NEW YORK STATE
MEDICAID FRAUD CONTROL UNIT

2007 Annual Report

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

Attorney General
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MESSAGE FROM THE DIRECTOR

This report constitutes the Annual Report for 2007 for the New York State Medicaid Fraud Control Unit ("NYMFCU" or "the Unit") to the Secretary of the United States Department of Health and Human Services. As required by 42 C.F.R. § 1007.17, the NYMFCU is reporting on 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 initiated, and the amount of recoveries collected during the period, projections for the 2007 year, and the costs incurred by the Unit. In addition, as required by the regulations, the report (in this section) includes an evaluation of the Unit's 2007 performance.

The Unit was highly productive in 2007. As shown in more detail in the tables in the Appendix to this report, NYMFCU completed a total of 383 investigations in 2007, of which 330 involved provider fraud. Of the 330 provider-fraud investigations, 37 were resolved through criminal prosecution, 161 as a result of civil proceedings, four were referred to other agencies, and 128 were closed because of insufficient evidence. In the area of patient abuse and neglect, a total of 50 investigations were resolved: 20 through prosecution, three as a result of referral to other agencies, and 27 by closure due to insufficient evidence.

The Unit initiated criminal prosecutions against a total of 99 defendants, of which 74 were providers accused of fraud and 25 were individuals charged with patient abuse and neglect (including the misuse of patient funds). The Unit obtained a total of 104 convictions, of which 72 involved provider fraud and 32 involved patient abuse or neglect or misuse of patient funds. The Unit had an overall conviction rate of 97%.

The Unit opened 423 investigations in 2007, of which 363 involved possible fraudulent billing by providers. The other 60 new investigations involved possible patient abuse or neglect (including possible misuse of patient funds) and resulted from 924 such complaints received by the Unit. (Of the remaining 864 such complaints, 91 were referred to other state agencies and the remainder were found to be unsubstantiated or to have been resolved.)

The Unit initiated or resolved a total of 296 recovery actions in 2007, of which 239 were civil and 57 criminal. During 2007, NYMFCU obtained court orders requiring the payment of approximately $86.6 million in civil damages and almost $26 million in criminal restitution, for a total of approximately $112.5 million, 90% higher than the $59.4 million achieved in 2006. The Unit collected a total of $86,633,916 in both civil and criminal recoveries.

In regard to costs, the Unit incurred total costs of approximately $41 million, the majority of which was for salaries and benefits.

Among the highlights of our year were successes in our industry-wide investigation of the home health care industry, dubbed "Operation Home Alone," which resulted in dozens of convictions and millions in ordered restitution. We have uncovered systemic abuse in this industry, including the sale of fake home health care certificates by corrupt home health aide training schools, the hiring of aides with fake certificates by home health agencies, and the splitting of Medicaid money between recipients and aides with no-show jobs. To address this abuse, the Attorney General's Office has submitted a proposal to the state legislature calling for a statewide registry of certified home health aides and personal care aides.

Other highlights include a lawsuit against Merck & Co., Inc., under the recently enacted New York State False Claims Act, for false marketing of the drug Vioxx; the prosecution of a nursing home owner for knowingly violating bed-hold regulations that resulted in a sentence of 2-6 years imprisonment for the owner and restitution of $6 million; an unprecedented conviction after trial of the owner of a nursing home for abuse and neglect of residents; and the conviction of the owner of a home health care agency for filing false cost reports.

We have worked diligently to increase our staff, particularly in the area of civil enforcement. During 2007, the Unit increased its overall legal staff by 11% and the number of its civil attorneys by 71%. The increase in civil attorneys was required in part to generate additional civil cases from within the Unit and in part to address the increase in our civil docket resulting from the passage of the New York State False Claims Act. In the nine months since the Act was passed, we have been served with 51 *qui tam* actions asserting claims under the Act.

The Unit obtained nearly double the amount of recoveries in orders and restitutions in 2007 as compared with 2006. With increased staff and an increased emphasis on civil litigation, we anticipate that our number of civil actions and the amount of our recoveries will continue to increase in 2008. We also expect to increase our collections, in part due to the 2008 hiring of an attorney with expertise in such matters. In addition, we plan to continue our focus on industry-wide investigations such as Operation Home Alone; our collaborations with local, state, and federal agencies; and our efforts to obtain systemic changes that will result not only in savings for the Medicaid program but also in better health care for New Yorkers.

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

OPERATIONS

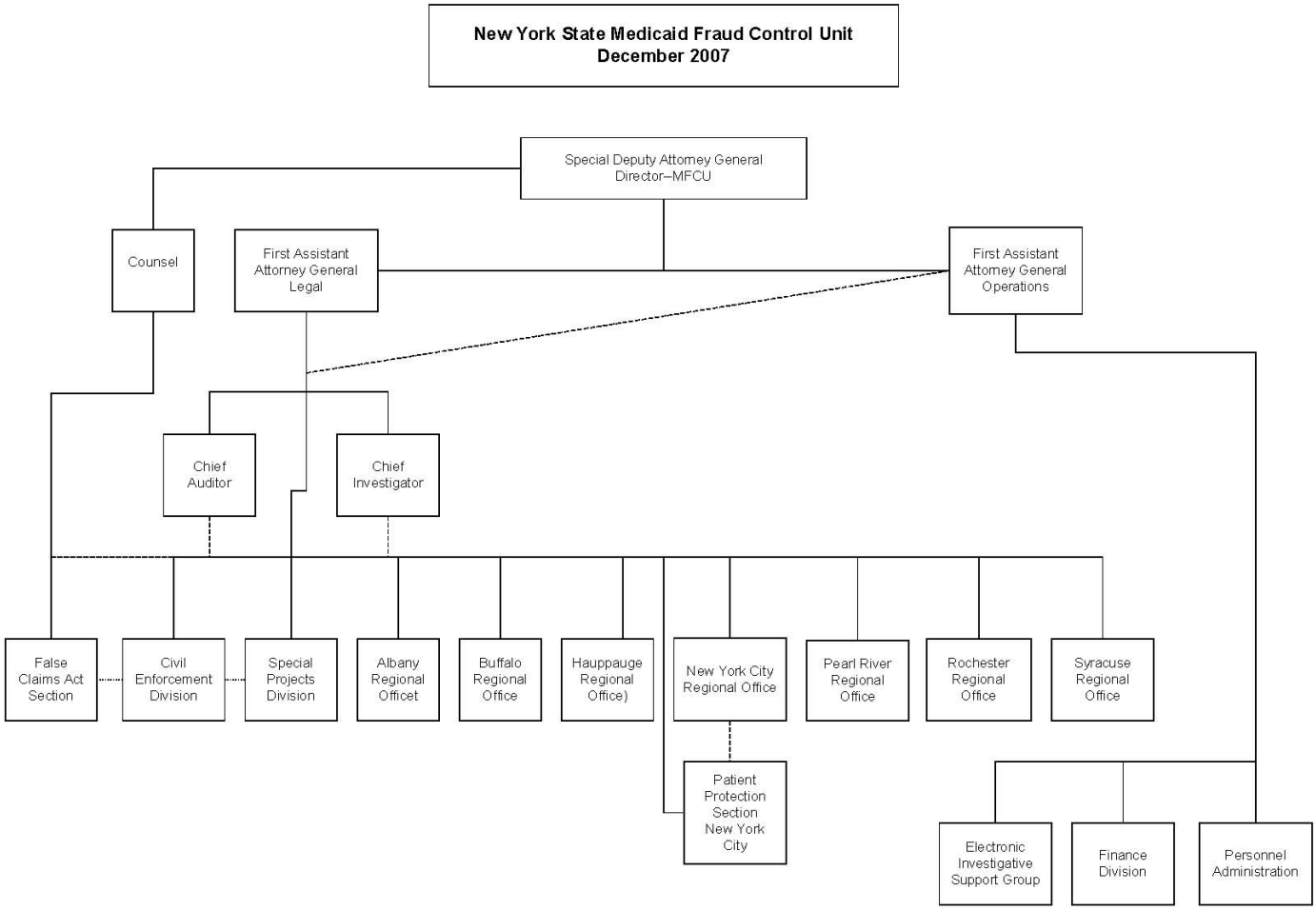
History and Organization

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 more than 310 employees, it is the largest unit within the Criminal Division of the attorney general's office.

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 Civil Enforcement Division (based primarily in New York City); the Special Projects Division (based largely in New York City and Pearl River); the New York City Patient Protection Section; the False Claims Act Section; and the Electronic Investigative Support Group (based in Rensselaer).

The MFCU's specialized divisions have a variety of functions. Civil Enforcement Division attorneys handle complex civil fraud investigations using the New York State False Claims Act, Social Services Law § 145-b, and Executive Law, and initiate asset forfeiture actions and other actions involving civil remedies. The Special Projects Division, among other responsibilities, joins and takes a leading role in nationwide task forces investigating corporations operating in states across the county. The New York City Patient Protection Section, comprised of attorneys, investigators and nurse analysts, focuses on the investigation and prosecution of patient abuse and neglect cases in the five boroughs of the city of New York. The False Claims Act Section shares responsibility with the Special Projects Unit for investigating and, when appropriate, superseding or intervening in *qui tam* civil actions filed pursuant to the 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, 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.



The Year in Brief

Appointment of New Director

On April 16, 2007, Attorney General Andrew M. Cuomo announced the appointment of Heidi A. Wendel as the new director of the New York State Medicaid Fraud Control Unit. Ms. Wendel previously served as the health care fraud coordinator in the Civil Division of the United States Attorney's Office for the Southern District of New York where she supervised large-scale civil health care fraud investigations. Ms. Wendel has extensive experience pursuing cases under the federal False Claims Act.

Increased Staffing

In accordance with Attorney General Cuomo's goal of increasing staffing and civil recoveries, the Unit increased its overall legal staff by 11% and the number of its civil

attorneys by 71%. At the end of 2006, the Unit employed five civil lawyers among its 44 special assistant attorney generals. By the end of 2007, the Unit employed 49 attorneys, including 12 civil attorneys.

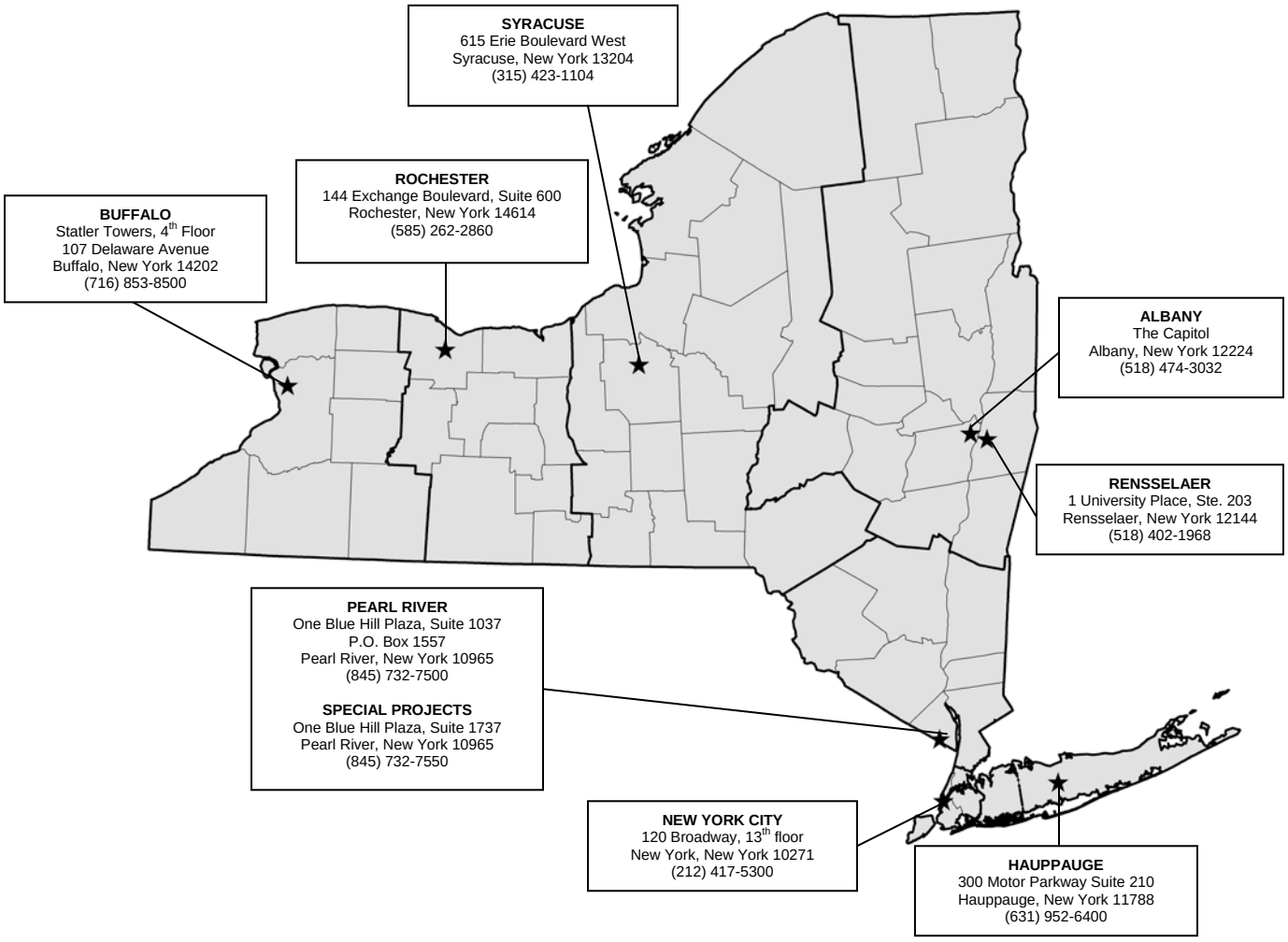
In addition to the 49 attorneys, at the end of 2007, the Unit employed 313 full-time employees: 96 auditors, 90 investigators, five medical analysts, three paralegals, 16 information technology specialists, 35 support staff members assigned to data entry, reception, clerical, and administrative assistant duties, and 19 employees handling personnel, purchasing, financial collections and inter-governmental affairs. During 2007, the Unit expended a total of $40,872,053 million: $22,590,111 million in personal services (salaries), $8,867,103 million in fringe benefits, and $9,414,839 million in non-personal services (for example, rent, vehicles, computers and supplies). (Table A-7, Appendix.)

Establishment of Partnerships with District Attorneys

In 2007, Attorney General Cuomo began an initiative to partner with local law enforcement to uncover and hold accountable individuals and companies engaging in Medicaid fraud. These partnerships enable NYMFCU to get the benefit of the counties' knowledge of the providers in their communities to assist the Unit in finding, fighting and fixing Medicaid fraud.

As part of this initiative, the New York State Attorney General entered into a memorandum of understanding with the District Attorney of Nassau County, creating a Nassau County Medicaid Prosecution Task Force. The investigation and prosecution of Charles Zizi and Ricardo Francois, discussed below, is a byproduct of the Nassau County task force. The New York State Attorney General created a similar county task force with the Chautauqua County District Attorney's Office. The NYMFCU also conducted a successful joint prosecution in 2007 with the Westchester County District Attorney's Office in a major case against a corrupt pharmacist, also discussed below.

New York State Medicaid Fraud Control Unit's Statewide Offices
December 2007



PROVIDER FRAUD PROSECUTIONS AND CIVIL ACTIONS

Statistical Overview

In 2007, the Unit opened 363 Medicaid fraud investigations and resolved 330. Thirty-seven of the cases were resolved through prosecutions and 161 as a result of civil settlements or actions. (See Tables A-1 and A-2, Appendix.) As of December 31, 2007, the Unit had 471 open fraud investigations. In fraud cases, the NYMFCU filed criminal charges against 74 defendants and obtained convictions against 72. One defendant was acquitted and charges were dismissed against another. (See Table A-4, Appendix.) The Unit obtained orders and settlements of Medicaid restitution totaling $112.5 million, 90% higher than the $59.4 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 2007.

Home Health Care

The NYMFCU's focus on systemic Medicaid fraud abuse is reflected in part by the resources it expended this past year on the home health care industry and the results of these efforts. Thirty-seven percent ($41,511,704) of the $112.5 million in Medicaid restitution orders the Unit obtained in 2007 stemmed from cases involving home health care. (See Table A-6, Appendix.)

Operation Home Alone

The NYMFCU conducted a far-reaching investigation of the home health care industry, dubbed "Operation Home Alone," aimed at exposing abuses that exist in this area of health care throughout the state. The Unit's investigation of agencies, schools and aides involved in home health care has revealed systemic problems in the delivery of these services to Medicaid recipients. As of December 31, 2007, the investigation, which is ongoing, resulted in the filing of criminal charges against two licensed home care service agencies and their owners, three schools and their administrators or owners, close to 50 home health aides and personal care aides and more than a dozen others, including nurses, recipients, and individuals involved in the sale of fake home health aide certificates. The defendants are also liable for millions in Medicaid restitution and damages.

Under New York State law, home health services provided to 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. The 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 employees. Armed with fraudulent certificates, the unqualified individuals secured work with licensed home care services agencies as home health aides or personal care attendants. The licensed agencies contract to supply the aides and attendants to certified home health agencies and long-term home health care plans, which bill Medicaid for the services performed by the unqualified workers. Compounding the problem, the investigation also uncovered numerous examples of unqualified aides causing Medicaid to be billed without ever appearing at the patient's home, and in many cases splitting their pay with complicit Medicaid recipients or the recipients' family members.

Thirty-two defendants pleaded guilty during 2007, including corporate defendants Immediate Home Care, Inc. and Borina Home Care, Inc., both licensed home care service agencies. Immediate Home Care, Inc. pleaded guilty to grand larceny in the second degree and was sentenced to pay $12.5 million in restitution. Its owners, Nachem Singer and Ervin Rubenstein, pleaded guilty to grand larceny in the third degree and the fourth degree, respectively. Between 2003 and 2006 Immediate's revenues increased from approximately $3 million to over $52 million. Immediate employed more than 2,000 home health aides, including 23 who have already been convicted of charges related to their involvement in the purchase of fake training certificates. In addition to employing uncertified aides—and causing Medicaid to be billed for their work—Immediate Home Care recruited aides from training facilities where false certifications could simply be purchased, with little or no training provided. Two owners of such businesses—Mary Smalls, of Brooklyn-based Smalls Training and Counseling School, and Laurette Escarment, of Queens-based On-Time Home Care Agency—pleaded guilty to supplying hundreds of home health aides with false training certificates. Ms. Escarment was sentenced to pay restitution of $100,000. Ms. Small's sentence is pending.

Some of the Immediate aides provided little or no care to patients at all, but would bill for their time—sometimes 24 hours in a single day and sometimes splitting the proceeds with their patients and with Singer and Rubenstein. In addition, Immediate Home Care caused Medicaid to be billed for aides who provided home care to their relatives. Under Medicaid rules, services for close relatives, such as parents, spouses and in-laws, are not reimbursable, and for other relatives are only reimbursable under exceptional circumstances.

The sentencing of Borina Home Care is pending.

As part of the continuing investigation, the Unit issued subpoenas to nearly 60 of New York State's certified home health agencies that bill Medicaid for care provided by aides and nurses. The NYOAG also submitted a proposal to the state legislature calling for a statewide registry of certified home health aides to be developed and maintained by the New York State Department of Health.

People v. Charles Zizi and Ricardo Francois—Defendants Submitted False Claims to Medicaid for Services Not Provided and Used Their Home Health Care Company to Enrich Themselves

In another type of home health care case, the Unit partnered with the Nassau County District Attorney's Office to investigate and charge a home care agency operator and his associate with a litany of Medicaid-related and other crimes they committed in order to bankroll their extravagant lifestyles.

In October 2007, Charles Zizi was charged by indictment with stealing more than $300,000 from Medicaid by submitting claims for services that his home care agency did not provide, inflating hours of service of the nurses he employed and billing for maximum authorized services rather than actual services rendered. He was further charged with forging documents, laundering proceeds and falsifying tax filings for personal gain. Ricardo Francois was charged with participating in the crimes as the billing agent in Zizi's agency.

In 2002, Zizi assumed managerial control of then-dormant Always There Homecare, which had locations in Carle Place, Long Island and in New York City. He was in the process of purchasing the company at the time. Zizi was charged with identity theft for obtaining a corporate credit card in the names of Always There and the company's original owner, without the owner's knowledge or permission. Zizi and Francois are accused of using the card for nearly $100,000 in lavish purchases such as jewelry and intercontinental trips. Zizi is also accused of funneling company funds into other personal uses, forging signatures to gain authorization to manage another home care agency and laundering money through another company he controlled. In addition, Zizi is charged with keeping payroll funds meant to be withheld for state and federal taxes.

Francois is charged with forging signatures and falsifying tax filings to obtain personal loans, and submitting false claims to Medicaid for services never rendered. He was also in possession of one of the credit cards Zizi falsely obtained.

The NYMFCU filed a civil lawsuit to recover the proceeds of these crimes as well as to recoup penalties under the False Claims Act and the Social Services Law. The lawsuit also seeks to recover for other violations by Always There, which 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 is the first to be brought by the New York State-Nassau County joint Medicaid fraud task force, which 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 makes provisions for the shared administration and supervision of such joint endeavors.

The Zizi and Francois cases are pending.

People v. Suzan Sheldon, Anna Reid, Michele Schug, and Monica Webster—Nurses Charged with Lying about Nearly $250,000 in Billings for Home-bound Young Adult Patient

The Unit also pursued corrupt nurses as part of its home health care initiative. During October and November 2007, the NYMFCU arrested and charged registered nurse Anna Reid with grand larceny in the third degree and licensed practical nurses Suzan Sheldon, Michele Schug and Monica Webster with grand larceny in the second degree for falsely billing Medicaid for the care of a young adult 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 three defendants cared for the same patient, a young adult with cerebral degeneration and pulmonary collapse who requires around-the-clock home care nursing services. Because the patient's parents provided up to 12 hours of care daily, the nurses routinely split up among themselves the billing for those hours. In part, the Unit's investigation was prompted by a complaint by the recipient's mother after she received and reviewed an Explanation of Medical Benefits mailing. The Unit's investigation and audit found nearly $250,000 in payments for services that were not rendered: $66,322.09 wrongfully paid to defendant Sheldon; $80,161 wrongfully paid to Webster; $77,259.77 wrongfully paid to defendant Schug; and $18,813.76 wrongfully paid to defendant Reid.

The charges have not yet been resolved.

Nursing Homes' Long-term Home Health Care Programs

Finally, the Unit has conducted state-wide audits examining Medicaid reimbursement to nursing homes and to their affiliated long-term home health care programs. Due to a Department of Health error, the audits revealed that providers included unallowable nursing home costs in their long-term home health care programs, resulting in higher than justified Medicaid rates. The NYMFCU's audits resulted in changes in the way that the Department of Health reimbursed nursing home capital costs beginning in rate year 2005, and in the way long-term home health care programs must report their costs. These programs now have to identify and eliminate the unallowable costs.

During 2007, the Unit completed two additional audits which resulted in recoveries of $5,350,000 from the Center for Nursing and Rehabilitation in Brooklyn and $1,600,000 from Bronx-based Beth Abraham Health Services. As of December 31, 2007, the NYMFCU had completed 22 audits, which in total identified $48,250,000 in overpayments.

Pharmaceutical Manufacturers and Distributors

In teams comprised of federal prosecutors and attorneys from the National Association of Medicaid Fraud Control Units, New York took a lead role on behalf of the states in negotiating several settlements with pharmaceutical companies that unlawfully misbranded or marketed drugs. As result, the companies agreed to pay New York State a total of $7.8 million for the Medicaid monies the state expended for patient prescriptions for these drugs.

In addition, as further discussed below, the Unit brought its first case under the newly-enacted New York State False Claims Act.

Purdue Pharma, L.P.—Misbranding of OxyContin

New York State received $7.33 million in damages from the makers of OxyContin for misrepresenting the dangers of the drug. The payment, from Purdue Pharma, L.P., and associated entity the Purdue Frederick Company, Inc., came as a consequence of a federal prosecution that charged the companies with misrepresenting the narcotic painkiller's potential for abuse and addiction, and an accompanying civil settlement. The NYMFCU headed the team charged with negotiating on behalf of the states and distributing the funds to the 46 other participant states.

In a federal case prosecuted in the Western District of Virginia, the Purdue Frederick Company and three former or current Purdue executives pleaded guilty in May 2007 to charges of knowingly and fraudulently misbranding OxyContin, a time-release version of oxycodone, as being less addictive, less subject to abuse and diversion and less likely to cause tolerance and withdrawal problems than other pain medications.

Pursuant to their written plea agreements and the accompanying civil settlement, Purdue and the executives paid $160 million to federal and state government agencies to resolve liability for resulting costs to state Medicaid and other state and federally funded programs.

Purdue taught sales managers that OxyContin produced less euphoria in users and had less potential for abuse than short-acting opioid medications. Prosecutors alleged that Purdue's own internal research contradicted these claims. A great deal of highly publicized anecdotal evidence further cast doubt on this characterization of OxyContin.

To illustrate their claims, some Purdue sales representatives used visual aids with physicians to indicate that OxyContin produced fewer "highs and lows" over time in users than other types of pain medications. This inaccurate information about OxyContin through written materials constituted a mislabeling, or misbranding, of the drug.

Under the federal Food, Drug and Cosmetic Act and related regulations, "written, printed, or graphic matter . . . accompanying [a drug]" disseminated by drug manufacturers constitutes part of the drug's label, and to the extent that information is "false or misleading in any particular," constitutes misbranding.

Medicis Pharmaceutical Corporation—Off-Label Marketing of Loprox

As part of a $9.8 million settlement with Medicis Pharmaceutical Corporation of Scottsdale, Arizona that involved 48 states, the District of Columbia and the federal government, New York State received $526,379. The agreement with Medicis resolved allegations that the company promoted the use of a topical skin preparation, Loprox, for use on children under the age of ten, without approval by the Food & Drug Administration (FDA). The settlement also resolves claims brought by four former Medicis sales representatives in the federal District Court of Kansas.

The National Association of Medicaid Fraud Control Units conducted the settlement negotiations on behalf of the states, with representatives of the Ohio, Illinois and New York Medicaid Fraud Control Units leading the effort.

The participating states and the federal government alleged that from approximately November 2001 through April 2004, sales representatives at Medicis targeted pediatricians, urging the doctors to use Loprox as a treatment for diaper rash. The FDA has approved the use of Loprox as a fungicide for patients over ten years of age. However, use of Loprox as a treatment of diaper dermatitis and other skin disorders in children under ten is not a "medically accepted indication" of the drug. As a result of this "off-label" promotion by Medicis, state Medicaid programs paid millions of dollars for Loprox prescriptions that would not have been reimbursed if government authorities had known that the prescriptions resulted from such a marketing campaign.

As part of the settlement, Medicis entered into a corporate integrity agreement with the United States Department of Health and Human Services' Inspector General. The agreement includes provisions that Medicis will implement an internal code of conduct to ensure that it will market, sell, promote, research, develop and advertise its products in accordance with all federal health care program and FDA requirements.

Merck & Co., Inc. —Misrepresentation of Vioxx Risks

On September 17, 2007, in the NYMFCU's first use of New York State's recently-enacted False Claims Act, the NYMFCU and the New York City Corporation Counsel filed a lawsuit against the maker of Vioxx for misrepresenting the dangers the drug posed to its users. The lawsuit seeks damages and civil penalties in addition to restitution for tens of millions of taxpayer dollars wrongfully spent on Vioxx prescriptions, and marks the first time the state and city have brought a joint action to fight Medicaid fraud.

The civil suit accuses Merck & Co., Inc. of deliberately suppressing and concealing information about the seriousness of the cardiovascular risks associated with Vioxx. The suit claims many of those prescriptions would never have been written had doctors been properly informed.

Between 1999, when Vioxx was introduced, and 2004 when it was pulled from the market, Medicaid and the Elderly Pharmaceutical Insurance Coverage (EPIC) spent over $100 million on Vioxx prescriptions in New York State. For its residents receiving Medicaid assistance, New York City paid a substantial share of those costs.

Approved to treat the symptoms of osteoarthritis, dysmenorrhea, rheumatoid arthritis, migraine headaches and juvenile rheumatoid arthritis, Vioxx quickly began to demonstrate adverse effects including increased incidence of heart attacks and strokes among its users. In fact, Merck's own research found that patients who took Vioxx had five times the risk of having a heart attack compared to those taking naproxen, a similar drug. Further, court documents show Merck researchers discussed tailoring clinical trials of Vioxx to minimize negative outcomes. Internal emails proposed allowing test subjects to take aspirin during trials to prevent heart attacks, and suggested "excluding high-risk CV (i.e., cardiovascular) patients" from an initial study. A later independent study corroborated these initial findings, estimating that Vioxx had contributed to 27,785 heart attacks and sudden cardiac deaths among Americans who had taken the drug between 1999 and 2003.

Nevertheless, according to the suit, Merck gave its sales representatives explicit instructions on downplaying or distorting data when questioned about Vioxx's cardiovascular risks. At the same time, Merck waged an aggressive direct-to-consumer advertising campaign that likewise misrepresented the safety of Vioxx. As a result, Merck is accused of having caused New York doctors to prescribe Vioxx to patients whose cardiovascular conditions made them especially susceptible to the drug's negative effects. Had the doctors been adequately informed, the suit alleges, they would not have prescribed Vioxx and thus Medicaid and EPIC would not have paid for them under these circumstances.

The False Claims Act permits the state and city to seek treble damages for Merck's conduct as well as civil penalties. The damages and penalties, which are expected to reach into the tens of millions, will be determined at trial. The suit is currently pending in the United States District Court for the Eastern District of Louisiana before the judge appointed to handle a large number of claims concerning Vioxx.

Managed Care Organizations

As part of a series of joint audits and investigations with the New York State Office of the Medicaid Inspector General, New York State recovered approximately $35 million from more than 30 managed care organizations for duplicate claim payments.

Managed care organizations have state contracts to provide or arrange for health services to Medicaid and Family Health Plus (FHP) patients. The organizations submitted and were paid for duplicate claims after more than one client identification number (CIN) had been erroneously assigned to the same Medicaid or FHP recipient.

Between July 1, 2000 and November 30, 2006, for example, Healthfirst PHSP, Inc. and its affiliate, Managed Health, Inc., submitted duplicate coverage claims for nearly 6,000 individuals who had more than one CIN assigned to them. Healthfirst received duplicate monthly payments, averaging $126 per month and maxing out at $626 per month, in addition to supplemental monthly payments averaging $2,957 and going as high as $4,995. In the largest single settlement amongst the 33 managed care organizations, Healthfirst reimbursed the state approximately $6 million.

Since 1996, Medicaid payments to managed care organizations rose from approximately $1 billion to over $7 billion in 2006, as they are playing an expanded role in providing healthcare to uninsured New Yorkers. These providers are contractually entitled to only one monthly payment for each person enrolled in Medicaid or FHP. The managed care organizations are responsible for alerting their local department of social services when multiple payments are received, so that the ineligible accounts can promptly be removed from the program and reimbursement can be made.

The NYMFCU worked closely with the New York State Department of Health in strengthening the existing contractual language concerning managed care organizations' obligations to promptly report the receipt of duplicate payments and to retain documents concerning duplicate CINs. In addition, the NYMFCU is continuing to work closely with other state and local agencies, including the NYS Department of Health, the NYS Office of the Medicaid Inspector General, the NYS Office of Temporary and Disability Assistance**,** and the New York City Human Resources Administration to minimize the risks of overpaying managed care organizations as a result of duplicate CINs. The task force's efforts have already led to changes in the statewide computerized data system that receives, maintains and processes information regarding the management of social service programs, including eligibility files for persons who have applied for and/or who are receiving Medicaid.

Drug Diversion and Pharmacy and Prescription Fraud

2002-2005 Conspiracy to Divert Millions of Dollars of Prescription Drugs and Launder the Illegal Proceeds—2007 Grand Jury Investigation Resulted in New Indictment Unsealed in January 2008

For approximately four years the NYMFCU has investigated, prosecuted and filed civil lawsuits against individuals and companies, including pharmacists, retail pharmacies and their owners and pharmaceutical wholesalers, engaged in a nation-wide drug diversion conspiracy involving the trafficking in black-market prescription medications. The investigation, which has relied upon the use of wiretaps, search warrants, hundreds of subpoenas and collaborative efforts with federal and state law enforcement agencies, resulted in charges being filed in three phases in New York and in federal court in Utah.

The investigation has uncovered a criminal conspiracy that operated from approximately March 2002 to approximately April 2005. The conspirators illegally obtained prescription medications, including unused medications and medications stolen from manufacturers, sold the drugs to wholesalers in New York, Utah and Texas, and then illegally resold the diverted drugs to pharmacies in New York and elsewhere for sale to retail customers, including Medicaid recipients. The diverted pharmaceuticals in these cases primarily consisted of expensive HIV/AIDS medications and also included medications stolen from the pharmaceutical manufacturers, Pfizer, Inc. and Novartis Pharmaceuticals. Conspirators also used numerous companies and entities to launder the millions of dollars in proceeds from the sale of diverted prescription medications. The latest indictment, filed in December 2007 and unsealed in New York County Supreme Court in January 2008, focuses on those defendants participating in the conspiracy as money-launderers.

The first set of charges, beginning in 2004, resulted in 12 convictions; the second set, focused on Utah wholesaler PDRX Marketing, Inc., resulted in three convictions; and charges filed in 2006 have thus far resulted in seven convictions of both individuals and companies. For example, on March 14, 2007, Lakhram "Larry" Mangar, who was a licensed pharmacist, was convicted in Nassau County of criminal diversion of prescription medications and prescriptions in the first degree and sentenced to four to 12 years in prison. Mangar had previously pleaded guilty to selling diverted prescription medications to an unlicensed and unauthorized wholesaler. Judgments and recovered funds exceed $4,000,000.

The new 156-count indictment charges seven individuals and eight companies operating around Manhattan's wholesale perfume district with conspiracy in the fourth degree, money laundering in varying degrees, and scheme to defraud in the first degree. The drug repackagers are alleged to have paid for the drugs through sham transactions disguised as payments for wholesale perfumes. The perfume companies charged criminally are also alleged to have conspired to evade restraining orders. Two defendants are charged with criminal diversion of prescription medications and prescriptions in the first and second degrees. In addition to the filing of criminal charges, the NYMFCU obtained restraining orders freezing defendants' assets and filed a lawsuit seeking forfeiture of $63 million from these defendants and an additional 14 individuals and entities which received the proceeds of the criminal activity. The defendants also face additional monetary liability for fraud.

TLC Medical, P.C.—Doctor's Medical Practice Sold Bogus Prescriptions Ultimately Resold to Corrupt Pharmacies Which Fraudulently Billed Medicaid for Drugs Never Dispensed

The NYMFCU's prosecution of a ring of 16 individuals and five corporations involved in selling unjustified prescriptions ultimately filled by corrupt pharmacies that billed Medicaid for drugs which were never dispensed, produced three convictions in 2007 and two in January 2008, and one guilty plea.

As discussed in last year's report, 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 fraudulent prescriptions. The investigation included undercover surveillance and the use of confidential informants.

As alleged in the criminal charges, TLC Medical was little more than a mill where the physician in charge 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—the physician simply wrote prescriptions for all of the "patients," for the same four drugs.

TLC Medical's staff provided security to manage the volume of individuals who lined up to get prescriptions at the clinic and screened those "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, eight of whom were charged in the case. 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 allegedly distributed the prescriptions to three other pharmacies in which he held a financial interest. These pharmacies used the patients' Medicaid cards to electronically bill Medicaid for the prescribed medications as though they had actually dispensed them. In fact, however, in the overwhelming majority of instances, no patients ever went to the pharmacies and no drugs were ever dispensed. One of the charged pharmacies billed Medicaid approximately $2 million for medications never dispensed and other related pharmacies in Brooklyn, Queens and the Bronx billed Medicaid for an additional $3 million for medications from prescriptions never filled.

During 2007, Marlon Miller, Evelyn Gonzalez and Jose Santana, who worked at TLC Medical and assisted in the sale of fake prescriptions, pleaded guilty. Miller and Gonzalez, who also bought and resold the prescriptions, pleaded guilty to felonies. Miller was sentenced to one year in jail; Gonzalez was sentenced to two to six years incarceration. Santana pleaded guilty to a scheme to defraud the state by unlawfully selling prescriptions, a misdemeanor, and was sentenced to one year incarceration. Other defendants in this case include Jesus Perez, who pleaded guilty to conspiracy in the fourth degree for buying and reselling prescriptions, and was sentenced in July to one and one-half to three years in prison, and Abadulah Ahmad, who pleaded guilty in June to conspiracy in the fourth degree and was sentenced in February 2008 to one year incarceration. Finally, Pedro Santiago, a high-ranking member of the Latin Kings gang, who bought prescriptions and Medicaid cards from "patients" and then resold them to Ahmad, pleaded guilty to a felony on January 29, 2008. He was sentenced in February to two and one-half to five years in prison.

The charges against the other individual and corporate defendants are still pending. In addition, the civil lawsuit filed against criminal defendants and others, seeking the recovery of more than $22 million, has not yet been resolved.

People v. Michael Chait—Doctor Charged in Prescription Drug Trafficking Scam

Following an investigation in which the NYMFCU worked cooperatively with the Special Narcotics Prosecutor for New York City, the New York State Bureau of Narcotics Enforcement, the U.S. Drug Enforcement Administration's Drug Diversion Unit, and New York City's Human Resources Administration's Bureau of Fraud Investigations, the NYMFCU arrested and obtained an indictment against Michael Chait, a Long Island doctor charged with writing hundreds of illegal prescriptions for patients from the Bronx and Manhattan that cost taxpayers hundreds of thousands of dollars in medically unnecessary Medicaid billings.

Chait wrote prescriptions for huge quantities of highly addictive and dangerous painkillers, including OxyContin and Dilaudid, for Medicaid recipients who traveled from New York City to his practice in the Town of East Hampton on the eastern end of Long Island, approximately 100 miles away.

Between January 1 and March 7, 2007, Chait saw up to 50 persons a day, many of whom were Medicaid recipients from New York City, and some of whom used their Medicaid cards to obtain the controlled medications from pharmacies in the Bronx and Manhattan. The drugs were frequently re-sold on the street for thousands of dollars per prescription and Chait caused the Medicaid program to pay more than $700,000 for the unnecessary prescriptions. Chait is charged with conspiracy in the second degree, grand larceny in the second degree, criminal sale of a prescription for a controlled substance, criminal facilitation in the second degree, and criminal possession of a controlled substance in the second degree. The case is pending.

People v. Neil Norwood—Joint Investigation with Local Law Enforcement and Westchester County DA Resulted in Conviction of Dishonest Pharmacist

On April 24, 2007, Neil Norwood, the former owner of pharmacies in Sleepy Hollow and Tarrytown, New York, was convicted of grand larceny in the first degree, sentenced to two to six years incarceration, and paid restitution to the state in the amount of $1.5 million ($1,336,054 as a result of Medicaid overpayments and $223,423 in overpayments made by the Elderly Pharmaceutical Insurance Coverage Program). Norwood's conviction was the result of a joint investigation with the Tarrytown Police Department and the Westchester County District Attorney's Office.

Tarrytown police initially arrested Norwood for insurance fraud. The ensuing investigation revealed that over a five-year period Norwood fraudulently billed for prescriptions and made cheating Medicaid, New York's Elderly Pharmaceutical Insurance Coverage Program and private insurers an everyday business practice. He regularly provided less medication than was prescribed yet billed for the full amount, submitted bills for phantom prescriptions, and dispensed brand-name drugs when he actually provided generic drugs. He even employed a computer code system to manage how much customers' prescriptions were to be shorted. When a customer's order was entered into the pharmacy's computer, a code would appear on the screen instructing Norwood's employees how to short the customer's order.

In addition to the $1.5 million repaid to New York State taxpayers, Norwood repaid an additional $1.4 million to private insurance companies.

People v. Roseann Silvia—Nurse Stole Narcotics for Personal Use

On June 15, 2007, Roseann Silvia, a registered nurse, was arrested and charged with numerous felonies stemming from her theft of drugs while working at a hospital and nursing home. In January 2008, Silvia pleaded guilty to criminal possession of a controlled substance in the fifth degree (a class D felony), falsifying business records in the first degree (a class E felony), and petit larceny (a class A misdemeanor). She is scheduled to be sentenced later this year.

On October 2, 2006, while employed at Brookhaven Memorial Hospital in Patchogue, the defendant falsified records to reflect that she had given a patient three doses (three milligrams each) of morphine from three separate vials (ten milligrams each) and had appropriately wasted the excess narcotic from two of the vials, when in fact, she had stolen the 30 milligrams for her own personal use. That morning, co-workers reported that Silvia could not stay awake, keep her eyes open or even stand on her own two feet. She could not attend to the needs of her patient and she was unable to communicate coherently with other nurses about her patient's condition. She was also unable to give a report to the nurse coming on duty, as is customary at the change of shift.

Silvia subsequently worked at West Islip's Our Lady of Consolation Nursing and Rehabilitative Care Center until March 23, 2007, when it was discovered that she had stolen a total of three, ten milliliter vials of Dilaudid and had falsified records to conceal her theft, including creating false narcotic inventory sheets and forging another nurse's name.

Hospitals and Hospices

Audits of Hospitals and Hospices to Uncover Double-Billing

The NYMFCU has continued to review hospice and hospital billings to ascertain whether both entities billed for the same services, since Medicaid pays for hospice patients admitted to hospitals by reimbursing the hospices, and not the hospitals. During 2007, the Unit completed 22 audits, which showed that hospitals across the state billed Medicaid for the same services billed by affiliated hospices. The Unit recovered $1,255,000 through these audits in 2007. In total, the two-year project has resulted in Medicaid recoveries of more than $1,670,000.

Clinics and Treatment Centers

Firms Operating Dialysis Clinics Erroneously Billed Services to Medicaid

The NYMFCU reached a settlement last fall with two of the nation's largest providers of dialysis services that erroneously overbilled the state's Medicaid system.

National Medical Care, Inc. and DaVita, Inc. agreed to pay back a total of $3,693,062 they received from Medicaid for claims erroneously submitted on behalf of several dialysis clinics across the state. Fresenius Medical Services and Renal Research Institute, subsidiaries of National Medical Care, Inc., provide administrative, billing and consulting services for 12 dialysis clinics in Buffalo and New York City, while DaVita provides services for 11 clinics in New York City, Buffalo, Ithaca, West Seneca, Tarrytown and Port Chester.

In two separate cases, audit-investigations by the NYMFCU discovered that from 2001 through 2006, Medicaid was billed for services that should have been paid by Medicare. Because of this, Medicaid overpaid National Medical Care subsidiaries by $2.2 million and DaVita by over $1.4 million. Both companies cooperated with the audit-investigations.

According to the settlements, the two companies failed to bill Medicare first when a patient was eligible for both Medicaid and Medicare coverage. In those cases, Medicare is required to serve as "primary payer" with Medicaid covering any remaining costs. However, in some instances only Medicaid was billed as the primary payer after patients became eligible for Medicare coverage. At other times, Medicare was billed after the fact, without a reversal of the Medicaid claim.

The settlements also implement a compliance program to prevent the problems uncovered from occurring again. The measures include: 1) the institution of compliance policies, including mandatory training for all staff involved in billing and 2) an annual internal compliance audit.

Under current law, for-profit, publicly traded corporations like National Medical Care and DaVita are prohibited from directly providing dialysis services in New York. Instead, these companies generally provide administrative, billing and consulting services. Together, the two companies provide approximately two-thirds of all dialysis treatments in the United States.

Nursing Homes

People v. Abe Zelmanowicz, Eastchester Health Care Center, LLC and Split Rock Multi-Care Center, LLC—Fraudulent Medicaid Billing Based on False "Bed Holds"

During 2007, the NYMFCU obtained convictions against the former owner of two Bronx nursing homes and the two companies that operated the nursing homes for defrauding the Medicaid program of millions of dollars by overcharging for services at the two facilities over a six-year period.

Abe Zelmanowicz, the owner, and Eastchester Health Care Center, LLC and Split Rock Multi-Care Center, LLC, the entities which ran the nursing homes, all entered guilty pleas to grand larceny in the second degree (a class C felony).

From 1997 to 2003, Zelmanowicz, through his nursing homes, submitted bills to Medicaid fraudulently claiming that the facilities were entitled to payments for reserving or "holding" residents' rooms during periods when the residents were temporarily hospitalized, commonly referred to as "bed holds." Under New York State law, nursing homes are allowed to temporarily bill Medicaid for bed holds only when 1) the nursing home is at 95% occupancy and 2) the resident lived in the nursing home for at least 30 days before his/her hospitalization.

Zelmanowicz admitted that his homes did not meet the requirements for "bed hold" reimbursement, but he still submitted billing for millions of dollars over the course of more than six years. He also admitted that he stole nearly $3 million on behalf of the nursing homes. Zelmanowicz was sentenced to two to six years in prison and paid $2.5 million in criminal restitution and civil damages for fraudulently billing Medicaid. He must pay $3.5 million more over the course of a three-year period.

Zelmanowicz and his partner sold the nursing homes in September 2002. The current owners of the nursing homes cooperated with the NYMFCU's investigation and were not accused of any misconduct.

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 $175,000 in improper billings involving bed holds. The Unit reached settlements with 17 nursing homes and recovered from them the improper overpayments. In addition, the NYMFCU's Rochester regional office audited and reached settlements with five nursing homes for bed hold overbillings, recovering $97,672.

Dentists

People v. Robert and Emilia Alonso—Husband and Wife Team Charged with Stealing $2.8 Million from Medicaid and Laundering Money to Conceal Assets

In May 2007, the NYMFCU filed an indictment charging Westchester County dentist Robert Alonzo and his wife, Emilia Alonso, who worked as her husband's billing agent, with stealing $2.8 million from the Medicaid program through fraudulent billings. As charged, from May 15, 2000 to October 1, 2006, Emilia Alonso fraudulently billed Medicaid for services her husband either did not provide, or which were not billable to Medicaid because he was working on salary at another care center. These included routine services such as cleanings and x-rays, as well as major procedures like gingivectomies and oral surgeries. In addition, Emilia Alonso submitted bills to Medicaid for dates when Robert was out of the country and traveling to locations including New Zealand, Fiji, Tahiti, Switzerland and Spain.

The NYMFCU further discovered that in November 2006, knowing that the NYMFCU was investigating the dental practice, Emilia Alonso withdrew $828,817 from one bank account and deposited these funds into another account at a different, foreign-based bank, which she later tried to put in their 18 year-old son's name. Both Robert Alonso and Emilia Alonso omitted the $828,817 from sworn statements regarding their total assets. When confronted with this discrepancy, the Alonsos claimed they had donated the money to charities located in the Dominican Republic and Argentina. Letters they submitted as evidence of such transactions turned out to be bogus. As a result, the NYMFCU rearrested the Alonsos and filed a second indictment in November 2007, charging them with the additional crimes of money laundering in the first degree, criminal possession of a forged instrument in the second and third degrees and criminal contempt in the second degree.

The court has consolidated the two indictments and the criminal charges are pending. The NYMFCU also filed a civil lawsuit against the couple seeking forfeiture of assets obtained through the proceeds of their crimes and, under the Social Services Law, compensatory and treble damages.

Doctors

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

In 2007, the Unit continued to review physician and hospital drug billing 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, and consisting primarily of injectable chemotherapy and therapeutic drugs, doctors and hospitals cannot bill Medicaid for these drugs beyond their actual cost, as determined through an examination of invoices. The Unit's audits, however, have revealed that many physicians and hospitals are billing Medicaid for these drugs well in excess of their actual cost.

Since beginning the project, the Unit has recovered just under $13 million from 114 providers, including hospitals, physician group practices and individual physicians. In 2007, the Unit's Special Projects Division completed 19 J-code audits, recovering over $1.4 million in restitution for the Medicaid program.

In addition, this past year the Unit's Syracuse regional office recovered approximately $340,000 from 11 doctors and medical centers as a result of J-code audits.

People v. Ioni Sisodia—Psychiatrist Cheated Medicaid by Falsely Billing for Face-to-Face Therapy Sessions

Dr. Ioni Sisodia pleaded guilty to petit larceny on June 6, 2007, admitting that she billed Medicaid for 45-minute face-to-face therapy session when in reality she met with recipients only briefly for medication management. She was sentenced on November 20, 2007, to a conditional discharge and repaid $75,645 to the Medicaid program.

People v. Nabil Elhadidy—Doctor Billed Medicaid for Non-Existent Patient

On August 1, 2007, physician Nabil Elhadidy pleaded guilty to offering a false instrument for filing in the second degree after the NYMFCU found that Elhadidy prescribed medication to a patient who did not exist, and then billed Medicaid for the office visit by the phantom patient. The court sentenced Elhadidy to a conditional discharge on August 1, 2007. The doctor performed 50 hours of community service as a part of his sentence.

Transportation Companies

Bates Ambulette—Billed Medicaid for Undocumented Trips

Raymond Bates, the owner of Bates Ambulette, a Port Chester, New York taxi company, agreed to reimburse $503,795 to the New York State Medicaid program. Bates Ambulette, which specializes in providing transportation to Medicaid recipients who attend day treatment programs in Westchester County, billed Medicaid for services that were not supported by documentation. Specifically, Mr. Bates agreed to repay Medicaid $372,772 for unsupported billings, together with $131,023 in interest.

The investigation conducted by the NYMFCU revealed that from January 1, 1998 through January 1, 2003, Bates Ambulette repeatedly billed Medicaid for services for which it lacked required records establishing that the company actually transported Medicaid recipients. To prevent and deter fraudulent billing, Medicaid requires its health care providers to document and retain records that establish the nature and extent of the services that they provide to Medicaid recipients. Under the law, Medicaid will not pay for services that are provided without this documentation. While the investigation revealed unsubstantiated billings, the investigation did not uncover evidence of fraudulent conduct, and Mr. Bates and his company cooperated with the investigation.

Shari Kessler and Kings & Queens Transportation Company—Default Judgment Obtained Against Company Which Could Not Substantiate Billings

In May 2007, the NYMFCU obtained a default judgment of $1,453,665 stemming from an action filed against Kings & Queens Transportation Co. and one of its principals, Shari Kessler. The company did not maintain records substantiating its billings, and its billings were contradicted by the service records of hospitals and other health care providers to which Medicaid recipients were allegedly transported. The service records showed that the recipients did not, in fact, receive treatment on the days billed. Kessler and the company failed to contest liability in the matter and the Unit obtained a judgment in the amount of $363,416 in compensatory damages resulting from Medicaid overpayments and $1,090,249 in treble damages. The NYMFCU is currently pursuing collection efforts.

Other Providers

People v. Kelly Strade—Medicaid Service Coordinator Stole $94,000 From Taxpayers

Medicaid service coordination is provided through the Office of Mental Retardation and Developmental Disabilities (OMRDD) to assist persons with developmental disabilities and mental retardation in gaining a good home, job, rewarding circle of friends, enjoyable leisure activities and access to needed medical and clinical services. In order to qualify for Medicaid reimbursement, the services must be provided by a qualified Medicaid service coordinator with either an associate's degree or a registered nurse's license.

In January 2004, Aspire of Western New York, Inc. hired Strade based upon her false claim that she had received a nursing degree from Lycoming College in Pennsylvania.

Strade worked as a Medicaid service coordinator for Aspire until February 2006, when it was discovered that she had no such degree. Aspire reported this to OMRDD and the NYMFCU commenced an audit-investigation, which determined that because of Strade's deception, Medicaid paid Aspire $94,696 for services that did not qualify for reimbursement.

Additionally, Strade forged signatures and falsely recorded face-to-face visits with recipients for services never provided—leading Aspire to bill Medicaid for services that never took place. In particular, she claimed to provide services to a Medicaid recipient at the New York State School for the Blind in Batavia that never happened.

On June 26, 2007, Strade pleaded guilty to grand larceny in the fourth degree and falsifying business records in the first degree. She was sentenced in September to five years probation and 50 hours of community service, and was ordered to pay $94,696 in restitution.

Various Providers Billed Medicaid for Services Rendered to Deceased Individuals

Since 2005, the NYMFCU has been auditing numerous providers throughout the state by comparing billing records against date of death records of former Medicaid recipients. The audits have revealed millions of dollars in overpayments to a variety of providers, including skilled nursing facilities, transportation companies, certified home health agencies and durable medical equipment companies. Through December 31, 2007, these investigations and audits have returned over $4.1 million dollars to the Medicaid program, $400,000 of which was refunded in 2007.

PATIENT ABUSE AND NEGLECT PROSECUTIONS AND CIVIL ACTIONS

Statistical Overview

In 2007, the NYMFCU reviewed 924 allegations of patient abuse and neglect, (including the theft of patients' money), opened 60 criminal investigations, initiated prosecutions against 25 defendants, and secured 32 convictions. One defendant was acquitted following a trial. (See Tables A-3 and A4, Appendix.)

This section reviews the status of the NYMFCU's prosecutions stemming from the 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 2007, reflecting the broad range of cases that fell within this category.

Hidden Camera Cases

Prosecutions stemming from the MFCU's use of cameras hidden in patients' nursing home rooms, with the consent of the patients' families, have continued to be successful, and resulted this past year in a rare conviction of the corporate owner and operator of a nursing home for neglecting a patient and falsifying business records to conceal its neglect. Across the state in 2007, 14 defendants were convicted after pleas or trials based on hidden camera surveillance operations.

Corporate Owner and Operator of the Northwoods Rehabilitation and Extended Care Facility Found Guilty of Falsifying Business Records and Wilful Violation of the Public Health Law

At the Northwoods Rehabilitation and Extended Care Facility, in Cortland, New York, a hidden video camera in the room of a comatose patient 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. One certified nurse aide was found guilty after trial in March, and another certified nurse aide and three licensed practical nurses were also convicted of felonies in 2007. On October 9, 2007, following a jury trial, Highgate LTC Management, LLC, the owner and operator of the facility, was found guilty of three felony counts of falsifying business records in the second degree and six counts of wilful violation of the Public Health Law. The corporate defendant, which

owns and operates five other facilities in upstate New York, is scheduled to be sentenced on May 15, 2008.

Jennifer Matthew Nursing and Rehabilitation Center

An investigation by the NYMFCU revealed systemic neglect of residents at the Jennifer Matthew Nursing and Rehabilitation Center in Rochester, New York. The investigation centered on the treatment, or lack thereof, provided to a 70 year-old resident of the facility. The resident suffered from dementia, cerebral vascular accident (stroke), type II diabetes, and other ailments that left him totally dependant on Jennifer Matthew's staff for all activities of daily living. He could not communicate, was immobile and bedridden. He obtained all of his nutrition, medications, and hydration through a feeding tube inserted in his stomach. The resident was also at risk for skin breakdown.

With the consent of his family, investigators installed a hidden camera in the resident's room for more than a month to record the treatment provided. The tapes documented gross neglect by the staff and, when matched against Jennifer Matthew's records, proved that nursing home staff repeatedly falsified the record of care. During the 39-day period, nurses and certified nurse assistants made more than 300 false entries. On scores of occasions, staff failed to provide required care and treatment. For example, the patient was not turned and repositioned every two hours as required and staff did not provide him with regular oral care and medications, timely incontinence care, adequate hydration or feeding, or range of motion therapy. The investigation subsequently revealed that certain caregivers slept, watched movies or left the facility during their shifts.

The investigation and prosecution of nursing home staff came to a close in 2007, when four certified nurse aides and one registered nurse were convicted of wilful violation of the Public Health Law (by neglecting the patient) and falsifying business records in the second degree. This brought the total number of caregivers convicted in the Jennifer Matthew investigation to 14 (nine certified nurse aides and five registered nurses), four of whom received sentences that included incarceration. The NYMFCU also filed a civil lawsuit against the principal shareholder and chief executive officer of the corporation who owned the nursing home seeking damages and injunctive relief. As a result of the investigation, new prospective owners are currently running the facility.

Hollis Park Nursing Home

The NYMFCU's prosecution of ten employees of Hollis Park Manor Nursing Home in Queens, New York resulted in the convictions of two licensed practical nurses and two certified nurse aides during 2007, for falsifying business records. Surveillance from a hidden camera 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, 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. In fact, the patient frequently went without any food or liquids.

Charges of wilful violation of the Public Health Law, endangering the welfare of an incompetent or physically disabled person, and falsifying business records are pending against six defendants, including the home's former medical director, four certified nurse aides and one licensed practical nurse.

Other Abuse and Neglect Cases

People v. William Morrison—Former Certified Nurse Aide Convicted after Trial for Raping 90 Year-old Nursing Home Resident

Following a five-day trial, on March 2, 2007, a jury found William Morrison guilty of rape in the first degree, a class B felony, sexual abuse in the first degree, a class D felony, and endangering the welfare of a vulnerable elderly person, a class E felony. On April 18, 2007, a judge sentenced Morrison to 25 years incarceration and five years of post-release supervision.

Morrison had been employed by Rome Memorial Hospital, in Rome, New York, for several months before he transferred to the hospital's affiliated 80-bed nursing home. Morrison raped a 90 year-old patient approximately two weeks after that transfer. When Morrison began work at the nursing home, the home sought to perform a criminal background check, but that process had not been completed before Morrison raped the elderly resident. Such a background check would have revealed that Morrison had previously been convicted of a felony drug offense in 1992 and several misdemeanors in the 1990s. His last conviction was for a misdemeanor drug offense in 1999.

Upon learning of the alleged incident, administrators at the nursing home immediately transferred the victim to the hospital for an examination. The Rome Police Department initiated an investigation, during which DNA evidence implicated the defendant. The nursing home immediately terminated Morrison and cooperated fully throughout the investigation and the trial.

People v. Debra Wilson—Defendant Found Guilty and Sentenced to Jail for Ignoring Care Plan and Improperly Lifting and Injuring Elderly Patient

On March 8, 2007, a jury found Debra Wilson, a certified nurse aide, guilty of jeopardizing the safety of an elderly nursing home resident by failing to follow specific instructions regarding the patient's care. All nursing home patients have an individual care plan to ensure their safety and health which include staff directions on transferring frail patients who are susceptible to injury due to ailments such as advanced osteoporosis or poor skin integrity.

Evidence showed that on April 28, 2005, Wilson, while working at the Shore Winds Nursing Home in Rochester, transferred a 92 year-old patient from a wheelchair to a bed without staff assistance. By doing so, she acted against the patient's written care plan that specified transfers were to be done by two staff members. While Wilson was moving the patient, the patient sustained a skin tear and bruises on the arms and hand. Two hours later,

a nurse at the facility found the patient in her room with a bloody towel wrapped around her arm.

The jury found Wilson guilty of endangering the welfare of an incompetent or physically disabled person and wilful violation of the Public Health Law. On May 14, 2007, Wilson was sentenced to incarceration every weekend for six months.

People v. Brenda Griffin—Nurse Charged with Injuring Patient and Concealing Actions

On August 20, 2007, the NYMFCU arrested a former nurse at Whittier Rehab and Skilled Nursing Center in Ghent who recklessly injured a patient and then hid the incident from facility staff.

Registered nurse Brenda Griffin was charged in a felony complaint with falsifying business records in the first degree and offering a false instrument for filing in the first degree, and the misdemeanors of reckless endangerment and wilful violation of the Public Health Law.

According to the charges filed against her, Griffin changed a resident's catheter without a physician's order, despite rules forbidding her to do so, causing injury to the patient. She then 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. Griffin is also accused of renewing her nursing license under false pretenses by failing to disclose that she had been restricted by the facility for which she had formerly worked and from which she had resigned to avoid the full imposition of those restrictions.

The case is currently pending.

People v. Virginia Wilson—Certified Nurse Aide Who Did Not Perform Required Safety Checks Charged with Falsifying Business Records

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 a 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 indicate the performance of such checks in the nursing home's business records.

Although Wilson indicated 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.

The case is currently pending.

Thefts of Residents' Money and/or Identity

Welcome Home—Operators of Family Type Home For Adults Ripped-Off Residents

In July 2007, following the filing of a grand jury indictment, the NYMFCU arrested the former operators of Welcome Home, a family type home for adults in Beaver Dams, New York, who used the credit cards, bank accounts and identities of their residents, one of whom was receiving hospice care, to acquire a swimming pool, a tractor and cash. Family type homes are certified by county departments of social services, and are typically single family homes in which homeowners provide supportive services, meals, supervision and personal care to four or fewer adults who are unrelated to the homeowner and/or operator. In this case, the two operators, a husband and wife, pleaded guilty in January 2008. Harry Smith pleaded guilty to grand larceny in the fourth degree and attempted criminal possession of a forged instrument in the second degree, both felonies, and will be sentenced later this year to one year of incarceration. His wife, Christine Smith, pleaded guilty to petit larceny. Together, they will have to pay restitution of $56,105.

People v. Darrell Evans—Unlicensed Adult Home Owner Stole Money From Resident; Residents of the Dangerous Home Relocated

The NYMFCU filed criminal charges in June against Darrell Evans, the owner of Alberta's House in Brooklyn, an unlicensed adult home. Evans unlawfully used a resident's ATM and PIN to withdraw money from the resident's bank account. In August, Evans pleaded guilty, was ordered to repay the resident, and was prohibited from running a residential care facility for one year. The investigation also found that Alberta House was unsanitary and dangerous, risking the health and safety of its residents. As a direct result of the NYMFCU's investigation, the New York State Department of Health's Metropolitan Area Regional Office Adult Home Unit arranged to relocate nine residents requiring adult home services to licensed facilities.

People v. Rebecca Sopko—Certified Nurse Aide Stole Money From Elderly Nursing Home Resident to Feed Cocaine Habit

In February 2007, Rebecca Sopko, a certified nurse aide at The Waters of Orchard Park, a nursing home in Erie County, stole two blank checks from a 97 year-old resident. She forged the checks as payable to herself for $2,000 and $6,000, respectively, and subsequently admitted that she used the money to pay off a debt stemming from a cocaine purchase. On May 22, 2007, Sopko was arrested, charged and pleaded guilty to grand larceny in the fourth degree and attempted forgery in the second degree (both felonies). On October 19, 2007, she was sentenced to one and one-third to four years in prison.

APPENDIX

Investigations

Table A-1[1]

Investigations Opened and Closed by Provider Category 2007				
Provider Category	**Investigations Opened**		**Investigations Closed**	
	Number	*Percent of Total*	*Number*	*Percent of Total*
Facilities—Hospitals	27	6%	61	16%
Facilities—Nursing Facility	87	21%	65	17%
Facilities—Other Long-term Care	4	1%	2	1%
Facilities—Substance Abuse Treatment Center	7	2%	4	1%
Facilities—Other	16	4%	1	0%
Physicians—Doctors of Medicine or Osteopathy	45	11%	51	13%
Dentists	10	2%	25	6%
Podiatrists	0	0%	0	0%
Optometrist/Optician	0	0%	0	0%
Counselor/Psychologist	2	0%	0	0%
Chiropractors	0	0%	3	1%
Practitioners—Other	1	0%	2	1%
Pharmacy	29	7%	26	7%
Pharmaceutical Manufacturer	25	6%	0	0%
Durable Medical Equipment and/or Supplies	22	5%	19	5%
Lab	1	0%	1	0%
Transportation Services	15	4%	8	2%
Home Health Care Agency	39	9%	29	8%
Home Health Care Aides	2	0%	0	0%
All Nurses, Physician Assistants, and Nurse Practitioners, including Certified Nurse Aides	11	3%	8	2%
Radiology	0	0%	0	0%
Medical Support—Other	1	0%	0	0%
Managed Care	4	1%	1	0%
Medicaid Program Administration	0	0%	0	0%
Billing Company	2	0%	0	0%
Program Related—Other	13	3%	9	2%
Subtotal Fraud Investigations	**363**	**86%**[2]	**330**	**86%**
Abuse and Neglect—Nursing Facility	17	4%	41	11%
Abuse and Neglect—Other Long-term Care	1	0%	0	0%
Abuse and Neglect—Registered/Licensed Nurse/PA/NP	5	1%	1	0%
Abuse and Neglect—Certified Nurse Aides	29	7%	7	2%
Abuse and Neglect—Other Practitioner	2	0%	1	0%
Subtotal Abuse and Neglect Investigations	**54**	**13%**	**50**	**13%**
Patient Funds—Non-direct Care	1	0%	0	0%
Patient Funds—Registered/Licensed Nurse/PA/NP	0	0%	0	0%
Patient Funds—Certified Nurse Aides	2	0%	0	0%
Patient Funds—Other Practitioner	3	1%	3	1%
Subtotal Patient Fund Investigations Patient Funds Investigations	**6**	**1%**	**3**	**1%**
Total All Investigations	**423**	**100%**	**383**	**100%**

[1] Statistics for the NYMFCU 2007 Annual Report have been updated and may not, as a result, mirror the totals of the four 2007 quarterly statistical reports the NYMFCU previously submitted to Department of Health and Human Services Office of the Inspector General.

[2] Because percentages are rounded to a whole number, adding the percentages does not always match subtotals or 100%.

Table A-2

Investigation Closures 2007					
	Closed by Prosecution	**Closed by Civil Action**	**Closed Due to Insufficient Evidence**	**Closed by Referral**	**Total**
Fraud Investigations	37	161	128	4	**330**
Patient Abuse and Neglect Investigations	20	0	27	3	**50**
Patient Fund Investigations	2	0	1	0	**3**
Total Completed Investigations					**383**

Patient Crime Complaints

Table A-3

Patient Abuse Complaints Received, Investigated and Referred 2007	
	Total
Patient Crimes Complaints Received	924
Patient Crimes Investigations Opened	60
Patient Crimes Referrals to Other State Agencies	91

Prosecutions

Table A-4

Criminal Prosecution Closures by Defendant 2007			
	Fraud	**Patient Abuse and Neglect (including Patient Fund Cases)**	**Total**
Criminal prosecutions filed	74	25	**99**
Convictions	72	32	**104**
Acquittals	1	1	**2**
Dismissals	1	0	**1**
Total Prosecutions Completed	**72**	**33**	**107**
Conviction Rate	**97%**	**97%**	**97%**

Monetary Recoveries[3]

Table A-5

Monetary Recoveries 2007			
	Criminal	**Civil**	**Total**
Number of Recovery Actions Initiated (and Resolved with Order or Settlement)	57	239	**296**
Medicaid Overpayments Identified	$25,829,921	$86,650,762	**$112,480,683[4]**
Penalties Imposed		$1,684,506	**$1,684,506**
Non-Medicaid Restitution Due to Third Parties	$1,900,889	$44,907	**$1,945,796**
Medicaid Overpayments Collected by the NYMFCU	$7,145,487	$79,488,429	**$86,633,916**
Non-Medicaid Restitution Due to Third Parties Collected by the NYMFCU	$290,145	$7,120,230	**$7,410,375**
Penalties Collected by the NYMFCU		$552,368	**$552,368**

[3] 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.

[4] Of the $112.5 million, approximately $35.5 million represents overpayments identified as a result of a joint investigation with the New York State Medicaid Inspector General. The Office of the Inspector General achieved pre-filing settlements of these overpayments by voiding providers' unrelated claims.

Table A-6

Monetary Recoveries by Provider Category 2007					
Provider Category	**Medicaid Restitution**	**Penalties**	**Fines**	**Non-Medicaid Restitution Due to Third Parties**	**Total**
Facilities—Hospitals	2,045,034				2,045,034
Facilities—Nursing Facility	7,269,795				7,269,795
Facilities—Other Long-term Care				900	900
Facilities—Substance Abuse Treatment Centers	100,000			25,000	125,000
Facilities—Other	3,824,012		1,000	7,500	3,832,512
Physicians—Doctors of Medicine or Osteopathy	1,729,407	18,288			1,747,695
Dentists	1,695,301			25,055	1,720,356
Counselor/Psychologist	55,619		3,000	22,258	80,877
Pharmacy	1,846,586		101,000	1,663,946	3,611,532
Pharmaceutical Manufacturer	7,860,080	526,380			8,386,460
Durable Medical Equipment and/or Supplies	155,122				155,122
Transportation Services	1,174,482	1,090,249			2,264,731
Home Health Care Agency	41,483,301		5,000	196,604	41,684,905
Home Health Care Aides	28,403				28,403
All Nurses, Physician Assistants, and Nurse Practitioners, including Certified Nurse Aides	142,766	41,889	200		184,855
Medical Support—Other	10,000				10,000
Managed Care	35,653,619				35,653,619
Program Related—Other	7,407,156	7,700	250		7,415,106
Subtotal Fraud Monetary Recoveries	**$112,480,683**	**$1,684,506**	**$110,450**	**$1,941,263**	**$116,216,902**
Patient Abuse—Nursing Facility			1,850		1,850
Patient Abuse—Certified Nurse Aides			200		200
Subtotal Abuse and Neglect Recoveries			**$2,050**		**$2,050**
Patient Funds —Other Practitioner				4,533	4,533
Subtotal Patient Fund Recoveries				**$4,533**	**$4,533**
Total All Monetary Recoveries	**$112,480,683**	**$1,684,506**	**$112,500**	**$1,945,796**	**$116,223,485**

Costs

Table A-7

Expenditures 2007	
Type of Expenditure	**Cost**
Personal Services	$22,590,111
Non-personal Services	$9,414,839
Fringe Benefits	$8,867,103
Total Expenditures	$40,872,053