patient in Onondaga County during times when they were out of the country on vacation, when the patient was receiving care from her parents, and when the patient was in the care of another nurse.

At various times between 2001 and 2005, all four defendants cared for the same patient, a young adult with cerebral degeneration and pulmonary collapse who requires around-the-clock home care nursing services. While the patient's parents provided up to 12 hours of care daily, the nurses routinely split up among themselves the billing for those hours. The Unit's investigation and audit, which was prompted by a complaint by the recipient's mother

after she received and reviewed an Explanation of Medical Benefits mailing, found nearly \$250,000 in payments for services that were not rendered.

All four defendants pleaded guilty to felony charges and were ordered to pay restitution. Sheldon, Schug, and Webster pleaded guilty to grand larceny in the third degree. The court sentenced Schug to six months' incarceration, five years' probation and restitution of \$77,000; Sheldon to 60 days' incarceration, five years' probation, and \$65,135 in restitution; and Webster to 90 days' incarceration, five years' probation and repayment of \$58,098. In July 2008, Reid pleaded guilty to grand larceny in the fourth degree and was sentenced to a conditional discharge and ordered to pay \$15,966 in restitution.

Personal Assistants Charged with Billing Medicaid When They Were Playing Bingo and Running Errands; They Stole Nearly \$5,000 for Services Not Provided to Paraplegic Patient

On November 25, 2008, the NYMFCU arrested and charged four personal assistants—Loretta Lowrie, Petrina Mason, Priscilla McCauley and Denise Wright—with falsifying time sheets, causing their employer to file false Medicaid claims and receive Medicaid monies to which it was not entitled.

The Center for Disability Rights employed the defendants as personal assistants and assigned them to provide home care to a paraplegic Medicaid recipient who participates in the state Medicaid's Consumer Directed Personal Assistance Program. The Unit's surveillance of defendants, which took place over a nine-month period in 2007 and 2008, and audit of records from the Center for Disability Rights, as well as Medicaid billings, revealed that the aides claimed in their timesheets that they provided care when in fact they played bingo, ran errands or were at home. Collectively, they bilked Medicaid out of \$4,735.

The Unit charged each defendant with falsifying business records in the first degree and offering false instruments for filing in the first degree, both class E felonies. Mason and Wright were also charged with grand larceny in the fourth degree, a class E felony, and Lowrie and McCauley were charged with petit larceny, a class A misdemeanor.

On December 10, 2008, and December 16, 2008, respectively, Lowrie pleaded guilty to petit larceny and Wright pleaded guilty to petit larceny and falsifying business records in the second degree, all class A misdemeanors. On February 4, 2009, Lowrie was sentenced to three years' probation, 30 hours of community service, and ordered to make restitution of \$756 to the Center for Disability Rights. On February 10, 2009, the court sentenced Wright to 26 weekends in jail, a one-year conditional discharge, and ordered her to pay restitution of \$747 to the Center for Disability Rights. The charges against Mason and McCauley are pending. The Center for Disability Rights has already repaid the \$4,735 to the Medicaid program.

Pharmaceutical Manufacturers and Distributors

In 2008, the NYMFCU reached six settlements with major pharmaceutical companies as a result of joint federal and multi-state investigations. In these complex and time-consuming cases, the NAMFCU appoints a team that collaborates and works jointly with the United States Department of Justice in investigating and resolving multi-state allegations of Medicaid fraud.

Of the six settlements reached in 2008, the NYMFCU was a member of three of the NAMFCU teams and staffed these teams with attorneys, auditors, investigators, and/or information technology specialists. The six settlements with New York State resulted in total recoveries of \$157.5 million.

Bristol-Myers Squibb Company's Pharmaceutical Pricing and Marketing Resulted in \$41 Million Settlement with New York State

The NYMFCU participated in a five-state team of the NAMFCU that investigated the Bristol-Myers Squibb Company's ("BMS") alleged fraudulent conduct and worked with the federal government in reaching a \$389 million national settlement with BMS and its former wholly-owned subsidiary Apothecan, Inc. The allegations against the company involved illegal drug marketing and fraudulent pricing of prescription medications. New York State received \$41.35 million of the settlement amount.

Forty-nine New York counties that sued BMS over allegations that BMS inflated prices for prescription drugs also participated in the settlement.

The settlement, announced in July 2008, addressed allegations that BMS engaged in a number of improper marketing and pricing practices, including:

- Reporting inflated prices for various prescription drugs, knowing that Medicaid and various federal health care programs would use these reported prices to pay for BMS and Apothecan products used by their recipients;
- Paying illegal remuneration to physicians, health care providers, and pharmacies to induce them to purchase BMS and Apothecan products;
- Promoting the sale and use of Abilify, an antipsychotic drug, for pediatric use and for treatment of dementia-related psychosis, uses which the federal Food and Drug Administration has not approved; and
- Misreporting sales prices for Serzone, an antidepressant, resulting in the improper reduction of the amount of rebates paid to the state Medicaid programs.

The settlement reimburses the federal government and the participating states for excessive amounts paid by Medicaid programs as a result of BMS's conduct. As part of the settlement, BMS also entered into a corporate integrity agreement with the Office of the Inspector General of the U.S. Department of Health and Human Services, under which BMS is required to report accurately its average sales prices and average manufacturers' prices.

As Part of \$649 Million National Settlement, Merck Reached \$72 Million Settlement with New York for Failing to Pay Medicaid Drug Rebate

In February 2008, New York State received \$72.2 million as part of two separate global settlements totaling \$649 million with Merck & Co., Inc. In the settlement agreements, Merck, the manufacturer of the drugs Zocor, Vioxx, and Pepcid, resolved allegations that the company failed to pay rebates due to state Medicaid programs under the federal Medicaid drug rebate statute for these drugs. The settlements also resolved claims filed by whistleblowers in the United States District Court for the Eastern District of Pennsylvania, the United States District Court of Nevada, and the Eastern District of Louisiana.

Pharmaceutical manufacturers that supply products to Medicaid recipients are required by the federal Medicaid drug rebate law to give Medicaid programs the benefit of the “best price” available for those products. The manufacturers are required to file “best price” information with the Centers for Medicare and Medicaid Services (“CMS”). This information is then used to calculate rebates to be paid by these manufacturers to the state Medicaid programs. In general, as the “best price” gets lower, the rebate obligation increases. The federal law requires the “best price” reported by the manufacturers to include discounts. However, discounts that are considered “merely nominal” are exempted from the reporting requirement. The states have maintained that a discount is not “merely nominal,” and therefore must be reported, if it is tied to any conditions, such as volume purchase requirements or market shares.

The question of what “merely nominal” means, and how those prices impact the rebates owed to the states, arose in the cases that were pending in Pennsylvania and Nevada as a result of two company discount programs through which Merck tried to use the nominal price exception. At the heart of these programs was an agreement that Merck would sell the drugs to hospitals at a 92% discount from the catalog price, but only if the hospitals reached certain market shares for the drugs. Because the 92% discounts were conditioned on the hospitals’ volume purchases and reaching certain market shares, the states contended that the resulting discounted prices were not “merely nominal.” Therefore, the states contended that Merck was required to report these discounted prices to CMS, and that their failure to do so resulted in less rebates paid to the state Medicaid programs.

The case in Louisiana involved Merck’s drug Pepcid, and another discount program, under which Merck sold various formulations of Pepcid to hospitals in bundled pricing arrangements. In exchange for the hospital meeting a certain market share or other purchase requirements, Merck gave hospitals an array of discounts of up to 92% on Pepcid tablets, and lesser discounts on other types and formulations of Pepcid. According to the government, the transactions under the program constituted “bundled sales,” which required Merck to adjust “best price” among the different formulations to reflect these discounts. The states contended that Merck failed to reflect these discounts in their “best price” reports, resulting in less rebates paid to the state Medicaid programs.

In addition to the monetary recovery, Merck entered into a corporate integrity agreement with the United States Department of Health and Human Services’ Inspector General. The

corporate integrity agreement includes provisions that will ensure that Merck will market, sell, and promote its products in accordance with all federal health care program requirements.

New York State Recovered \$36 Million from Cephalon Due to Off-label Drug Marketing

New York State reached an agreement with Cephalon, Inc., based in Pennsylvania, to settle allegations of improper off-label marketing of three pharmaceutical products. Cephalon paid the states and the federal government \$375 million in damages and penalties, of which New York received \$36.5 million in December 2008. The settlement reimburses the federal government and the participating states for Medicaid payments made as a result of Cephalon's improper off-label marketing campaign.

The settlement resolves allegations that Cephalon engaged in improper off-label marketing of the drugs Provogil, Gabitril, and Actiq.

In addition to the monetary terms of the settlement, Cephalon pled guilty to a misdemeanor charge of misbranding in violation of the Food, Drug, and Cosmetic Act, and as part of the plea agreed to pay a \$50 million criminal fine. The company also agreed to the terms of a corporate integrity agreement, which will be implemented and monitored by the Office of the Inspector General for the U.S. Department of Health and Human Services.

CVS/Caremark Paid New York \$2.75 Million for Switching Prescribed Drug from Tablet Form to More Expensive Capsules

The NYMFCU joined a five-state team from the National Association of Medicaid Fraud Control Units, which investigated and negotiated, along with federal authorities, a \$36.7 million settlement with CVS/Caremark Corporation to settle allegations of billing improprieties on behalf of 23 states and the District of Columbia. Under the terms of the settlement, in March 2008, New York State recovered \$2.75 million. CVS/Caremark, which currently operates retail pharmacies in 38 states, furnishes pharmacy services to Medicaid members throughout New York State.

The settlement resolved allegations that from April 1999 through 2006, CVS filled prescriptions for numerous Medicaid recipients by systematically switching dosage forms of the anti-ulcer medication ranitidine (the generic form of Zantac) from tablets to the higher-priced capsule form of the drug without physician involvement, violating various federal and state statutes and regulations. Substituting ranitidine capsules for tablets resulted in higher payments under the automated Medicaid reimbursement system, with no corresponding medical benefit to the individuals receiving the prescriptions.

In addition to the payment of cash settlements to the state and federal governments, CVS/Caremark agreed to the terms of a corporate integrity agreement with the Office of the Inspector General of the United States Department of Health and Human Services. This agreement includes provisions that will ensure that CVS will not switch dosage forms of medications if the result would increase the costs to third-party payers, including Medicaid, and will subject the company's billing practices to ongoing federal scrutiny.

New York State Reached \$3.6 Million Settlement with Aventis for Drug Pricing Scheme

The NYMFCU reached a \$3.6 million dollar settlement with Aventis Pharmaceuticals, Inc. as part of a \$22.7 million nationwide settlement involving the United States, the District of Columbia, and 38 states. The settlement resolved claims that Aventis defrauded the states' Medicaid programs through its drug pricing and marketing practices. The NYMFCU was a member of the NAMFCU's team that represented the states and the District of Columbia in the joint investigation and settlement negotiations.

The national investigation, which arose from a whistleblower lawsuit, focused on allegations that Aventis reported false and fraudulent average wholesale prices of its drug, Anzemet, used in oncology and radiation treatment to prevent nausea and vomiting, thereby causing false claims to be submitted to federally funded health care programs.

From September 1, 1997, through June 30, 2004, Aventis allegedly "marketed the spread" on Anzemet to increase market share for Anzemet and its own profits. The "spread" is the difference between the discounted price healthcare providers (pharmacies, hospitals, clinics, etc.) actually pay a pharmaceutical company for a drug, and the amount Medicaid programs reimburse healthcare providers for the drug, which is based upon the reported average wholesale price ("AWP"). Under the scheme, the Aventis inflated the AWP, increasing the spread, which the healthcare providers kept. Aventis marketed the spread between the AWP and the discounted price as a way of increasing the healthcare providers' profits when they received reimbursement from Medicaid for the drug.

Under the terms of the federal and state civil settlements, Aventis also agreed to the terms of a corporate integrity agreement with the Office of the Inspector General for the U.S. Department of Health and Human Services to ensure Aventis' future compliance with price reporting requirements.

Managed Care Organizations

Largest New York State Medicaid Managed Care Provider Reached \$35 Million Settlement for Violating Contracts with State and Local Government Agencies

Following an intensive multi-year investigation, in September 2008 the NYMFCU reached a \$35 million settlement with Healthfirst, the largest Medicaid managed care provider in New York State. The NYMFCU's investigation centered on Healthfirst's practice from 1999 through 2003 of compensating its marketing representatives based on productivity, in violation of its contracts with state and local government agencies, and Healthfirst's false statements to those agencies about its marketing practices.

Managed care organizations have state contracts to provide or arrange for health services to Medicaid and Family Health Plus patients. Since 1996, Medicaid payments to managed care organizations rose from approximately \$1 billion to over \$7 billion in 2007, as they are playing an expanded role in providing healthcare to uninsured New Yorkers.

Healthfirst violated its Medicaid managed care contract by paying bonuses or other compensation incentives to its employees based on the number of people Healthfirst enrolled from 1999 to September 2003. At the time, the Medicaid managed care contract prohibited such compensation. Healthfirst also filed marketing plans with New York City and the New York State Department of Health, as well as local social services districts in Nassau and Suffolk Counties, which falsely represented that its marketing representatives were compensated based solely on qualitative criteria, when in fact its bonuses and other compensation incentives were based on productivity. By this conduct, Healthfirst violated the integrity of the enrollment process.

Healthfirst, which cooperated with the NYMFCU's investigation, disclosed certain matters concerning improper compensation practices and enrollment fraud committed by certain of its former marketing representatives. Healthfirst also replaced its senior management, hiring a new president, chief executive officer, and chief operating officer. In addition, it commenced an extensive review of past and current practices, and demonstrated its commitment to comply with all of its contractual obligations.

In May 2008, the NYMFCU also filed an indictment charging James Boothe, Healthfirst's former executive vice president and chief operating officer, with causing Healthfirst to submit false marketing plans to the state and to local government agencies, which concealed the fact that Healthfirst was compensating its marketing representatives based on productivity. The criminal case is currently pending.

Hospitals and Hospices

Staten Island University Hospital Agreed to \$24.8 Million Settlement to Resolve Allegations That It Submitted False Medicaid Claims for Treatment Provided by Unlicensed Detoxification Unit

In September 2008, the NYMFCU reached a settlement with Staten Island University Hospital and S.I.U.H. Systems, Inc. (collectively, "SIUH"), resolving a whistleblower lawsuit alleging that SIUH defrauded the Medicaid program. Under the terms of the settlement, SIUH will return \$24,806,471 to Medicaid. Of this amount, New York State will receive \$14,883,883.

The settlement resolved allegations that SIUH knowingly presented, or caused to be presented, false claims to Medicaid for reimbursement for inpatient detoxification treatment provided in a special unit within the hospital, for which SIUH had not obtained a certificate of operation from the New York State Office of Alcoholism and Substance Abuse Services ("OASAS").

The settlement is the result of a joint investigation conducted by the NYMFCU and the United States Attorney for the Eastern District of New York into allegations made by a physician who formerly worked at SIUH. The doctor filed a "whistleblower" complaint under the New York False Claims Act, which authorizes persons who have uncovered fraud

against New York State to file a civil action against the alleged wrongdoer and come forward with information about the false claims to the New York State Attorney General's Office. The False Claims Act provides an incentive to whistleblowers under which the person who filed the complaint may share in a portion of money recovered by the State on the claims and provides whistleblowers with protection from job retaliation.

Our Lady of Mercy Medical Center Reached \$4.3 Million Settlement to Resolve Allegations of Operating Unlicensed Detoxification Program and Paying Kickbacks for Patient Referrals; Lawsuits Filed against Other Hospitals

On July 15, 2008, the NYMFCU and the United States Attorney's Office for the Eastern District of New York reached a \$4.3 million settlement with Our Lady of Mercy Medical Center of the Bronx (now the North Division of Montefiore Medical Center). The settlement resolved allegations that the hospital violated both federal and state False Claims Acts by presenting false claims to Medicaid from February 25, 1998, through April 24, 2006. Pursuant to those claims, the hospital received Medicaid payments to which it was not entitled because it operated an inpatient detoxification service without having the requisite state license and it paid for the referral of patients in violation of federal and state anti-kickback statutes.

The settlement resulted from two whistleblower civil suits that were initially filed in 2002 pursuant to the federal False Claims Act. With the passage of the New York State False Claims Act in April 2007, the plaintiffs amended the complaints to add claims under the state act. The NYMFCU conducted an investigation of the complaints, working jointly with the U.S. Attorney's Office for the Eastern District of New York. New York State intervened in the suits on July 7, 2008, and subsequent to the settlement with Our Lady of Mercy Medical Center, filed complaints on behalf of New York State on October 8, 2008, against other named defendants. The lawsuit is pending.

The NYMFCU's lawsuit names as defendants SpecialCare Hospital Management Corporation and its Chief Executive Officer Robert McNutt, and seven New York hospitals: Benedictine Hospital, Columbia Memorial Physicians Hospital Organization, Inc., Long Beach Medical Center, New York Downtown Hospital, Parkway Hospital, New Parkway Hospital, and Saint Joseph's Medical Center. The complaint alleges that from 2002 through 2006, each hospital lacked the license required by the OASAS for the inpatient detoxification services they provided and billed Medicaid for inpatient detoxification services that were not medically necessary and/or failed to meet professionally accepted standards. As alleged in the complaints, the hospitals presented more than 14,000 false claims to Medicaid, in that the hospitals certified that they had provided the services in compliance with all relevant laws and regulations.

In addition, the complaints allege that Columbia Memorial, Long Beach, New York Downtown and St. Joseph's engaged in an unlawful kickback scheme with SpecialCare and McNutt to obtain patients for the detoxification programs. The complaints allege that these hospitals entered into purported administrative services agreements with SpecialCare, ostensibly to provide management and administrative services related to each hospital's detoxification program. In reality, the purported "administrative services agreements"

embodied SpecialCare's illegal referral of Medicaid patients to each hospital for a fee, violating anti-kickback laws. Specifically, the complaints assert that SpecialCare recruited Medicaid recipients from purported storefront assessment centers, the street, homeless shelters and soup kitchens—many of whom did not need emergency detoxification service—and transported them to the defendant hospitals.

Erie County Medical Center Corporation Overcharged Medicaid \$2.5 Million for Drugs It Dispensed to Outpatients

The NYMFCU recovered \$2,491,192 from Erie County Medical Center, which overcharged the Medicaid program for pharmaceuticals it dispensed to seniors and low-income patients from 2002 through 2006. The hospital fully cooperated with the NYMFCU's investigation.

The March 2008 settlement with Erie County Medical Center is the first stemming from an ongoing statewide investigation of hospitals that participate in the 340B drug pricing program. The 340B drug pricing program provides deeply-discounted pricing on outpatient prescription drugs to eligible hospitals, clinics, and health care centers that primarily service low-income patient populations. The investigation revealed that the hospital overcharged Medicaid by failing to bill Medicaid at its acquisition cost (plus dispensing fee) for outpatient drugs purchased through the 340B program. Hospitals participating in the 340B drug pricing program are required to submit Medicaid claims for outpatient drugs at their acquisition cost (plus a dispensing fee), rather than the higher Medicaid reimbursement rates, thereby passing on the price savings to New York State.

Drug Diversion and Pharmacy and Prescription Fraud

New York City Pharmacy Owner Rauf Ahmad Convicted and Sentenced to State Prison for Bilking Medicaid of More Than \$5 Million for Bogus Prescriptions

The NYMFCU's prosecution of a ring of 16 individuals and five corporations involved in selling unjustified prescriptions produced eight convictions in 2008, including that of Rauf Ahmad, the scheme's kingpin. Eleven individual and corporate defendants have thus far been convicted. The prescriptions were ultimately filled by corrupt pharmacies that billed Medicaid for drugs that were never dispensed.

As discussed in two previous reports, the Unit arrested and charged five individuals associated with TLC Medical, P.C., a Bronx-based medical practice, including the board-certified neurologist who operated the practice. Eight other individuals were charged with buying and selling bogus prescriptions produced at TLC Medical and for stealing millions from Medicaid by falsely claiming that drugs had been dispensed to patients based upon these prescriptions. The investigation included undercover surveillance and the use of confidential informants.

TLC Medical was little more than a mill where the physician in charge, Dr. Deepak Sachdev, wrote thousands of prescriptions for expensive AIDS-related and anti-psychotic medications for hundreds of individuals who intended to sell the prescriptions. The

physician did not treat the individuals, obtain legitimate medical histories, conduct physical examinations or otherwise provide medical services. Instead, after seeing the individuals—sometimes in groups of four or five at a time—Sachdev simply wrote prescriptions for all of the “patients” for the same four drugs. (Due to Sachdev’s mental illness, this past year the NYMFCU granted Sachdev and TLC Medical, P.C. adjournments in contemplation of dismissal. Sachdev, as part of his agreement with the NYMFCU, surrendered his New York and New Jersey medical licenses.)

Gang members provided security to manage the volume of individuals who lined up to get prescriptions at the clinic and screened the “patients” to ensure that only those with functioning Medicaid cards were able to meet with the physician. In transactions that were often negotiated and consummated in the office of TLC Medical or on the street right outside, the “patients” sold their prescriptions for less than \$100 to buyers who frequented the clinic. The “patients” also provided the buyers with their Medicaid cards so that Medicaid could be billed for the prescriptions. Medicaid paid pharmacies approximately \$2,700 for the four prescriptions the patients typically received.

The buyers subsequently sold the prescriptions to Rauf Ahmad, the owner-operator of Seven D Pharmacy in the Bronx, for between \$200 and \$250. Ahmad distributed the prescriptions to Seven D Pharmacy and three others in which he held an ownership interest: 2001 Bath Avenue Pharmacy, Inc. (known as Family Pharmacy), Shop Rite Pharmacy (known as Shop Wise Pharmacy), and Best Pharmacy. These pharmacies used the patients’ Medicaid cards to bill Medicaid electronically for the prescribed medications as though they had actually dispensed them. In the overwhelming majority of instances, however, no patients ever went to the pharmacies and no drugs were ever dispensed. In total, Ahmad submitted fraudulent billings to and was paid by Medicaid for more than \$5 million for bogus prescriptions that were never filled.

On June 6, 2008, Ahmad pleaded guilty to grand larceny in the first degree, conspiracy in the fifth degree, and scheme to defraud the state by unlawfully selling prescription drugs. On July 2, 2008, he was sentenced to three and one-third to ten years in prison. During 2008, Seven D Pharmacy, Best Pharmacy, and Shop Rite Pharmacy pleaded guilty and were sentenced to conditional discharges. Additionally, on October 28, 2008, Biny Biag, the owner of Shop Rite Pharmacy in Queens, pleaded guilty to conspiracy in the fifth degree and was sentenced to time served, which was approximately two months. Biag agreed to pay a total of \$84,000 in restitution.

Ahmad is also a defendant in a civil action filed by the NYMFCU, seeking the recovery of the money Ahmad stole, including more than \$1 million transferred by Ahmad’s wife to Ahmad’s family in Pakistan. Since Ahmad’s arrest, the Unit has secured the return of more than \$400,000 of Ahmad’s funds from Pakistan. The civil action, which is pending, has resulted in an order freezing Ahmad’s and other defendants’ assets.

Clinics and Treatment Centers

Accounting Firm That Certified Substance Abuse Clinic's False Cost Report Reached \$1 Million Settlement

The Fagliarone Group CPAs, P.C., and one of its partners, Daniel Dreimiller, reached a \$1 million settlement with the NYMFCU in September 2008, to resolve claims that they improperly certified a substance abuse clinic's cost report containing false data that inflated the clinic's per-treatment reimbursement rate. The settlement stems from a civil lawsuit the NYMFCU filed in February 2008, against D.A. Mancuso Counseling Services, Inc. and its sole shareholder and officer David Mancuso, the Fagliarone Group and Dreimiller.

As alleged in the suit, Mancuso and Mancuso Counseling Services, which operates outpatient counseling clinics in Utica and Oneida to individuals dealing with alcohol and drug abuse, submitted to the Office of Alcoholism and Substance Abuse Services ("OASAS") a cost report that grossly under-reported the number of threshold visits and over-reported allowable costs for its drug clinic, resulting in substantially higher per-drug-treatment reimbursement rates than were justified. The Fagliarone Group and Dreimiller, the suit claimed, knew that the OASAS would set reimbursement rates based upon the cost report but failed to review the OASAS's instructions pertaining to preparation of the report and did not examine the accuracy of the data Mancuso provided to them. Nevertheless, they certified that the false and fraudulent information in the cost report fairly presented the true facts and complied with the OASAS's instructions. Consequently, for services rendered from 1999 through 2002 at Mancuso's drug clinic, Medicaid paid \$1.2 million for 8,690 claims based upon unjustified reimbursement rates.

The groundbreaking \$1 million settlement is one of the first instances of a recovery from accountants in the history of the NYMFCU. It is significant because New York State relies on accountants to vouch for the financial data contained in cost reports used to set Medicaid reimbursement rates. The civil suit against Mancuso and his company are still pending.

Nursing Homes

Audits of Nursing Homes Uncovered Improper Bed-hold Billings

The NYMFCU's Buffalo regional office conducted systemic audits of numerous nursing homes within the geographical area for which the office is responsible and uncovered approximately \$507,816 in improper billings involving bed holds. Under New York State law, nursing homes are allowed to temporarily bill Medicaid for holding a bed for a resident who is hospitalized only when 1) the nursing home is at 95% occupancy and 2) the resident has lived in the nursing home for at least 30 days before his/her hospitalization. The Buffalo regional office reached settlements with 42 nursing homes and recovered the improper overpayments.

Dentists

Dental Practice Employed Dental Assistant to Perform Root Canals and Other Services a Licensed Dentist Must Perform

Following an investigation of Manhattan-based Praise the Lord Dental, Inc., the NYMFCU filed felony charges against and obtained convictions of the practice's sole shareholder and administrator, dentist Jacinto Martinez, and Sandra Aguiar, a certified dental assistant. The NYMFCU's investigation revealed that from July 2004 to March 2006, Martinez employed and paid Aguiar as a dentist, though she was only certified as a dental assistant. (Aguiar was a licensed dentist in the Dominican Republic.) Martinez and Praise the Lord Dental, Inc. received Medicaid reimbursement for claims Martinez submitted for services a dentist is required to perform, but that Aguiar actually completed.

In April 2008, the NYMFCU charged both Martinez and Aguiar with unauthorized practice of a profession (dentistry), scheme to defraud in the first degree, and grand larceny in the third degree. Martinez was also charged with multiple counts of offering a false instrument for filing in the first degree. On November 14, 2008, Martinez pleaded guilty to offering a false instrument for filing in the first degree. On December 12, 2008, the court sentenced him to five years' probation and restitution of \$100,000. Aguiar pleaded guilty to grand larceny in the third degree and unlicensed practice of a profession on November 21, 2008, and was sentenced to probation and restitution of \$100,000.

Doctors

The "J Code" Project—Doctors and Hospitals Improperly Billed for Drugs Administered On-site

In 2008, the Unit continued to review physicians' and hospitals' drug billings throughout the state to ensure their compliance with state pricing rules. Under New York law, to prevent physicians' medical judgment from being affected by inappropriate financial incentives, doctors and hospitals are not allowed to make a profit on the drugs they administer on site.

Commonly referred to as "J codes" because of the "J" prefix in the procedure codes used when these drugs are administered and billed, doctors and hospitals cannot bill Medicaid for these drugs beyond their actual cost, as determined through an examination of invoices. The drugs are primarily injectable chemotherapy and therapeutic drugs and vaccines. The Unit's audits revealed that many physicians and hospitals were billing Medicaid for these drugs well in excess of their actual cost.

Since beginning the project, the Unit has recovered almost \$16 million from 125 providers, including hospitals, physician group practices and individual physicians. In 2008, the Unit's Special Projects Division completed twelve J Code investigations, recovering over \$2.5 million in restitution for the Medicaid program.

People v. Sung Moon Choo—Doctor Who Billed Medicaid for Services Not Rendered Convicted of Felony

The Unit's investigation of solo practitioner Dr. Sung Moon Choo discovered that Choo submitted claims to Medicaid for vaccines he never administered and vaccines he received for free from the Vaccines for Children Program. Choo also billed Medicaid for treating multiple family members when in fact he treated only one for treating patients he did not see on the purported date of service. In addition, he billed for hearing and tuberculosis tests he never performed.

On October 2, 2008, Choo, who is now retired, pleaded guilty to grand larceny in the third degree. As part of his plea, Choo paid \$250,573 in restitution. On December 15, 2008, the court sentenced Choo to a conditional discharge.

Transportation Companies

People v. M & M Medical Transport, Inc. and Murtada Ebrahim—Medical Transport Company Used Unqualified Drivers and Filed Nearly \$1 Million in False Medicaid Claims

The NYMFCU's investigation of M & M Medicaid Transport, Inc., which offered taxi and ambulette services to Medicaid recipients from Monroe and Wayne Counties, revealed that from January 1, 2003, to December 6, 2007, its owner and president, Murtada Ebrahim, submitted false reimbursement claims to Medicaid stating that his company complied with Medicaid and state motor vehicle regulations when, in fact, M & M's drivers failed to meet minimum qualifications to provide services. Due to the false claims filed by M & M, Medicaid paid the company \$971,267 to which it was not entitled.

The Unit's investigation also found that on July 25, 2006, one of M & M's ambulette drivers was involved in an accident while transporting an elderly wheelchair-bound patient and ran from the accident scene, abandoning the patient. Ebrahim was aware of the accident but still filed an annual affidavit of compliance with the New York State Department of Motor Vehicles stating that none of M & M's drivers had been involved in any accidents during 2006.

On July 8, 2008, M & M Medical Transport, Inc. and Ebrahim pleaded guilty to stealing \$971,267 from Medicaid, and agreed to pay full restitution to the state. The company, which pleaded guilty to grand larceny in the second degree, was fined \$10,000 and ordered to pay \$971,267 in restitution. Ebrahim, who pleaded guilty to grand larceny in the third degree and offering a false instrument for filing in the first degree, was sentenced on September 26, 2008, to two to six years' incarceration. The court also ordered Ebrahim to repay the \$971,267. (The company and Ebrahim are jointly and severally liable for the \$971,267 restitution payments.)

Durable Medical Equipment Suppliers

People's Choice Surgical Supplies, Inc. and Its Executives Stole Identities of Physicians to File False Claims for Medical Equipment Never Actually Ordered

On October 3, 2008, the NYMFCU charged People's Choice Surgical Supplies, Inc., formerly the largest Medicaid medical equipment supplier on Long Island, with stealing over one million dollars in Medicaid funds by filing fraudulent bills. The now-closed company is charged with stealing the identities of physicians by using their identity information to submit false Medicaid claims for equipment without the doctors' knowledge or permission.

Along with the company, the Unit charged its executives: President and Chief Executive Officer Cynthia Williams; her husband, Vice President David Williams; and their niece, Billing Supervisor Kenya Gadson. The indictment follows a civil suit that the NYMFCU's Civil Enforcement Division filed in February 2007 against the company, Cynthia Williams, and David Williams, seeking over \$11 million in damages for fraudulent, inaccurate, and ineligible Medicaid claims.

The indictment against People's Choice and its executives charges that between 2003 and 2006, the Long Island durable medical equipment supplier engaged in schemes to defraud Medicaid, which resulted in payments of over \$1 million for durable medical equipment that physicians never ordered, as required. Instead, People's Choice and its executives stole the identities of physicians in order to file false claims and be reimbursed for unnecessary equipment. In many cases, the doctors listed on the billings submitted to Medicaid were not even the supposed recipients' treating physician. People's Choice and its executives were all charged with grand larceny in the first degree, a class B felony, and other charges. The company itself was charged with 13 counts of possessing forged order forms of three doctors for different Medicaid recipients and People's Choice, its vice president and billing supervisor were charged with stealing the identity of these three doctors.

Both the criminal charges and civil lawsuit are pending.

PATIENT ABUSE AND NEGLECT PROSECUTIONS AND CIVIL ACTIONS

Statistical Overview

In 2008, the NYMFCU reviewed 1,028 allegations of patient abuse and neglect (including the theft of patients' money), opened 54 criminal investigations, initiated prosecutions against 44 defendants, and secured 28 convictions. The Unit dismissed charges against one defendant and three defendants were acquitted following a trial. (See Tables A-3 and A-4, Appendix.)

This section reviews the status of the NYMFCU's prosecutions stemming from its statewide use of cameras hidden in nursing home residents' rooms with the consent of the residents' families. In addition, the section details a variety of other patient abuse and neglect cases the Unit handled during 2008, reflecting the broad range of cases that fell within this category.

Hidden Camera Cases

This past year, the NYMFCU, which leads the nation in its use of covert surveillance in nursing homes to uncover and deter the criminal neglect of vulnerable residents, filed criminal charges against six health care workers at the Medford Multicare Center for Living in Suffolk County based upon hidden camera evidence. The Medford case marks the fourth nursing home in which the NYMFCU has utilized covert surveillance to bring prosecutions against health care workers. Through 2008, the NYMFCU has obtained criminal convictions of 27 defendants through the use of hidden cameras, including the corporate owner and operator of a nursing home.

Investigation of Medford Multicare Center for Living in Suffolk County Leads to Arrests of Eight Health Care Workers

In October 2008, the NYMFCU arrested and charged eight health care workers at the Medford Multicare Center for Living with endangering patients and falsifying business records to conceal their neglect. Footage from a hidden camera concealed in a patient's room captured six of these eight workers allegedly neglecting the patient. The charges against the eight facility staff members are pending; the investigation is ongoing.

The NYMFCU initiated an investigation of Medford Multicare Center after receiving complaints from residents' family members and the facility's own employees. With the consent of the family of an 84 year-old resident completely dependent on the facility for his daily needs, the Unit installed a hidden camera in the patient's room and monitored it for

approximately 45 days during the first three months of 2007. The footage revealed that facility staff members:

- failed to turn and position the patient as required to prevent skin breakdown and pressure sores;
- failed to provide the patient with the required amount of water through his gastrostomy tube;
- failed to provide required range of motion therapy to prevent muscles from contracting;
- failed to change the patient's brief at least every two hours, as required by his care plan, instead leaving him in his own waste for as long as seven hours at a time;
- failed to shower the patient twice a week as required and at one point failed to shower the patient for more than one week; and
- failed to take the patient's apical pulse rate to determine whether it was safe to give him heart medication.

For the safety of the resident, staff was required to transfer him out of his bed to his wheelchair and from his wheelchair back to his bed using a mechanical Hoyer lift with the assistance of two caregivers. However, the surveillance recordings showed that it was common practice for the aides charged to transfer him without assistance. In one instance, one of the aides was seen using her cellular telephone while conducting this dangerous transfer without assistance and on another occasion, she banged the resident's head into the side rail of his bed while performing a one-person transfer.

Following a detailed review of the surveillance footage and comparing the footage with the patient's medical records and the facility's staff records, the NYMFCU investigators further found that the patient's medical records did not accurately reflect the staff member's actions, but were fabricated to conceal their neglect. The Unit charged three licensed practical nurses and three certified nurse aides with endangering the welfare of an incompetent or physically disabled person, a class A misdemeanor, and falsifying business records in the first degree, a class E felony.

As part of the Unit's investigation of the facility, the Unit also brought charges against defendants regarding the care provided to two other patients (not captured by hidden cameras). In one case, the Unit charged two aides⁶ for falsifying business records in an effort to conceal one of the aide's failure to shower a resident as required. In the second case, the Unit charged a licensed practical nurse with falsifying a resident's chart to conceal her failure to order the necessary blood tests needed to monitor dosages of a blood thinning medication, Coumadin. The lack of this routine testing and monitoring resulted in the resident suffering internal bleeding and extensive external bruising. When Medford finally did order the standard blood test, the patient's levels were so grossly abnormal that the patient required an emergency injection of vitamin K, was rushed to the emergency room and immediately admitted to the hospital for treatment. As these events were unfolding, the nurse went back into the records and altered them to make it appear as if she had originally included the usual order, months earlier.

⁶ One of these two aides was also one of the six defendants charged on the basis of hidden camera evidence.

Convicted Corporate Owner and Operator of the Northwoods Rehabilitation and Extended Care in Cortland Barred from Operating a Health Care Facility

At the May 15, 2008 sentencing of Highgate LTC Management, LLC, the owner and operator of the Northwoods Rehabilitation and Extended Care Facility in Cortland and five other facilities in upstate New York, the court sentenced the company to a one-year conditional discharge, barring the company during that time from operating a nursing home, long-term care facility or other health care facility. The court also fined the company \$15,000.

In October 2007, a jury found Highgate guilty of three counts of falsifying business records in the second degree and six counts of wilful violation of health laws. The sentencing brought to a conclusion the NYMFCU's investigation of the Northwoods Rehabilitation and Extended Care Facility in Cortland. The Unit installed a hidden video camera in the room of a comatose patient that recorded 24 hours a day, seven days a week—for more than two months—the treatment provided by the nursing home staff to a 59 year-old resident in a chronic vegetative state. Review of the recordings showed hundreds of instances in which various health care services mandated by the patient's care plan were not provided, but the patient's medical records falsely showed that the services had been given. The mandated care that the nursing home failed to provide included turning and positioning the patient, following protocols for the patient's feeding tube, and providing care to the patient's skin, mouth, and tracheotomy. Two certified nurse aides and three licensed practical nurses were convicted of crimes in 2007.

Prosecution of Staff Members from Hollis Park Nursing Home Ended in Seven Convictions

The NYMFCU's prosecution of employees of Hollis Park Manor Nursing Home in Queens, New York concluded in 2008, and resulted in a total of seven criminal convictions: five certified nurse aides and two licensed practical nurses. The prosecution ended on June 18, 2008, when three certified nurse aides pleaded guilty to an attempt to falsify business records in the first degree, a class A misdemeanor, and were sentenced to conditional discharges. One licensed practical nurse pleaded guilty to a violation during 2008, and two defendants received adjournments in contemplation of dismissal. Last year, two licensed practical nurses and two certified nurse aides were convicted of falsifying business records in the second degree, a class A misdemeanor.

The prosecution stemmed from evidence obtained from a camera secreted over a five-week period in the room of a 67 year-old patient suffering from psychosis, depressive disorder, coronary disease, pulmonary infarct and seizure disorder, and requiring assistance with all activities of daily living. The surveillance showed that staff repeatedly failed to provide a variety of required care including range of motion therapy, turning and positioning to prevent the development of pressure sores, administering prescribed medications, and providing assistance for eating. As in the other camera cases, the defendants falsified the patient's medical records to conceal their neglect.

Other Abuse and Neglect Cases

People v. Cory Austin—Judge Found Certified Nurse Aide Guilty of Abusing and Attacking 85 Year-old Resident

Following a non-jury trial, on November 12, 2008, a judge found Cory Austin, a former certified nurse aide at Gowanda Nursing Home in Gowanda, New York, guilty of both misdemeanors with which he was charged: willful violation of health laws and endangering the welfare of an incompetent or physically disabled person.

On February 19, 2007, a licensed practical nurse attempted to give medication to an 85 year-old resident suffering from Alzheimer's disease. The resident, who was in the facility's lounge, became agitated and swung another patient's walker at Austin. Austin, 27 years old at the time of the incident, ripped the walker from the resident's hand, screamed at the resident and with the assistance of another staff member, took the resident to his room and put him in a chair. When the other staff member closed the door at Austin's request, Austin threw the resident to the floor, yelled at him, called him a "nigger," and pushed the resident up and down on the floor. In response to the protestations of the other staff member, Austin picked up the resident from the floor, threw him on the bed and, while repeatedly referring to the resident as a "nigger," pinned the resident to the bed with his knee on the resident's back. Austin pulled back on the resident's shoulder and screamed at him, "Are you going to fucking hit me with a walker?" Austin finally complied with the other staff member's entreaties to stop and "get off" of the resident. The other staff member immediately reported the incident to nursing home administrators.

On February 11, 2009, the court sentenced Austin to three years' probation and required Austin to participate in anger management counseling.

Nurse Convicted of Falsifying Business Records to Conceal Unauthorized Catheter Change that Injured Patient

On April 30, 2008, Brenda Griffin, a former registered nurse at Whittier Rehab and Skilled Nursing Center in Ghent, who recklessly injured a patient and then hid the incident from facility staff, pleaded guilty to falsifying business records in the first degree, a felony. She was sentenced on June 25, 2008, to five years' probation and she surrendered her nursing license.

Griffin changed a resident's catheter without a physician's order, despite rules forbidding her to do so, and perforated a section of the patient's small intestine, causing leakage, pain, and vomiting. Griffin failed to inform the treating physician of what she had done even as the resident's symptoms worsened. In addition, she covered up her actions by omitting them from the resident's medical chart. The patient was subsequently hospitalized for ten days.

Volunteer Convicted of Fondling Nursing Home Residents

On February 15, 2008, the NYMCU charged 60 year-old Chauncey Easley, who worked as a volunteer at the Rosewood Heights Health Center in Syracuse, New York, with three counts of sexual abuse in the third degree, a class B misdemeanor, three counts of endangering the welfare of an incompetent or physically disabled person, a class A misdemeanor, and public lewdness, a class B misdemeanor. The charges stemmed from Easley's interactions with three of the facility's female residents.

In April 2007, Easley got in the elevator with a 67 year-old resident confined to a wheelchair and put his hands on her breast through her shirt. He dropped his hands when the resident told him, "No, no." Later that month, Easley went to the resident's room and asked the resident, who was sitting on her bed, whether she needed anything. After looking in both directions at the doorway, he approached the side of the bed, unzipped his pants, and exposed his penis and said, "I'll bet you never saw anything like this before." Easley left when the resident ordered him to leave.

Easley was also charged with touching the breasts of a 50 year-old resident suffering from schizoaffective disorder and a 58 year-old resident requiring 24-hour care.

On April 28, 2008, Easley pleaded guilty to endangering the welfare of an incompetent or physically disabled person. The court sentenced Easley on June 30, 2008, to 60 days of incarceration and three years' probation. One of the terms of his probation requires Easley to undergo mental health counseling.

People v. Virginia Wilson—Certified Nurse Aide Guilty of Falsifying Business Records after She Failed to Perform Required Safety Checks

At approximately 5:00 a.m. on May 24, 2007, at the Daughters of Sarah Nursing Center in Albany, a staff member found a pool of blood on the floor of an 85 year-old resident's room. The resident, who had fallen from her bed, sustained a head injury requiring treatment at a hospital.

Virginia Wilson was the certified nurse aide on duty in the early morning of May 24, responsible for conducting safety checks on each resident of the facility every half hour. Wilson was also required to record the performance of such checks in the nursing home's business records.

Although Wilson indicated that she had conducted all required checks, the facility's security camera footage revealed that Wilson had not, in fact, checked on the injured resident at any time during her shift, nor had she conducted required safety checks on other residents. Following a thorough investigation, the Unit arrested Wilson on November 27, 2007, and charged her with 17 counts of falsifying business records in the first degree, a felony. On September 15, 2008, on the eve of trial, Wilson pleaded guilty to falsifying business records in the second degree, a class A misdemeanor. Wilson was sentenced to a one-year conditional discharge.

People v. Ivy Nabie—Surveillance Footage Captured Certified Nurse Aide Violating Care Plan and Twice Dropping Resident on Ground

The care plan of a 67 year-old resident of the Golden Gate Rehabilitation and Health Care Center in Staten Island, who suffered from Parkinson's disease and dementia, required the presence of two caregivers to move or complete any of the resident's transfers, including from a chair to a standing position. On August 14, 2006, the facility's own surveillance camera captured the resident sitting alone in the facility's day room. The footage further showed Ivy Nabie, at the time a certified nurse aide, pick up the resident without assistance from the chair and drop her on the ground where the resident fell onto her back. Nabie tried to pick up the resident from the ground without assistance and dropped her for a second time on the ground, again causing the resident to fall backwards. Nabie picked up the resident for a third time without assistance and finally succeeded in holding up the resident and walking her out of the day room.

Nabie, whom the NYMFCU arrested and charged on February 15, 2007, pleaded guilty on January 25, 2008, to willful violation of health laws, a misdemeanor. The court sentenced Nabie to 15 days of community service.

Thefts of Residents' Money and/or Identity

Nursing Home Employee Stole More than \$350,000 from Residents: Convicted of Grand Larceny in the Second Degree

From 2004 to 2006, New Fordham Arms Assisted Living Facility in the Bronx employed Frances Landrini to assist the facility's elderly and infirm residents in paying their bills and conducting financial transactions on their behalf. Instead of assisting the residents, Landrini used a variety of deceptions to steal more than \$350,000 from approximately a dozen of them.

Over the course of two years, Landrini convinced residents to sign blank checks, claiming that she would fill in the rest to pay the residents' bills. Instead, she made them payable to herself or to "cash," and either cashed or deposited the checks into her own account. She also stole blank checks from one resident and later duped the resident into endorsing them. In total, Landrini fraudulently obtained and negotiated more than 150 checks from approximately twelve New Fordham Arms residents. From one victim alone, Landrini stole \$195,685. Three others lost more than \$50,000, and the remaining residents lost amounts ranging from \$475 to \$12,335. Landrini also used a resident's credit card to make ATM withdrawals and make purchases at The Gap, Toys 'R Us, and Shell Oil.

On January 24, 2008, Landrini pleaded guilty to grand larceny in the second degree, a class C felony, and on March 28, 2008, was sentenced to one year of incarceration and ordered to pay restitution to the victims of \$343,130.

Certified Nurse Aide Convicted of Stealing Nursing Home Residents' Social Security Numbers to Obtain Cable Service and Gas and Electric Service

Tara Smith, formerly a certified nurse aide at Blossom North Nursing Home in Rochester, New York, had primary care responsibilities for residents of the facility's first floor and access to their patient charts, which contain patients' social security numbers. In September 2007, Smith stole the social security numbers of two residents and in October 2007, assumed the identity of one of the residents to obtain for her own residence cable television service, digital telephone service, and equipment from Time Warner Cable for more than one month, thefts that totaled \$863. At the same time, Smith also took the identifying information of a second resident to obtain gas and electric service from Rochester Gas and Electric, Inc. and over a period of more than one month received approximately \$558 in gas and electric service.

On May 22, 2008, the NYMFCU charged Smith with two counts each of identity theft in the second degree and theft of services. Smith pleaded guilty on July 10, 2008, to one count of identity theft in the third degree, a class A misdemeanor, and was sentenced on September 4, 2008, to eight weekends of incarceration, restitution of \$1,004, and three years' probation.

Two Nursing Home Employees Convicted of Stealing and Then Pawning 89 Year-old Resident's Engagement Ring

On October 6, 2008, Amanda Thaler, a certified nurse aide at Bethany Gardens Skilled Living Center in Rome, New York, took two rings from an 89 year-old resident: a gold and diamond engagement ring given to the victim by her husband in 1940, and a family ring containing various gemstones. The rings were visibly loose on the victim's finger and Thaler offered to have them fixed so they would not fall off her hand and took them from the resident. Approximately a half hour later, the victim requested the rings be returned, but Thaler ignored her. Later, in the dining room, the victim again called out to Thaler to return the rings, at which point Thaler handed back the family ring, but not the engagement ring.

When pressed for the engagement ring, Thaler responded that she was feeling ill and needed to leave work. She called her boyfriend and co-worker, Sheldon Stoddard, who was employed as a dietary technician at the facility, to come pick her up at the nursing home. Thaler gave Stoddard the engagement ring and they drove together to a pawn shop where they sold it for \$15.00. The engagement ring was recovered and returned to the resident. Thaler and Stoddard have since been terminated from Bethany Gardens.

The NYMFCU filed criminal charges against Thaler and Stoddard on November 19, 2008; the Unit charged Thaler with petit larceny and Stoddard with criminal possession of stolen property in the fifth degree, both misdemeanors. Thaler pleaded guilty to petit larceny on January 16, 2009, and was sentenced to 90 days' incarceration. She also agreed to surrender her certified nurse aide license. Stoddard pleaded guilty to criminal possession of stolen property in the first degree on January 29, 2009, and was sentenced on March 18, 2009, to a term of six months of incarceration.

APPENDIX

Investigations

Table A-1⁷

Investigations Opened and Closed by Provider Category 2008				
Provider Category	Investigations Opened		Investigations Closed	
	Number	Percent of Total	Number	Percent of Total
Facilities—Hospitals	44	10%	33	10%
Facilities—Nursing Facility	55	13%	69	20%
Facilities—Other Long-term Care	1	0%	0	0%
Facilities—Substance Abuse Treatment Center	1	0%	7	2%
Facilities—Other	5	1%	24	7%
Physicians—Doctors of Medicine or Osteopathy	12	3%	27	8%
Dentists	9	2%	4	1%
Podiatrists	0	0%	0	0%
Optometrist/Optician	1	0%	0	0%
Counselor/Psychologist	4	1%	1	0%
Chiropractors	0	0%	0	0%
Practitioners—Other	1	0%	2	1%
Pharmacy	22	5%	25	7%
Pharmaceutical Manufacturer	51	12%	5	1%
Durable Medical Equipment and/or Supplies	14	3%	17	5%
Lab	3	1%	0	0%
Transportation Services	10	2%	6	2%
Home Health Care Agency	30	7%	23	7%
Home Health Care Aides	10	2%	3	1%
All Nurses, Physician Assistants, and Nurse Practitioners, including Certified Nurse Aides	37	8%	19	5%
Radiology	1	0%	0	0%
Medical Support—Other	56	13%	22	6%
Managed Care	4	1%	3	1%
Medicaid Program Administration	0	0%	0	0%
Billing Company	0	0%	0	0%
Program Related—Other	14	3%	5	1%
Subtotal Fraud Investigations	385	88%	295	85%
Abuse and Neglect—Nursing Facility	5	1%	3	1%
Abuse and Neglect—Other Long-term Care	0	0%	0	0%
Abuse and Neglect—Registered/Licensed Nurse/PA/NP	16	4%	8	2%
Abuse and Neglect—Certified Nurse Aides	25	6%	31	9%
Abuse and Neglect—Other Practitioner	3	1%	2	1%
Subtotal Abuse and Neglect Investigations	49	11%	44	13%
Patient Funds—Non-direct Care	1	0%	1	0%
Patient Funds—Registered/Licensed Nurse/PA/NP	1	0%	0	0%
Patient Funds—Certified Nurse Aides	3	1%	5	1%
Patient Funds—Other Practitioner	0	0%	2	1%
Subtotal Patient Fund Investigations	5	1%	8	2%
Total All Investigations	439	100%	347	100%

⁷ Statistics for the NYMFCU 2008 Annual Report have been updated and may not, as a result, mirror the totals of the four 2008 quarterly statistical reports the NYMFCU previously submitted to Department of Health and Human Services Office of the Inspector General.

Table A-2

Investigation Closures 2008					
	Closed by Prosecution	Closed by Civil Action	Closed Due to Insufficient Evidence	Closed by Referral	Total
Fraud Investigations	36	164	92	3	295
Patient Abuse and Neglect Investigations	22	0	18	4	44
Patient Fund Investigations	5	0	3	0	8
Total Completed Investigations					347

Patient Abuse Complaints⁸

Table A-3

Patient Abuse Complaints Received, Investigated and Referred 2008	
	Total
Patient Abuse Complaints Received	1028
Patient Abuse Investigations Opened	54
Patient Abuse Referrals to Other State Agencies	105

Prosecutions

Table A-4

Criminal Prosecution Closures by Defendant 2008			
	Fraud	Patient Abuse and Neglect (including Patient Fund Cases)	Total
Criminal prosecutions filed	122	44	166
Convictions	115	28	143
Acquittals	0	3	3
Dismissals	5	1	6
Total Prosecutions Completed	120	32	152
Conviction Rate	96%	88%	94%

⁸ This table includes all complaints of patient abuse and neglect and misuse of patient fund complaints the Unit received during the reporting year.

Monetary Recoveries⁹

Table A-5

Monetary Recoveries 2008			
	Criminal	Civil	Total
Number of Recovery Actions Initiated (and Resolved with Order or Settlement)	82	175	257
Medicaid Overpayments Identified	\$3,865,380	\$259,621,524	\$263,486,904
Penalties Imposed	\$47,274	\$89,315	\$136,589
Non-Medicaid Restitution Due to Third Parties	\$548,093	\$2,264,333	\$2,812,426
Medicaid Overpayments Collected by the NYMFCU	\$2,918,535	\$253,259,588	\$256,178,123
Non-Medicaid Restitution Due to Third Parties Collected by the NYMFCU	\$62,943	\$369,361	\$432,304
Penalties Collected by the NYMFCU	\$49,623	\$91,248	\$140,871

⁹ 42 C.F.R. § 1007.17(e) requires Medicaid fraud control units' annual reports to include "the number of recovery actions initiated by the Medicaid agency under its agreement with the unit, and the total amount of overpayments actually collected by the Medicaid agency under this agreement." However, the NYMFCU's memorandum of understanding with the New York State Department of Health (DOH) does not require DOH to report its recoveries to the NYMFCU.

Additionally, in response to information required by § 1007.17(d), the NYMFCU did not refer any recovery actions to another agency.

Table A-6

Monetary Recoveries by Provider Category 2008					
Provider Category	Medicaid Restitution	Penalties	Fines	Non- Medicaid Restitution Due to Third Parties	Total
Facilities—Hospitals	42,244,074			2,101,468	44,345,542
Facilities—Nursing Facility	1,048,691				1,048,691
Facilities—Child Foster Care Agencies	697,008				697,008
Facilities—Clinics	1,018,502				1,018,502
Facilities—Other	1,838,385				1,838,385
Physicians—Doctors of Medicine or Osteopathy	2,475,019	53,298		147,125	2,675,442
Dentists	430,037				430,037
Counselor/Psychologist	400,000				400,000
Pharmacy	2,241,167	10,400			2,251,567
Pharmaceutical Manufacturer	156,962,532			161,548	157,124,080
Durable Medical Equipment and/or Supplies	816,402				816,402
Transportation Services	971,268		10,000		981,268
Home Health Care Agency	13,770,178	10,683			13,780,861
Home Health Care Aides	565,055	341	250	1,874	567,520
All Nurses, Physician Assistants, and Nurse Practitioners, including Certified Nurse Aides	2,622,615	61,867	1,000		2,685,482
Medical Support—Other					
Therapists	75,000				75,000
Managed Care	35,000,000				35,000,000
Program Related—Other	310,970			53	311,023
Subtotal Fraud Monetary Recoveries	263,486,903	136,589	11,250	2,412,068	266,046,810
Patient Abuse—Nursing Facility			15,000		15,000
Patient Abuse—Certified Nurse Aides			300		300
Subtotal Abuse and Neglect Recoveries			15,300		15,300
Patient Funds —Other Practitioner				56,105	56,105
Patient Funds —Facilities				343,130	343,130
Patient Funds —Certified Nurse Aides				1,123	1,123
Subtotal Patient Fund Recoveries				400,358	400,358
Total All Monetary Recoveries	263,486,904	136,589	26,550	2,812,426	266,462,468

Costs

Table A-7

Expenditures 2008	
Type of Expenditure	Cost
Personal Services	\$26,706,308
Non-personal Services	\$8,482,937
Fringe Benefits	\$9,063,367
Total Expenditures	\$44,252,612