NEW YORK STATE
MEDICAID FRAUD CONTROL UNIT

2009 Annual Report

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

Attorney General
Andrew M. Cuomo

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MESSAGE FROM THE DIRECTOR

This report constitutes the 2009 Annual Report of 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 report 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 amount of recoveries collected, the costs incurred by the Unit, and projections for 2010. In addition, as required by the regulations, the report includes an evaluation of the Unit's 2009 performance.

The NYMFCU was highly productive in calendar year 2009. It obtained 148 convictions, the most the Unit has ever recorded, filed criminal charges against 139 defendants, and obtained ordered recoveries totaling $283,243,016, surpassing ordered recoveries in 2006, 2007, and 2008. The Unit reached substantial settlements with home health care agencies, pharmaceutical companies, and hospitals, and 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 337 investigations and completed a total of 357. Of the 357 investigations it closed, the Unit resolved 84 through criminal prosecution and 161 as a result of civil actions. It referred 13 cases to other agencies and closed 99 due to insufficient evidence. At year's end, the Unit's docket included 605 active investigations. Of the 635, 535 involved allegations of provider fraud, including 133 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 2009, the Unit initiated criminal prosecutions against a total of 139 defendants. Of these prosecutions, 111 involve alleged provider fraud and 28 alleged patient abuse and neglect or misuse of patient funds. The Unit obtained a total of 148 convictions, of which 113 involved provider fraud and 35 involved patient abuse and neglect or misuse of patient funds. The Unit had an overall conviction rate of 94%.

In 2009, the NYMFCU obtained settlements and court orders requiring the payment of more than $274 million in civil damages and $8.9 million in criminal restitution, exceeding the $59.3 million total achieved in 2006, $113.8 million in 2007, and $263.5 million in 2008.

The Unit continued its focus on attacking systemic, industry-wide fraud. Through Operation Home Alone, NYMFCU's investigation into the home health industry, we brought criminal charges against corrupt home health aide training schools and agencies and obtained $24 million in civil settlements with a number of agencies that employed unqualified aides with fraudulent certificates.

We also maintained our strong commitment to protect our state's most vulnerable residents from abuse and neglect through the use of covert surveillance in nursing homes,

including charges against sixteen health care workers obtained from hidden camera evidence, and seven convictions. In addition, the Unit reached a seminal settlement with a nursing home operator requiring the implementation of technology in the operator's homes that involves the recording of care at the time and point of service.

In the coming year the Unit will continue its initiatives in combating industry-wide fraud and patient abuse and neglect, and, as in the past, will continue to work collaboratively with our local, state, and federal partners and with the National Association of Medicaid Fraud Control Units to fight fraud and abuse 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 325 employees, it is 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 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 that 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 residents are Medicaid recipients 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 problems of abuse and victimization of residents in nursing homes.

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 to the New York State Office of the Medicaid Inspector General, an independent entity within the New York State Department of Health. In addition, the Office of the New York State Attorney General occasionally submits legislative proposals designed to deter fraud to the state legislature. The NYMFCU also makes referrals to New York State licensing agencies, when appropriate, to recommend sanctions against licensed health care providers.

Organization

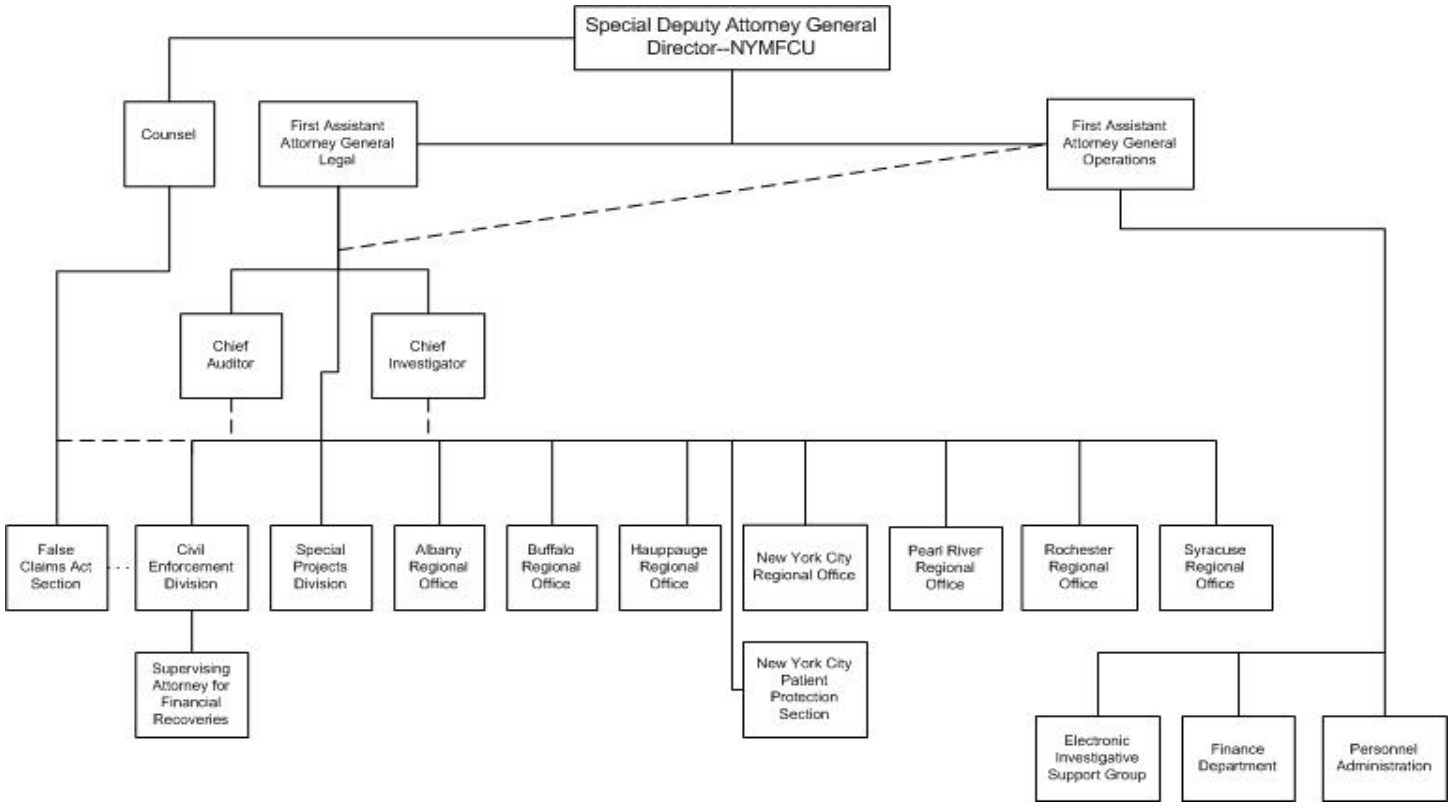
The NYMFCU is comprised of seven statewide regional offices located in Albany, Buffalo, Hauppauge, New York City, Pearl River, Rochester and Syracuse, and five other specialized legal, audit and/or investigative sub-divisions and sections: the New York City Patient Protection Section; the Civil Enforcement 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 each office's geographic area. (See map on page 7.) Due to the large number of residential care facilities in New York City, 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 seeking civil remedies. The Special Projects Division, among other responsibilities, is involved in nationwide investigations. The False Claims Act Section shares responsibility with the Special Projects Division for investigating and, when appropriate, intervening in *qui tam* (whistleblower) civil actions filed pursuant to the New York State 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 2009



The Year in Brief

NYMFCU Named Medicaid Fraud Control Unit of the Year by HHS OIG for 2008

In June 2009, the Department of Health and Human Services' Office of Inspector General ("OIG") named NYMFCU Medicaid Fraud Control Unit of the year for 2008 based on the Unit's "return of investment of approximately $6.64 for every [f]ederal dollar expended." It was the first time the Unit has ever received the award. In conferring the award on the NYMFCU, OIG stated that the NYMFCU "clearly demonstrated its outstanding ability to effectively and efficiently detect, investigate and prosecute Medicaid provider fraud and patient abuse and neglect in the State throughout the grant award year."

Expanded National Leadership Role in Policing Medicaid Fraud

During 2009, the NYMFCU continued to increase 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 five multi-state and federal global settlements concluded in 2009, the NYMFCU was a member of three of the NAMFCU teams representing the states. As of December 31, 2009, NYMFCU attorneys, auditors, investigators, and/or information technology specialists were assigned to 24 NAMFCU global case teams. NYMFCU attorneys led ten of these teams.

NYMFCU staffers are also active members of the NAMFCU executive staff and committees. The Unit's Director is serving as NAMFCU's Vice President. Unit staff also chair and/or are members of eight NAMFCU committees and working groups. In addition to chairing the Finance Committee, the Unit's Director is a member of the Association's Executive Committee, which manages the association. Two NYMFCU attorneys, including the Director, are members of the Association's Global Case Committee, which manages the Association's global case docket. The NYMFCU's Special Projects Division chief is the co-chair of the NAMFCU Qui Tam Subcommittee and the Unit's Counsel is also a member. 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.

Through the NAMFCU's Electronic Systems Working Group, during 2009, the NYMFCU spearheaded the NAMFCU's effort to create a central repository for global case data that utilizes several document management and e-discovery software programs to index, search, and review documents. The NYMFCU's Electronic Investigative Support Group is currently hosting the NAMFCU's case data repository in its Rensselaer office. The centralized system provides members of each NAMFCU global case team with the ability to coordinate their investigation and avoid duplication of efforts and includes group document editing, group instant messaging, and customized email alerts.

Public Outreach

To promote reporting of Medicaid fraud and patient abuse and neglect and encourage compliance with applicable laws, NYMFCU attorneys expended significant energy during 2009 educating members of the public about the Unit's mission and responsibilities. NYMFCU staff made 48 presentations throughout the state to senior citizen groups, nursing home staff, college and law school classes, advocacy groups, hospital staff, and a county legislature. At these presentations, NYMFCU attorneys described the Unit's jurisdiction and authority, gave examples of Medicaid fraud and patient abuse and neglect, and distributed pamphlets on "Residential Care: Protecting Patients from Abuse and Neglect."

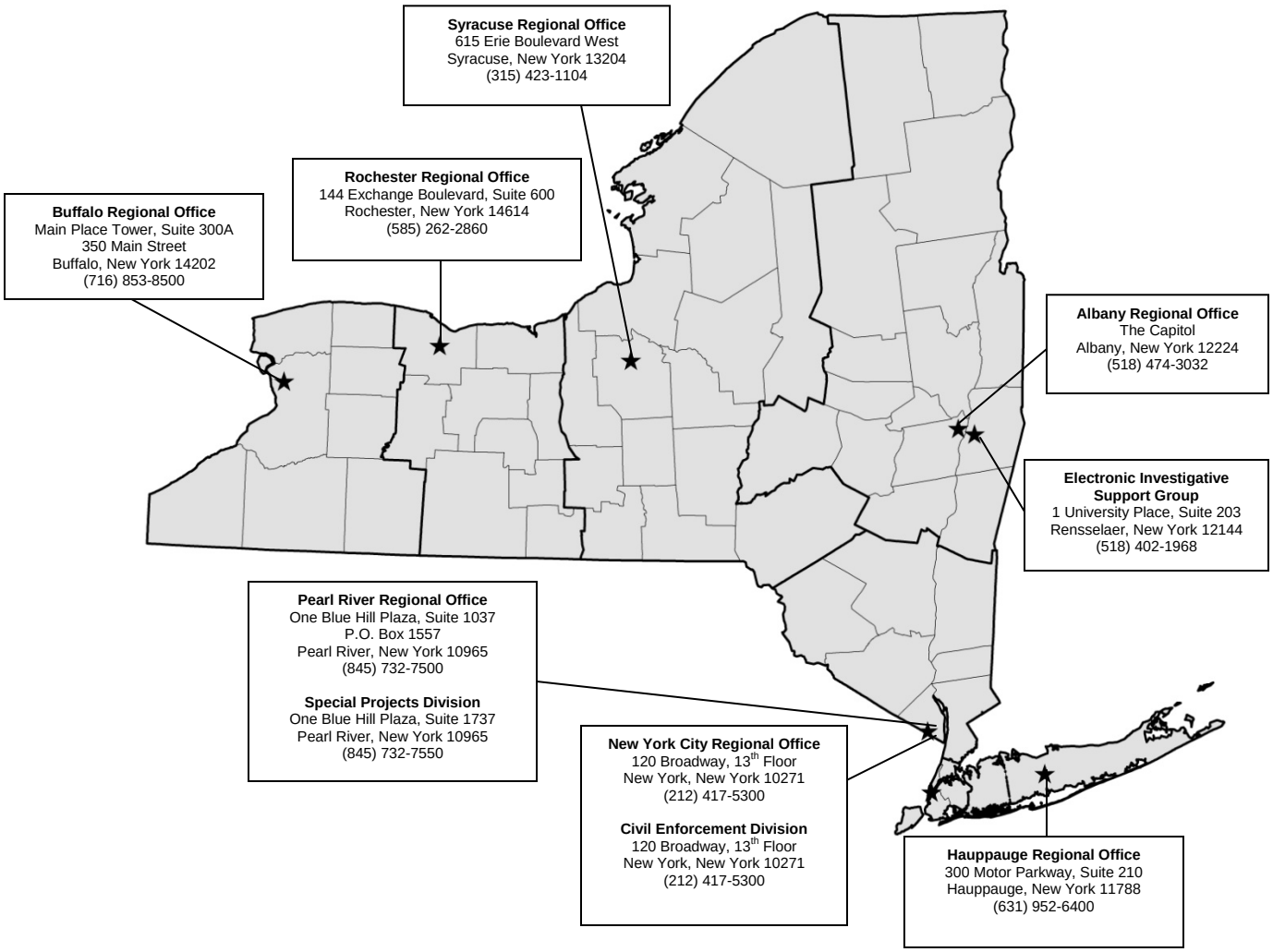
Staffing and Resources

As of December 31, 2009, the Unit employed 325 full-time employees: 54 attorneys, 102 auditors, 91 investigators, five medical analysts, three paralegals, 18 information technology specialists, 36 support staff members assigned to data entry, reception, clerical, and administrative assistant duties, and 16 employees handling personnel, purchasing, financial collections and inter-governmental affairs. During 2009, the Unit expended a total of $43,863,658: $25,306,654 in personal services (salaries), $10,783,462 in fringe benefits, and

$7,773,542 in non-personal services (for example, rent, vehicles, computers and supplies). (Table A-7, Appendix.)

Additionally, the Unit sent attorneys, auditors, investigators, medical analysts and information technology specialists to training conferences organized by the NAMFCU.

New York State Medicaid Fraud Control Unit's Statewide Offices
December 2009



PROVIDER FRAUD PROSECUTIONS AND CIVIL ACTIONS

Statistical Overview[1]

In 2009, the Unit opened 286 Medicaid fraud investigations and resolved 306. Fifty-three 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, 2009, the Unit had 535 open fraud investigations, of which 133 were *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 111 defendants and obtained convictions against 113. Charges against four defendants were dismissed. No defendants were acquitted. (See Table A-4, Appendix.) The Unit obtained orders and settlements of Medicaid restitution totaling $283.2 million, as compared to $263.5 million in 2008, $113.8 million in 2007, and $59.3 million 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 2009.

Home Health Care: Operation Home Alone

During 2009, the NYMFCU continued to aggressively fight fraud in the home health care industry. The Unit's efforts resulted in significant prosecutions and convictions and civil settlements. 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, compromised 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 agencies, and ordered restitution of more than $15 million. The Unit has also reached civil settlements with licensed home health care service and certified home health agencies totaling $51.7 million.

Due to state initiatives designed to improve care and reduce costs through care at home instead of in institutions, the number of Medicaid patients receiving home health care has grown significantly. Every month, more than 150,000 New Yorkers receive some form of Medicaid-funded home health services. In 2009, Medicaid spent nearly $4.3 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.

[1] 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.

Corrupt Training Schools Provided Falsified Certificates to Untrained Aides

The NYMFCU's home health care investigation 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 125 such defendants and obtained convictions against approximately 100, 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 2009, the Unit obtained convictions of approximately 20 defendants in the industry engaged in fraud involving false certificates.

Under the New York State Medicaid program, 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 discovered that hundreds of individuals in the New York City area purchased bogus training certificates when they had not in fact received the required training. 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.[2]

NYMFCU Reached $24 Million Settlement with Three Home Health Agencies that Employed Home Health Aides With Fraudulent Certificates

In December 2009, the NYMFCU and the federal government reached a $24 million settlement with three home health agencies involving allegations that the agencies billed the Medicaid program, or caused the Medicaid program to be billed, for services provided by aides with fraudulent certificates. It is the largest settlement the Unit has reached with the home health industry in New York State.

Under the terms of the settlement, B&H Health Care Services, Inc., known as Nursing Personnel Home Care ("Nursing Personnel"), a Brooklyn-based home care service agency,

[2] 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.

along with Excellent Home Care Services, LLC ("Excellent") of Brooklyn, and Extended Nursing Personnel CHHA, LLC ("Extended") of Manhattan, will return $23,963,100 to the Medicaid program.

During the course of the NYMFCU's industry-wide investigation, the Unit discovered that Nursing Personnel employed hundreds of home health aides with fraudulent certificates they obtained from corrupt training schools without receiving the required training. These aides were subsequently assigned to work for Extended and Excellent, which sent them into the homes of New York's elderly, frail, and indigent to provide care.

The settlement resulted from a multi-agency effort led by the NYMFCU, that also included the Civil Division of the United States Department of Justice, the United States Attorney for the Eastern District of New York, and the Office of Investigations for the U.S. Department of Health and Human Services' Office of Inspector General ("HHS-OIG"). The investigation included allegations from two whistleblowers who filed complaints under the New York State and federal False Claims Acts.

In addition to payment of the settlement amount, all three agencies will be subject to the terms of a corporate integrity agreement entered into with the New York State Office of the Medicaid Inspector General ("OMIG") requiring continuing efforts to employ policies and procedures to ensure that all future home health aides are properly certified. Nursing Personnel must also employ an outside monitor who will report to OMIG and the NYMFCU.

Global Health Care Training Center Charged with Manufacturing Fraudulent Certifications for Home Health Aides Costing Medicaid More than $1 Million

The NYMFCU charged a home health aide training facility, its owner, and two of its employees with engineering and participating in a scheme to distribute falsified home health aide certificates. Brooklyn-based Global Health Care Training Center ("Global"), owner/operator Wayne Lynch, and employee Charles Trevor were charged with grand larceny in the first degree, a class B felony, and four counts of falsifying business records in the first degree, a class E felony, for their involvement in providing bogus certifications to individuals who were ultimately employed to care for patients. The indictment also charged Donald Vibert, a Global employee who conducted "training sessions" he was unqualified to teach, with criminal facilitation in the fourth degree, a class A misdemeanor.

According to the indictment, Global, Lynch, and Trevor provided home health aide certificates falsely stating that registered nurses trained students when no training was provided or the training failed to adhere to the applicable rules and regulations for home health care training. Global charged individuals $300 for each certification and provided students with letters falsely stating that they had completed the required number of hours of practical training supervised by a registered nurse. The Unit alleges that Medicaid was billed more than $1 million for services provided by home health aides operating with the fake Global certificates.

Vibert pleaded guilty to criminal facilitation in the fourth degree on September 17, 2009. He has not yet been sentenced. The charges against Global, Lynch and Trevor are pending.

Home Health Aide Training School Operator Ronald Kehinde Convicted of Selling Phony Certificates

On April 8, 2010, a Brooklyn jury found Ronald Kehinde guilty of forgery in the second degree, a class D felony, offering a false instrument for filing, a class E felony, five counts of falsifying business records in the second degree, an A misdemeanor, and three counts of petit larceny, an A misdemeanor, in connection with his operation of a corrupt home health training school that sold certificates without providing the required amount of training or using properly licensed teachers.

Holistic Home Care Agency and Its Owner Convicted of Stealing More than $1 Million from Medicaid by Billing for Individuals Not Licensed to Practice as Nurses in New York State

During 2009, the NYMFCU obtained convictions of 25 defendants in connection with the NYMFCU's investigation and prosecution of Holistic Home Care Agency, a home care services agency in New York City, and its owner and administrator, Julianna Nwaogu. 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.

The NYMFCU's investigation of Holistic Home Care, whose patients were predominantly 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 offered individuals employment as licensed practical nurses and registered nurses regardless of whether they were licensed in New York State.[3]

On April 22, 2009, Nwaogu pleaded guilty to grand larceny in the first degree, offering a false instrument for filing, and aiding and abetting the unauthorized practice of a profession (nursing), both class E felonies. Under the terms of Nwaogu's plea, on February 1, 2010, the court sentenced her to one to three years in prison and ordered her to repay $175,000 in restitution. Holistic Home Care Agency, Inc. also pleaded guilty on April 22, 2009, to grand larceny in the first degree and was sentenced to pay a fine of $5,000.

Charges against one Holistic employee are still pending.

Licensed Practical Nurse Stole More Than $40,000 from Medicaid—Claimed She Provided Services When She Was on a Caribbean Cruise and When Her Patient Was on a Make-A-Wish Foundation Trip

In 2009, the NYFMCU also convicted Licensed Practical Nurse Denise Dent of a felony for stealing more than $40,000 from Medicaid by billing for services she did not perform.

[3] 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.

From January 2008, to September 2008, Dent falsely claimed that she provided more than $40,000 of home nursing services to a developmentally disabled child residing in Suffolk County. The NYMFCU examined Medicaid records and compared them to Dent's travel and billing records. The investigation found that Dent received Medicaid payment for services she claimed she provided from March 16 to March 28, 2008, when travel records revealed she was actually on a Caribbean cruise. Dent also billed Medicaid while the child was on a Make-A-Wish Foundation trip without her.

In addition, Dent received Medicaid payment for 20 hours worth of nursing services per shift when her nursing notes indicated she only rendered 10 hours of care per shift, or she had no notes to document that she provided any care at all. Dent also billed Medicaid for a second Medicaid recipient during a period when that recipient was hospitalized and Dent's nursing services were neither authorized nor rendered.

On June 17, 2009, Dent pleaded guilty to grand larceny in the fourth degree, a class E felony. On August 19, 2009, the court sentenced Dent to five years' probation and ordered her to pay restitution of $43,723.

Owner of Home Health Care Business Convicted of Felony for Fraudulent Billings of $105,000

Maria Golowaty, the sole owner of the now-defunct home health care business One to One Care, Inc., of Saugerties, pleaded guilty to grand larceny in the third degree, a class D felony, on June 2, 2009, for billing Medicaid for hours of nursing services One to One had not provided.

The NYMFCU's investigation established that from November 2003 through May 2007, Golowaty fraudulently billed and received $105,000 for nursing services she claimed two nurses in her employ provided to One to One's only client. The Unit found that Golowaty billed for hours far beyond those the two nurses provided.

On August 7, 2009, the court sentenced Golowaty to five years' probation and ordered her to make full restitution in the amount of $105,000, which Golowaty did at the time of sentencing. In addition, as a condition of the plea, Golowaty executed a confession of judgment for an additional $105,000, which the court ordered Golowaty to pay as a condition of her probation.

Camera Recordings and Investigators' Surveillance Helped Prove Nurses Failed to Provide Services for which Medicaid Paid Over $300,000

The NYMFCU's investigation of two nurses responsible for providing home nursing services to a physically disabled man revealed that Melissa Thompson and Veronica Gordon billed Medicaid for more licensed practical nurse hours than they actually worked. NYMFCU investigators conducted physical surveillance of the recipient's Dutchess County's home, utilized a pole camera (installed on a utility pole) aimed at the home, interviewed the recipient's mother and the defendants, and established that from 2000 through 2006, Thompson and Gordon collectively billed and received from Medicaid $306,641 to which they were not entitled.

Thompson, a registered nurse and licensed practical nurse, pleaded guilty on May 5, 2009, to grand larceny in the third degree. On July 7, 2009, the court sentenced her to 90 day's incarceration, five years probation, and ordered her to pay restitution in the amount of $290,982. Gordon, also a registered nurse and licensed practical nurse, who pleaded guilty in 2008 to petit larceny, was sentenced on September 1, 2009, to a conditional discharge and ordered to pay restitution in the amount of $16,658.

Pharmaceutical Manufacturers and Distributors

In 2009, the NYMFCU reached four settlements with major pharmaceutical companies as a result of joint federal and multi-state investigations. In these complex 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 four settlements with pharmaceutical companies reached in 2009, 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 four settlements with New York State resulted in total recoveries of $188,559,524.

Pharmaceutical Giant Pfizer Agreed to Largest Health Care Fraud Settlement in History for Kickbacks and Illegal Marketing Campaigns Resulting in $67 Million Recovery for New York State

New York, along with other states and the federal government, negotiated the largest health care fraud settlement in history—$2.3 billion—resolving allegations that Pfizer, Inc. provided kickbacks and engaged in off-labeling marketing campaigns to illegally promote its drugs. Pfizer, the largest pharmaceutical manufacturer in the world, allegedly engaged in a pattern of illegal marketing activities to promote multiple drugs for uses not approved by the Food and Drug Administration ("FDA") and paid kickbacks to health care professionals in the form of entertainment, cash, travel, and meals to induce them to promote and prescribe various drugs such as Bextra, Geodon, Lyrica, Zyvox, Aricept, Celebrex, Lipitor, Norvasc, Relpax, Viagra, Zithromax, Zoloft, and Zyrtec.

Under the agreement, which includes the vast majority of states, Pfizer must pay a total of $1 billion in civil damages and penalties to compensate Medicaid, Medicare, and various federal healthcare programs for harm suffered as a result of its conduct. New York State received nearly $67.2 million as part of the settlement, based upon usage of the drugs covered by the settlement. In addition, Pfizer subsidiary Pharmacia & Upjohn Company, Inc. agreed to pay a $1.3 billion fine and forfeiture and to plead guilty to a felony violation of the Food, Drug, and Cosmetic Act for misbranding the anti-inflammatory drug Bextra with the intent to defraud or mislead. Pfizer pulled Bextra from the market in 2005.

While a physician can prescribe drugs for an unapproved use, federal law prohibits a manufacturer from promoting a drug for uses the FDA has not approved. Pfizer and its

subsidiaries allegedly engaged in multiple illegal marketing and promotional activities for its drugs in an attempt to increase usage and sales, including:

- Marketing Bextra for conditions and dosages other than those for which it was approved;
- Promoting the use of the antipsychotic drug Geodon for a variety of off-label conditions such as attention deficit disorder, autism, dementia, and depression for patients including children and adolescents;
- Selling the pain medication Lyrica for unapproved conditions; and
- Making false representations about the safety and efficacy of Zyvox, an antibiotic only approved to treat certain drug resistant infections.

As a condition of the settlement, Pfizer entered into a corporate integrity agreement with the HHS-OIG, which will closely monitor the company's future marketing and sales practices.

The Pfizer settlement was based on nine cases that were filed in the United States District Court for the District of Massachusetts, the United States District Court for the Eastern District of Pennsylvania and the United States District Court for the Eastern District of Kentucky by private individuals who filed actions under state and federal false claims statutes.

Eli Lilly and Company Reached $91.4 Million Settlement with New York State to Resolve Allegations that It Illegally Promoted Zyprexa for Off-label Uses

New York State recovered $91,412,355 in a national Medicaid fraud settlement with Eli Lilly and Company regarding allegations that it conducted an illegal, off-label marketing campaign that improperly promoted the antipsychotic drug Zyprexa.

Under the national settlement, Eli Lilly will pay the states and the federal government a total of $800 million in damages and penalties to compensate Medicaid and various federal healthcare programs for harm suffered as a result of its conduct. The NYMFCU took a leading role in investigating the claims and negotiating the agreement as a member of the seven-state NAMFCU team that worked in cooperation with the federal government. The settlement arose from four federal and state false claim actions that were consolidated in the U.S. District Court for the Eastern District of Pennsylvania. The four *qui team* cases were filed by private parties on behalf of the government.

Zyprexa is one of a newer generation of antipsychotic medications (called atypical antipsychotics) used to treat certain psychological disorders. Between September 1999 and December 31, 2005, Eli Lilly willfully promoted the sale and use of Zyprexa, primarily through a marketing campaign called "Viva Zyprexa," for certain uses that the Food and Drug Administration had not approved. The promotional activities Eli Lilly undertook in the "Viva Zyprexa" campaign promoted Zyprexa not only to psychiatrists, but also to primary care physicians, for such unapproved uses as the treatment of depression, anxiety, irritability, disrupted sleep, nausea, and gambling addiction. In implementing the campaign, Eli Lilly also provided remuneration and other things of value to physicians and other health care professionals. As a result of these promotional activities, Eli Lilly caused physicians to

prescribe Zyprexa for children and adolescents and dementia patients, among other uses that were not within the indications for the drug approved by the FDA.

As part of the settlement, Eli Lilly entered into a corporate integrity agreement with the HHS_OIG, which will closely monitor the company's future marketing and sales practices. In addition to the civil settlement, Eli Lilly agreed to plead guilty to a misdemeanor violation of the Food, Drug and Cosmetic Act and pay a $615 million criminal fine.

New York State Secured More than $18 Million as Part of Multi-State Settlement with Four Pharmaceutical Companies for Submitting False Rebate Claims

New York State joined a three-state team from the NAMFCU that investigated, along with federal authorities, claims that four pharmaceutical companies violated the federal False Claims Act by failing to pay appropriate rebates for drugs covered by Medicaid. Negotiating a settlement on behalf of the states, the efforts of the NAMFCU team and the United States government resulted in a $124 million settlement, of which $18,868,730 was New York State's share.

Mylan Pharmaceuticals, Inc. (MPI), UDL Laboratories, Inc. (UDL), AstraZeneca Pharmaceuticals LP, and Ortho McNeil Pharmaceutical, Inc. participate in the Medicaid rebate program and executed rebate agreements with the United States. The companies agreed to pay quarterly rebates to Medicaid based upon the amount of money that Medicaid paid for each company's drugs. The precise amount of a rebate is determined in part by whether a drug is considered an "innovator" drug or a "non-innovator" drug. The rebate owed to Medicaid programs is higher for innovator drugs than the rebate for non-innovator drugs. The participating states and the federal government found that the four companies sold innovator drugs that they classified as non-innovator drugs for Medicaid rebate purposes. As a result, the subject companies underpaid their rebate obligations to Medicaid.

Under the terms of the settlement, MPI and UDL must pay a combined $118 million to resolve allegations that they underpaid their rebate obligations with respect to several MPI drugs. AstraZeneca must pay $2.6 million to resolve allegations that it underpaid its rebate obligations with respect to Albuterol and Ortho McNeil must pay $3.4 million regarding rebate underpayments for Dermatop.

Aventis Pharmaceutical, Inc. Paid New York $11 Million to Resolve Allegations of Misreporting Best Prices to Medicaid

Aventis Pharmaceutical, Inc., a wholly-owned subsidiary of Sanofi-Aventis U.S., LLC., paid New York State $11,087,270 as part of a nationwide $95.5 million settlement with state and federal governments. The settlement resolved allegations that between 1995 and 2000, Aventis and its corporate predecessors knowingly misreported best prices for the steroid-based anti-inflammatory nasal sprays Azmacort, Nasacort and Nasacort AQ. Under the Medicaid Drug Rebate Statute, Aventis was required to report to Medicaid the lowest, or "best" price that it charged commercial customers, and pay quarterly rebates to state Medicaid programs based on those reported prices. To avoid triggering a new best price that would obligate it to pay millions of dollars in additional drug rebates to Medicaid, Aventis entered into "private label" agreements with Kaiser Permanente, a large health maintenance

organization, that simply repackaged Aventis' drugs under Kaiser's private label. As a result, Aventis underpaid drug rebates to the Medicaid program and to several other federal health programs.

As part of the settlement, Sanofi-Aventis entered into an addendum to its existing Corporate Integrity Agreement with the HHS-OIG that requires it to report certain best price information for drugs covered by Medicaid and other health care programs. The agreement already in place requires Sanofi-Aventis to report other pricing information to the government as a result of a prior drug pricing settlement concerning the company's drug Anzemet.

Hospitals and Hospices

Bronx Lebanon Hospital Center Overcharged Medicaid $3.46 Million for Drugs It Dispensed to Outpatients

The NYMFCU recovered $3,464,795 from Bronx Lebanon Hospital Center, which overcharged the Medicaid program for pharmaceuticals it dispensed to seniors and low-income patients from 2002 through 2004. The hospital fully cooperated with NYMFCU's investigation.

The April 2009 settlement with Bronx Lebanon Hospital Center is the largest thus far in 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.

Through December 31, 2009, as a result of its 340B program audits the NYMFCU has recovered nearly $6 million from three hospitals.

Statewide Audit of Hospitals and Hospices to Uncover Double-billing: Continuum Health Partners' Hospitals Reached Settlements Totaling $507,815

During 2009, the NYMFCU continued its audit of hospitals and hospice billings throughout the state 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. Consequently, hospitals providing care to hospice patients are required to bill the hospice directly. This past year, three Continuum Health Partners' Hospitals—Beth Israel Medical Center, Long Island College Hospital, and St. Luke's-Roosevelt Hospital reached settlements with the NYMFCU totaling $507,815 for billing Medicaid for the same services for which the hospices billed Medicaid. In addition, Montefiore Medical Center reached a settlement requiring it to pay restitution of $120,940.

As of December 31, 2009, the NYMFCU's hospital-hospice audit investigation has recovered $4,802,706.00 from 116 hospitals.

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

In 2009, the Unit continued to review hospitals' and physicians' drug billings to ensure their compliance with state pricing rules. Under New York State 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 Code" drugs because of the "J" prefix in the procedure codes used when these drugs are administered and billed, these drugs must be billed by doctors and hospitals to Medicaid at 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 nearly $16 million from 131 providers, including hospitals, physician group practices, and individual physicians. In 2009, the Unit's Special Projects Division completed six J Code investigations, recovering $417,613 in restitution for the Medicaid program, including $223,299 from Benedictine Hospital and $136,071 from Good Samaritan Hospital.

Laboratories

Quest Diagnostics Paid $506,180 to New York as Part of Nationwide Settlement Involving Inaccurate Blood Tests Billed to Medicaid

The NYMFCU participated in a four-state NAMFCU team that negotiated a nationwide Medicaid civil settlement with Quest Diagnostics Incorporated and its former subsidiary, Nichols Institute Diagnostics (NID), to resolve claims concerning the accuracy of various NID diagnostic tests manufactured, marketed, and sold to laboratories from 2000 to 2006, which were used to perform tests billed to and paid for by state Medicaid programs.

The national Medicaid settlement occurred after Quest resolved federal allegations involving the same conduct in April 2009. The federal and state cases stemmed from a *qui tam* or whistleblower lawsuit alleging that certain test kits NID manufactured and laboratories used to measure parathyroid levels in blood samples produced an unacceptable level of elevated results. Medical practitioners generally used the test kits to determine whether patients suffering from end-stage renal disease also had overactive parathyroid glands. The government also alleged that other NID tests produced inaccurate results during specified limited time periods. Quest denied the government's civil allegations but agreed to the settlement.

The test kits at issue were disproportionately billed to Medicare, limiting the amount of monies state Medicaid programs expended on them. In April 2009, NID pled guilty in federal court to misbranding charges under the Food, Drug and Cosmetic Act, admitting that one of the parathyroid tests NID marketed as having "excellent correlation" to a prior generation of the test in fact did not consistently provide results equivalent to the predecessor test. Quest voluntarily closed NID in April 2006, before the federal government filed a criminal case against it.

As part of the federal and state settlements, Quest entered into a corporate integrity agreement, requiring it to retain an expert to review how compliance concerns are communicated to senior management and the Quest board of directors, and to retain an independent review organization to examine Quest's in vitro diagnostic products subsidiaries' adherence to FDA quality system regulation and labeling requirements.

Drug Diversion and Pharmacy and Prescription Fraud

People v. Dimple Lagdiwala—Pharmacist Convicted for Billing Medicaid for $1.3 Million in Prescription Refills Never Dispensed

An exhaustive investigation of Bronx-based Starhill Pharmacy Corporation proved that Starhill's owner and supervising pharmacist, Dimple Lagdiwala, stole approximately $1.3 million from Medicaid by submitting claims for prescription refills the pharmacy never dispensed.

Following up on a referral from the OMIG, the NYMFCU sent three undercover "shoppers" to Starhill with prescriptions for which multiple refills were authorized. Monitoring Medicaid claims data, the NYMFCU learned that the pharmacy subsequently billed Medicaid for refills for each of the prescriptions without authorization from the undercover recipients. The NYMFCU analyzed the pharmacy's high refill rates and also determined that the pharmacy billed for recipients' refills even when the recipients were hospitalized. The NYMFCU obtained a search warrant and seized Starhill's prescription log books, original prescriptions, and drug distributor invoices, and received records from Starhill's drug distributors. By analyzing Starhill's billings, prescriptions, and wholesale drug purchases, the NYMFCU found that defendant billed Medicaid for $1.3 million in drugs that the pharmacy never purchased.

On November 9, 2009, Lagdiwala pleaded guilty to grand larceny in the third degree. Thereafter he sold the pharmacy and repaid $1.3 million to the Medicaid program. On January 7, 2010, he was sentenced to one year in jail.

Nursing Home Nurse Addicted to Painkillers Convicted of Possessing Narcotics: Stole Fentanyl Patches and Forged Prescriptions for Opiates to Obtain Unauthorized Refills

Woodhaven Center of Care Nursing Home staff members discovered three foil packages that were supposed to contain individual fentanyl pain patches had been cut open. The patches were missing from each package. The director of nursing asked staff to submit to

drug testing and Registered Nurse Maureen Cavaggioni confessed to a drug problem and to stealing the patches. After the director reported the incident to the NYMFCU, the Unit's investigators found that Cavaggioni had taken prescriptions she received for various narcotic painkillers, including Hydrocodone, and forged the prescriptions to authorize several refills. The original prescriptions did not authorize any refills.

The NYMFCU arrested Cavaggioni in May of 2009, and on September 30, 2009, Cavaggioni pleaded guilty to criminal possession of a controlled substance in the fifth degree, a class D felony. Under the terms of her plea, if Cavaggioni successfully completes a drug treatment program, she will be permitted to withdraw her plea and enter a plea to a misdemeanor for which she will receive probation.

Program Fraud

Hospital Debt Collecting Company and Its Owner Charged with Scamming Medicaid for More than $730,000 by Bribing County Employee: Defendants Convicted in First of Two Trials for Submitting False Medicaid Application on Behalf of Hospital Debtor

In May 2009, the NYMFCU filed a civil lawsuit and the first of two indictments against a western New York hospital contractor for bribing a county worker and submitting a false Medicaid application on behalf of a hospital debtor.

Deborah Kantor and her company, H.I.S. Holdings, Inc. ("H.I.S."), a debt collection agency that services Niagara Falls Memorial Medical Center and other western New York hospitals, is accused of bribing Michael Albrecht, a Niagara County Department of Social Services ("DSS") employee, in exchange for assistance in approving Medicaid coverage for certain hospital patients. In conjunction with the indictment, the NYMFCU filed a lawsuit against Kantor and H.I.S. in Niagara County Court seeking recovery of $732,787, which represents the amount of fraudulent Medicaid benefits New York State paid as a result of the alleged scheme. The suit seeks an additional $2,198,362 in damages from Kantor and H.I.S. for fraud under New York State's False Claims Act and Social Services Law.

Kantor and her company, H.I.S., were compensated based on a percentage of the hospital bills upon which she was able to collect. But, the lawsuit alleges, she profited from fraudulent Medicaid payouts falsely approved by Albrecht, who was secretly on her payroll. Albrecht allegedly sold Kantor confidential Medicaid client identification numbers, approved Medicaid applications that had incomplete or false information, and approved applications despite information that the applicant was not eligible to receive benefits.

To circumvent the Medicaid application process, Kantor allegedly offered to pay Albrecht $50 for each active Medicaid client identification number that he provided. In his position with DSS, Albrecht had access to the welfare management system (WMS) computer, which contains confidential information about persons who have applied for public benefits in New York. According to the lawsuit, using names provided by Kantor, Albrecht researched individuals on the WMS computer to determine whether they were or had been Medicaid recipients, and he provided Kantor with the client identification numbers required for

Medicaid billing regarding any active accounts he uncovered. Kantor also paid Albrecht for client identification numbers on inactive Medicaid accounts that he allegedly improperly re-activated without requiring a new patient application from H.I.S.

The criminal indictments charge Kantor and H.I.S. with bribery in the second degree and 52 counts of rewarding official misconduct in the second degree, class C and E felonies, respectively, and allege that from 2000 to 2007, Kantor and H.I.S. paid more than $17,749 in checks and cash to Albrecht as part of scheme to defraud Medicaid. The indictments also allege that Kantor rewarded Albrecht with a cell phone, cell phone service, and other gratuities for approving substandard Medicaid applications submitted by her company on behalf of hospital patients.

On June 11, 2009, Albrecht pleaded guilty to attempted bribe receiving in the third degree, a class E felony. His sentence is pending.

Kantor, H.I.S., and another H.I.S. employee, Amy Gardner, were also charged with submitting a Medicaid application they knew falsely reported the address of the applicant, in order to persuade DSS to approve the applicant's Medicaid eligibility. Following a trial conducted in January 2010, a jury convicted Kantor, H.I.S., and Gardner of offering a false instrument for filing in the first degree and attempted grand larceny in the third degree. The evidence presented proved that on October 30, 2006, Kantor and Gardner prepared and submitted to the DSS a Medicaid application containing false information on behalf of Tim Linkowski, who owed more than $5,000 to Niagara Falls Memorial Medical Center. The application falsely asserted that Linkowski lived with his grandmother rather than his mother. As Kantor and Gardner strategized initially with Linkowski and his mother, if the application accurately reported that Linkowski lived with a parent, information about others in the household would be considered in determining Linkowski's eligibility and Linkowski would not be given credit for any rent that he paid. If he lived with his grandmother, as the application falsely stated, DSS would take into account only information about Linkowski in assessing his eligibility and he would get credit for $75 per week in rent the application falsely asserted he paid. Ultimately, Linkowski withdrew the Medicaid application, he and his mother cooperated with NYMFCU investigators, and they both surreptitiously recorded conversations with Kantor that corroborated their account. Kantor, H.I.S., and Gardner will be sentenced in early 2010.

The bribery and rewarding official misconduct charges and the civil lawsuit filed against Kantor and H.I.S. are pending.

Clinics and Treatment Centers

Jury Convicted Clinic Owner and Operator of Substance Abuse Clinic of Submitting False Medicaid Claims; Court Sentenced Defendant to Prison

Following a week-long trial, on February 10, 2009, a jury convicted Ole Pettersen, the owner and operator of the Center for Addiction Recovery, an alcohol and substance abuse clinic located in Oneida County, of three counts of offering a false instrument (a Medicaid

claim form) for filing in the first degree. On May 27, 2009, the court sentenced Pettersen to one to three years in state prison and ordered him to pay $675,984 in restitution.

The Center for Addiction Recovery operated both a methadone program and an alcohol and substance abuse clinic. Under New York State Medicaid rules, the defendant was obligated to provide counseling services to recipients enrolled in the methadone program. However, evidence presented at trial revealed that Pettersen falsified documents involving recipients enrolled in the methadone program in order to justify submitting claims for counseling services he provided to these same recipients through the substance abuse clinic. Although Pettersen was already receiving reimbursement from Medicaid for each recipient in the methadone program, Pettersen could obtain even more money from Medicaid by billing for counseling services provided by the clinic. In the case of three Medicaid recipients, the jury found Pettersen guilty of submitting claim forms falsely stating that he had provided them with medically necessary chemical dependency treatment.

Though Pettersen was not convicted of larceny, the court possessed the authority to order Pettersen to make restitution for the full amount of the criminal transaction of which his false filings convictions were a part. Prior to sentencing, the Unit submitted proof to the court that Pettersen received a total of $675,000 from the New York State Medicaid program to which he was not entitled.

Nursing Homes

Nursing Home and Its Owner Charged with Paying Kickbacks to Hospital Employee for Patient Referrals

This past fall, the NYMFCU filed criminal charges and a civil lawsuit seeking actual and treble damages of at least $5 million against Kingsbridge Heights Rehabilitation and Care Center, its owner and former Chief Executive Officer Helen Sieger, and Frank Rivera, formerly a social work assistant in the Discharge Planning Unit at New York-Presbyterian Columbia University Medical Center. Kingsbridge and Sieger stand accused of paying Rivera to refer patients to Kingsbridge and then billing Medicaid for their care, falsely claiming that they rendered services to these patients in accordance with the law. New York State law explicitly prohibits Medicaid providers from accepting payments for referring services (i.e., patients) or offering any payment to induce referrals for any services for which Medicaid pays.

As alleged in court documents, beginning in January 2005, Siegel and Rivera entered into an illegal kickback scheme. Rivera steered patients being discharged from New York-Presbyterian Columbia University Medical Center to Kingsbridge in return for payments from Sieger once Kingsbridge admitted the patients. Rather than furnishing patients with the names of five nursing homes as required by hospital policy, Rivera presented discharging patients seeking nursing home care with four, three of which routinely denied Rivera's referrals. Thus, patients' only remaining option would be to seek admission at Kingsbridge. From approximately November 2005 to June 2006, Sieger paid Rivera at least $19,750 in checks drawn from the Kingsbridge bank account for these referrals. Through February 9,

2009, Kingsbridge received from Medicaid approximately $1.25 million for patients Kingsbridge admitted under the illegal kickback scheme.

Kingsbridge and Sieger are charged with grand larceny in the first degree and all three defendants are charged with violating the New York Social Services anti-kickback law, a class E felony.

Both the criminal charges and civil lawsuit are pending.

Dentists

New York Secured $15.6 Million Judgment from Queens Dentists Who Employed Felon Barred from Participating in Medicaid Program and Paid Kickbacks for Medicaid Patient Referrals

The NYMFCU secured a judgment, in September 2009, entitling the state to recover $15.6 million in Medicaid funds paid to Queens dentists Lewis R. Brestin and Marina Bonaparte and several of their business entities. The dentists violated Medicaid program rules by employing Osmin Ferran, a felon barred from the Medicaid program, in their mobile dental business and by making illegal payments to have "runners" and "hustlers" refer Medicaid patients to the buses for treatments billed to Medicaid.

Based upon Ferran's recommendation and proposal, Brestin and Bonaparte started their mobile dental business in late 2001. They used tour-type buses refitted as mobile dental offices stationed at New York City housing projects and recruited Medicaid recipients as patients. Ferran provided the buses, supplied the self-described "runners" and "hustlers," who drove the buses, fanned out into the neighborhoods to identify Medicaid patients, and brought recipients to the buses for treatment, and processed patient paperwork. Brestin and Bonaparte hired dental staff for the buses and made substantial unlawful kickback payments to Ferran's businesses for the referral of the Medicaid patients.

In October 2003, Ferran was barred from the Medicaid program and most other government healthcare programs as a result of his conviction, in Florida, for Medicaid fraud. Notice of Ferran's exclusion was published in the Federal Register. Nevertheless, Ferran continued to operate and be involved in Brestin's and Bonaparte's mobile dental business that serviced Medicaid patients, and Brestin and Bonaparte continued to pay substantial amounts—well over $1 million—for his services.

In early 2005, the NYMFCU arrested and charged Ferran with grand larceny in the first degree for stealing from the Medicaid program by illegally participating in it. Apart from identifying Ferran as the main operator of the mobile dental business, the investigation, which utilized hidden cameras, documented the "runners" and "hustlers" taking patients' confidential medical histories, advising them on medical treatment, and discussing sex, drugs, and alcohol use in front of the school-age patients. Later that year, Ferran pleaded guilty to grand larceny in the second degree. He has not yet been sentenced.

At the same time, the NYMFCU seized the mobile dental buses and filed a civil lawsuit against Brestin and Bonaparte and their numerous businesses, including Dental Wagon, LLC and Dental Wheels, LLP, seeking to recover the Medicaid funds the dentists' businesses received in violation of Medicaid rules. These rules prohibit payments where an excluded person is involved in any activity relating to the furnishing of medical care, services or supplies to Medicaid recipients. They also prohibit payments stemming from kickbacks for patient referrals.

In the course of the litigation, the dentists claimed that neither they nor their attorneys could find the published notices of Ferran's conviction or his expulsion from the Medicaid program, even though both were readily available on the internet and in the U.S. Government's official publications of Medicaid exclusions.

On September 9, 2009, a New York State Supreme Court judge granted the NYMFCU's motion for summary judgment. As a result, the NYMFCU obtained a judgment against Brestin and Bonaparte and several of their businesses in the amount of $15,631,145. Of that amount, $11,071,935 represents the funds paid to Brestin's and Bonaparte's businesses, and $4,559,210 represents interest for the period of time the dentists failed to return the money to New York State.

Doctors

People v. Michael Chait—Doctor Sentenced to Three Years in Prison for Writing Illegal Prescriptions for Narcotics to Medicaid Recipients

Michael Chait, a Long Island physician charged in 2007 with writing hundreds of illegal prescriptions for patients from the Bronx and Manhattan, was sentenced on October 1, 2009, to three years in prison and five years of post-release supervision following his plea of guilty on April 3, 2009. Chait pleaded guilty to criminal possession of a controlled substance in the second degree, conspiracy in the second degree, and grand larceny in the second degree, all felonies. Chait also surrendered his license to practice medicine.

An investigation conducted by the NYMFCU and various city, state, and federal agencies found that Chait wrote unnecessary prescriptions that put huge quantities of highly addictive and dangerous painkillers worth millions of dollars—including OxyContin, an opium derivative, and Dilaudid—on the black market. Between January 1 and March 16, 2007, Chait sold the narcotic prescriptions to Medicaid recipients—up to 50 patients per day—who traveled from New York City to Chait's practice in the Town of East Hampton on the eastern end of Long Island, approximately 100 miles away. Patients used their Medicaid cards to obtain the medications from New York City pharmacies, costing taxpayers hundreds of thousands of dollars in medically unnecessary Medicaid billings.

People v. Godfrey Mbonu and Sisck, Inc.—Psychiatrist to Be Incarcerated for Stealing More than $200,000 from Medicaid

On December 22, 2009, Dr. Godfrey Mbonu, a psychiatrist, and his corporate medical group Sisck, Inc., pleaded guilty to grand larceny in the second degree. Mbonu must pay

more than $214,000 in restitution to the state and faces up to five to fifteen years in prison. Mbonu's plea stems from a NYMFCU investigation, which revealed that from 2003 to 2009, Mbonu individually and through his corporation, Sisck, Inc., located in Manhattan, systematically submitted hundreds of claims to New York State's Medicaid program for medical services that he or his medical group did not provide.

Records the NYMFCU obtained showed that Mbonu submitted claims to Medicaid that indicated he performed psychotherapy sessions in his New York office when he was actually traveling in Nigeria. An audit of patient records proved that Mbonu also claimed to have performed in-office psychotherapy sessions when the patient listed in the claim was actually in the hospital. To double his payment from Medicaid, Unit auditors discovered, Mbonu billed Medicaid at the higher psychiatrist rate when a clinical social worker actually performed the psychotherapy sessions.

As part of his plea, the NYMFCU required that Mbonu pay $214,157 in restitution to the state. If Mbonu fails to pays the full restitution by the time of his sentence on April 28, 2010, the court can sentence him to the maximum permissible term of imprisonment—five to fifteen years. If Mbonu pays the restitution in full, he will be permitted to withdraw his plea to the class C felony, plead guilty to grand larceny in the third degree, and will receive a sentence of one year in jail.

Psychologists

Psychologist and His Wife Charged with Stealing over $250,000 from Medicaid and Medicare

In July 2009, the NYMFCU charged Rochester-area psychologist Michael Miran, his wife, Esta Miran, and his practice, Michael Miran, PhD. Psychologist, P.C. with defrauding the Medicaid and Medicare programs out of approximately $258,000. The charges result from an investigation in which the United States Department of Health and Human Services' Office of the Inspector General and other federal agencies assisted the NYMFCU.

The Mirans are accused of allowing unqualified staff, including Esta Miran, to perform therapy sessions, charging for longer sessions than were actually performed, and billing for group therapy sessions when records show that the same practitioner, Michael Miran, was conducting individual therapy sessions occurring at the exact same time. The 31-count indictment charges the Mirans and the corporation with grand larceny in the second degree and the individual defendants with a variety of other crimes, including scheme to defraud in the first degree, a class E felony. The indictment also charges Michael Miran with multiple counts of falsifying business records in the first degree and Esta Miran with unauthorized practice of a profession (clinical psychology).

The criminal charges are pending.

Durable Medical Equipment Suppliers

People's Choice Surgical Supplies, Inc. and Its Executives Convicted of Stealing Physicians' Identities and Filing False Claims for Medical Equipment Never Actually Ordered

On April 6, 2009, People's Choice Surgical Supplies, Inc., formerly the largest Medicaid durable medical equipment supplier on Long Island, its President and Chief Executive Officer Cynthia Williams, and her husband, Vice President David Williams, admitted to stealing Medicaid funds by filing fraudulent claims. Between 2003 and 2006, the defendants engaged in schemes to defraud Medicaid, which resulted in payments of over $1 million for durable medical equipment that physicians never ordered. Instead, People's Choice and its executives stole the physicians' identities and in some instances paid Medicaid recipients cash in return for Medicaid numbers 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. Additionally, People's Choice billed Medicaid for over $50,000 of medical equipment that it never provided to Medicaid recipients.

On November 13, 2009, David Williams, who pleaded guilty to grand larceny in the second degree, was sentenced to three to nine years imprisonment. Cynthia Williams, who pleaded guilty to grand larceny in the third degree, was sentenced on June 23, 2009, to six months' in jail and five years probation. People Choice, which pleaded guilty to grand larceny in the second degree and identity theft in the first degree, was fined $10,000. All three defendants together were ordered to pay restitution of $1.1 million.

The NYMFCU also obtained misdemeanor convictions of two other People's Choice employees. Kenya Gadson, formerly People's Choice's billing supervisor and the Williams' niece, pleaded guilty to petit larceny and on August 10, 2009, was sentenced to three years probation and ordered not to seek employment in the healthcare field during the term of her probation. Ramona Wiley, a People's Choice marketer, pleaded guilty to petit larceny and admitted to applying for and receiving Medicaid benefits while falsely claiming to have no income. She was sentenced to pay a $1,000 fine and restitution of $2,303.

The NYMFCU filed a civil lawsuit against the company, Cynthia Williams and David Williams in February 2007, seeking over $11 million in damages for fraudulent, inaccurate, and ineligible Medicaid claims. The civil lawsuit is still pending.

Other Providers

Alexander Levy and Others Charged with Stealing $47 Million from Medicaid through Elaborate Scheme to Circumvent Levy's Exclusion from Medicaid—Defendants Provided Services through Medical Clinics and Transportation and Home Health Companies Levy Secretly Controlled

In July 2009, the NYFMCU filed an indictment charging six individuals and seven corporations for participating in a scheme that defrauded Medicaid out of $47,000,000. Over

ten years, Alexander Levy, with the assistance of others, allegedly secretly controlled a string of health care entities that illegally obtained payment for the treatment of Medicaid recipients and then laundered the profits.

According to the criminal charges and a companion civil suit filed by the NYMFCU in 1997, the New York State Department of Health excluded Levy from participating in the Medicaid program because he submitted false claims to Medicaid for medically unnecessary services and for services that were never actually performed. Despite his exclusion, Levy unlawfully continued to own and operate various health care entities that billed New York for the treatment of Medicaid recipients. Levy set up a series of corporations elaborately structured to conceal his control and ownership interest. In all, through the assistance of relatives, friends, and associates placed into various nominally high-level management or ownership positions within the provider entities, Levy controlled and managed one home health care agency, two ambulette companies, and two medical clinics, all of which billed Medicaid for millions of dollars of services. Over the last ten years, the scheme resulted in Medicaid paying over $47 million to the health care entities Levy controlled.

As detailed in the indictment and civil suit, Levy was careful not to put his name on any documents filed with the New York State Department of Health. However, the large flow of Medicaid monies going to the Levy-controlled health care entities—through a series of bank accounts and transfers—ultimately led investigators to Levy. The various health care entities Levy controlled funneled monies to shell companies that he created and owned and to a construction company he specifically set up to receive Medicaid funds. In addition, Levy manipulated funds through a home health care agency he controlled to spend hundreds of thousands of dollars on luxury cars and on paying his ex-wife to settle their divorce proceeding.

For their roles in operating ANR Advance Home Care Inc, of Brooklyn, the indictment charged Levy and his cohorts with grand larceny in the first degree and health care fraud in the first degree. In addition, Levy was charged with money laundering in the second degree for allegedly attempting to conceal the proceeds of the crimes. All defendants were also indicted for conspiracy to defraud Medicaid.

Due to his prohibited control and interest in the two ambulette companies and three medical clinics, the indictment charged Levy and others with additional counts of grand larceny, health care fraud, money laundering, and conspiracy. In one aspect of this scheme, bogus, unlicensed doctors allegedly treated Medicaid patients at Levy's various clinics. Thereafter, a licensed physician would sign off on patients' charts brought to him in bulk by individuals working with Levy. Medicaid was then billed for these services as if a licensed physician had cared for the patients. These clinics—incorporated under the names Rainbow Medical, P.C. and Bath Medical, P.C.—catered to the elderly Russian population of the Brighton Beach area of Brooklyn.

The civil forfeiture complaint filed against Levy and his co-defendants and non-criminal defendants seeks to recover $47,000,000 in damages, representing the amount of Medicaid funds the defendants received as part of their scheme to conceal Levy's involvement. The

suit also seeks triple that amount and additional penalties for fraud under New York's False Claims Act and health care fraud statutes.

Through December 31, 2009, the NYMFCU obtained convictions of Bath Management, Inc., and Meridian Construction & Development, LLC, companies Levy owns and to which Medicaid monies flowed. Bath Management was convicted of money laundering in the second degree and conspiracy in the fourth degree and sentenced to pay restitution of $172,867. Meridian Construction was convicted of money laundering in the second degree and ordered to pay restitution of $888,762. A judge also convicted Global Line Transportation, Inc., one of the ambulette companies Levy secretly controlled, of grand larceny in the first degree and other charges and sentenced it to pay restitution of $1.08 million.

The criminal charges against Levy and eight other defendants are pending. The civil lawsuit is also pending.

Architectural Design Firm and Its Owner Convicted of Stealing $300,000 from Medicaid for Home Modifications It Did Not Complete, for which It Submitted Inflated and Phony Bids, and which Did Not Comport with Applicable Regulations

Based upon evidence discovered while conducting an unrelated audit, the NYMFCU initiated an investigation of Kenneth Skender, the owner and chief executive officer of Accessibility Designs and Management, Inc., an architectural design firm. The firm provided environmental modifications ("e-mods") to Medicaid recipients suffering from traumatic brain injuries enrolled in the home and community-based services Medicaid waiver program. As a provider of e-mods such as ramps, lifts, hand rails and grab bars, roll-in showers, and other adaptations to kitchens, baths, cabinets, and shelving, Skender was responsible for obtaining and submitting bids and ensuring contractors complied with local and state building ordinances and completed projects. An e-mod provider liaisons with the recipient's service coordinator for the regional resource development specialist, who must approve the modification plan, and can only submit claims to Medicaid after the modification is completed and the regional resource development specialist approves the project's final cost.

Pursuant to a search warrant, the NYMFCU obtained Accessibility Designs' records, including computer records from Skender's hard drive, reviewed Department of Health and Medicaid billing records, and interviewed and studied records from relevant contractors. The Unit found that from 2003 to 2007, Skender billed for e-mod projects that he personally did not complete or were not in fact completed at all, completed projects without obtaining necessary permits, and inflated the costs of projects by altering and inflating contractors' bids and in some cases completely fabricating bids and forging contractors' signatures.

Following the filing of criminal charges in August 2009, on October 29, 2009, Skender and his company pleaded guilty to grand larceny in the second degree. The company, which was sentenced on January 29, 2010, agreed to pay $300,529 in restitution and a fine of $10,000. Skender also pleaded guilty to offering a false instrument for filing in the first degree and falsifying business records in the first degree and in January was sentenced to two consecutive sentences of one year in jail and six months in jail and five years probation. (On

the third count, Skender's sentence of five years' probation will run concurrently with the other sentences.) Jointly and severally liable with his company, the court ordered Skender to pay $300,529 in restitution. Skender also agreed to re-pay an additional $300,000 in lieu of treble damages for which he could be civilly liable.

Statewide Investigation of Child Foster Care Agencies Produced $1,984,800 in Restitution

In 2009, the NYMFCU reached settlements with 42 child foster care agencies for engaging in practices that resulted in double-billing. These settlements produced $1,984,800 in reimbursement to the Medicaid program.

Medicaid pays child foster care agencies a daily rate for providing foster care children with medical and other services—a rate that is based upon the child foster care agencies' cost reports. The investigation revealed that agencies frequently billed Medicaid for providing foster care children with medical services when the children were hospitalized. Under these circumstances, the foster parents were supposed to notify the agency so that the agency did not bill Medicaid for the per diem rate during the hospitalization.

The NYMFCU also found that transportation companies billed Medicaid directly for services it provided to foster care children rather than directly billing the foster care agency. The per diem rate Medicaid pays to the agencies makes the agencies responsible for absorbing transportation costs—costs that are reflected in the agencies' cost reports. Thus, the settlements required that the agencies reimburse Medicaid for the amount the transportation companies billed Medicaid. At the recommendation of the NYMFCU, the Department of Health altered its billing system to prevent transportation companies from submitting claims for foster care children.

Since the NYMFCU's investigation commenced in 2007, the NYMFCU has obtained ordered recoveries of $2,681,800 from 63 child foster care agencies.

PATIENT ABUSE AND NEGLECT PROSECUTIONS AND CIVIL ACTIONS

Statistical Overview

In 2009, the NYMFCU reviewed 1,002 allegations of patient abuse and neglect (including the theft of patients' money), opened 51 criminal investigations, initiated prosecutions against 28 defendants, and secured 35 convictions. Five defendants were acquitted following a trial. (See Tables A-3 and A-4, Appendix.)

This section reviews the status of the NYMFCU's cases 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 2009, 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, reached a first-of-its-kind settlement requiring that a nursing home operator implement real-time electronic monitoring to improve patient care and deter care givers from falsifying medical records. The settlement resulted from the NYMFCU's use of a camera in a resident's room at the now-defunct Jennifer Matthew Rehabilitation Center.

Based upon hidden camera evidence, in 2009 the NYMFCU obtained convictions of one licensed practical nurse and two certified nurse aides formerly employed at the Medford Multicare Center for Living in Suffolk County. The Medford case marks the fourth nursing home in which the NYMFCU has utilized covert surveillance to bring prosecutions involving criminal conduct by health care workers. Through 2009, the NYMFCU has obtained criminal convictions of 30 defendants through the use of hidden cameras, including the corporate owner and operator of a nursing home.

With the consent of residents' families, the NYMFCU installed hidden cameras in two nursing homes during 2009 and is currently conducting investigations related to the evidence obtained from these recordings.

Operator of Nine Nursing Homes Reached Settlement Requiring It to Implement Real-time Electronic Monitoring Technology to Improve Patient Care and Prevent Falsification of Patient Records

The NYMFCU reached an innovative civil settlement with the estate of Anthony Salerno, the former principal owner of the now-defunct Jennifer Matthew Rehabilitation Center in

Rochester, and with Salerno-related corporate entities. The estate continues to be the principal owner and administrator of nine other nursing homes across New York under the name HealthCare Associates ("HCA"). The settlement stems from the NYMFCU's use, during 2005, of a camera concealed in a Jennifer Matthew resident's room that uncovered a pattern of patient neglect and record falsification.

The settlement is the first in New York to require a nursing home operator to use technology designed to prevent falsification of care records and to improve the quality of care provided to nursing home residents. The equipment, known as "point-of-care" technology, requires that patient care be recorded electronically and in real time, permitting management to see whether nursing home staffers have in fact provided care as prescribed in patient care plans. In addition, the settlement increases oversight of the nursing home operator, HCA. The settlement requires HCA to appoint a compliance officer, who must prepare periodic reports for the NYMFCU and the New York State Department of Health, and adopt a code of conduct that obligates all HCA employees to report suspected wrongdoing.

The covert surveillance at Jennifer Matthew, conducted with the consent of the resident's family, revealed rampant neglect of a completely immobile 70 year-old resident, who used a feeding tube and suffered from dementia, type II diabetes, and other ailments. Among many other instances of neglect, the recordings showed that staff did not turn and position the resident every two hours as required for extended periods, and did not provide needed hydration and other treatment, including oral hygiene. Staff also failed to change and clean the resident every two to three hours as required, leaving the individual to lay in urine and stool.

The evidence produced during the investigation proved that supervision was wholly inadequate; staff slept on the night shift, watched movies, skipped rounds, took smoking breaks, and left the home for personal activities while falsely stating on the resident's medical chart that the tasks had been completed. In total, 14 employees including nurses and certified nurse aides were convicted of crimes such as wilful violation of health laws and falsifying business records.

Comprehensive Investigation of Medford Multicare Center for Living in Suffolk County Led to Charges against 16 Health Care Workers: Seven Convicted in 2009

The MFCU's ongoing investigation of Medford Multicare Center for Living, which included deployment of a camera secreted in a resident's room, has thus far resulted in the filing of criminal charges in 2008 and 2009 against 16 health care workers. Through December 31, 2009, seven of these defendants have pleaded guilty.

Criminal Cases Involving Medford Employees Based upon Hidden Camera Evidence

The NYMFCU initiated an investigation of Medford Multicare Center in 2007 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 atypical 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. Consequently, in October of 2008, 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.

Of these six defendants, three—Licensed Practical Nurse ("LPN") Toni Miller and Certified Nurse Aides ("CNA") Betty Cheslak and Jacqueline Francis—pleaded guilty in 2009. Miller pleaded guilty to falsifying business records in the first degree and endangering the welfare of an incompetent or physically disabled person for failing to hydrate the resident as required and falsely asserting in the resident's medical record that she took the resident's atypical pulse. She was sentenced to five years' probation, a condition of which prohibits her from caring for any incompetent individual. As part of her plea she also surrendered her nursing license.

Cheslak and Francis both pleaded guilty to falsifying business records in the second degree, a class A misdemeanor, and endangering the welfare of an incompetent or physically disabled person. The court sentenced these two defendants to three years' probation and also prohibited them from caring for incompetent individuals.

Criminal Cases against Medford Employees Not Based upon Hidden Camera Evidence

The Unit also brought charges in 2008 against defendants regarding the care provided to two other patients who were not the subject of a hidden camera. In one case, the Unit charged two aides[4] for falsifying business records in an effort to conceal one of the aide's failure to shower a resident as required. Charges against one of these defendants, Paulette George, are still pending. In the second case, the Unit charged LPN Kim Purdum with falsifying a resident's chart to conceal her failure to order the necessary blood tests needed to monitor dosages of the 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, Purdum went back into the records and altered them to make it appear as if she had originally included the usual order, months earlier. On March 20, 2009, Purdum pleaded guilty to falsifying business records in the second degree and surrendered her nursing license. The court sentenced Purdum to three years probation on May 20, 2009.

As part of its ongoing investigation of the facility, during 2009, the NYMFCU charged eight additional Medford health care workers with a variety of criminal conduct. Four of these defendants have already pleaded guilty. The Unit arrested LPN Melissa Buschor on March 9, 2009, for stealing narcotics intended for residents and falsifying medical records to conceal her theft. Buschor pleaded guilty on May 4, 2009, to criminal possession of a controlled substance in the seventh degree, a class A misdemeanor, and was sentenced in July to three years' probation. The NYMFCU charged CNAs Nicole Stumpf and Leticia Virgil-Green on May 6, 2009, with transferring a resident without a Hoyer lift as required, resulting in the resident breaking her leg. On July 1, 2009, both Stumpf and Virgil-Green pleaded guilty to endangering the welfare of an incompetent or physically disabled person and were sentenced to a conditional discharge. On July 16, 2009, the NYMFCU arrested LPN Nicole Campo for falsifying documents in connection with an incident in which staff ignored a resident's call bell for hours. Campo pleaded guilty on January 28, 2010, to falsifying business records in the second degree. Campo has not yet been sentenced. Charges against defendants LPN Teresa Bynum, CNA Christine Butzbach, LPN Patricia Ellis, and CNA Valerie Bryant – involving three separate incidents – are pending.

Other Abuse and Neglect Cases

Certified Nurse Aide Jailed for Taking Inappropriate Photograph of Nursing Home Resident and Sending It to a Co-worker

A judge sentenced Shane Spooner to 45 days in jail, three years probation, a $500 fine, and 150 hours of community service on October 23, 2009. Spooner previously pleaded guilty on August 18, 2009, to attempted dissemination of unlawful surveillance, a class A misdemeanor.

[4] One of these two aides, Jacqueline Francis, was also one of the six defendants charged on the basis of hidden camera evidence.

Spooner worked as a CNA at Clinton County Nursing Home in Plattsburgh. On March 28, 2009, Spooner used his cell phone to take a picture of the genitals of a 49-year-old patient suffering from a traumatic brain injury. He sent a text message with this photograph to a fellow employee, who was not working at the time. In the text message, Spooner asked his co-worker to send the picture to a mutual friend. Instead, the co-worker reported the incident to her superiors at the nursing home. Spooner subsequently admitted his conduct to a NYMFCU investigator and conceded that he took and sent the photograph for his own amusement.

Certified Nurse Aide Convicted of Sexually Abusing Physically Helpless Nursing Home Resident

In May 2009, the NYMFCU charged Robert Gundersen, a CNA, with touching the breasts and vaginal areas of a physically helpless, 78 year-old patient at the Northwoods Extended Care and Rehabilitation Center in Troy, between December 15, 2007, and January 7, 2008. Gunderson pleaded guilty on January 26, 2010, to attempted sexual abuse in the first degree, a class E felony. As a result, he must register as a sex offender and is banned from future employment in any health care facility. Gundersen will be sentenced in March 2010.

The guilty plea also settles additional charges of sexual abuse in the third degree against Gundersen based on a separate incident stemming from his employment at the Eddy Ford Nursing Home in Albany County. In that case, it was alleged that between August and September 2008, Gundersen forcibly French-kissed a female wheelchair-bound patient with multiple sclerosis.

People v. John Ette—Aide Sentenced to Jail for Hitting and Injuring 88 Year-old Wheelchair-bound Resident of Nursing Home

The NYMFCU obtained a conviction of CNA John Ette, whom it charged in May 2009, with physically abusing an 88 year-old wheelchair-bound resident at the Adirondack Medical Center/Mercy Nursing Home.

Ette admitted to NYMFCU investigators that while employed as a CNA in October 2008, he struck, grabbed, and pushed an 88 year-old bedridden woman suffering from dementia and impaired vision. According to Ette, he hit the resident after she became "combative". Nursing home staff reporting to work the next morning noticed the resident's extensive injuries and notified their superiors. In addition to suffering from severe facial bruising, the criminal charges alleged that the resident sustained a fractured right clavicle.

Ette pleaded guilty to endangering the welfare of an incompetent or physically disabled person on July 22, 2009. The court sentenced Ette that same day to time served in jail (71 days) and ordered Ette to complete an anger management program.

People v. Pierre Obas—Certified Nurse Aide Tied Resident to Wheelchair and Put Her in a Dark Room

On April 27, 2009, CNA Pierre Obas pleaded guilty to wilful violation of health laws, a misdemeanor, and admitted he unlawfully restrained an 83 year-old, physically disabled resident of Waterview Hills Rehabilitation and Healthcare Centers.

At approximately 2:30 a.m. on May 16, 2008, after the elderly resident required assistance several times, Obas, who was working as a CNA, entered the resident's room, tied her to a wheelchair with a bed sheet and, against her will, transported the resident to a darkened room, where she remained restrained in her wheelchair for approximately 50 minutes while Obas napped. Obas eventually took the resident back to her room and placed her back in bed.

The court sentenced Obas to a one-year conditional discharge, pursuant to which Obas surrendered his CNA certificate.

Certified Nurse Aide Convicted of Endangering an 80 Year-old Incompetent Resident

CNA Rhonda Woodson was assigned to provide care to an 80 year-old resident who was incompetent due to progressive dementia. The resident also suffered from a host of physical maladies causing him to require assistance in all daily activities, including transport to and from his bed and the shower. On March 31, 2009, outside the shower room at the Pines at Utica Center for Nursing and Rehabilitation and in view of another aide, Woodson flicked the resident's ear and nose and slapped the resident's head. Inside the shower, Woodson sprayed water up the resident's nose. The aide who witnessed the incident reported it to the facility.

On July 20, 2009, Woodson pleaded guilty to endangering the welfare of an incompetent or physically disabled person. On September 16, 2009, Woodson was sentenced to three years' probation, one of the conditions of which required her to surrender her CNA certificate.

Thefts of Residents' Money and/or Identity

Facilities Coordinator Stole More than $25,000 from 81 Year-old Resident's Personal Needs Account and Other Bank Accounts

Catherine Semczuk was the facilities coordinator for Park Hill Adult Home in Montgomery County. As facilities coordinator, Semczuk was responsible for residents' personal needs accounts, which are accounts that hold residents' own money from which the resident can purchases goods and services at the home.

Semczuk gained the trust of an 81 year-old resident, who gave Semczuk access to her personal needs account to pay for her care and maintenance at the home, including rent, pharmaceutical needs, and other personal items. At Semczuk's suggestion, the resident also

gave Semczuk access to several other accounts so that Semczuk could assist the resident in managing her money. The evidence the NYMFCU gathered during its investigation, however, showed that from August 2005, through December 2006, Semczuk systemically stole money from the resident's personal needs account, from the resident's insurance annuity, and from an account the resident had established to secure her social security funds. By way of example, Semczuk faxed withdrawal forms to the insurance company, received checks payable to the resident, had the resident endorse the checks, and then cashed the checks against her (Semczuk's) own personal account and used the money to fund her own personal expenditures.

On February 3, 2009, Semczuk pleaded guilty to petit larceny and on June 9, 2009, was sentenced to three year's probation. As the court required, by her sentencing date Semczuk had made all required restitution payments, totaling $19,000.

People v. Teah Bender—Counselor Used Residents' Electronic Benefit Transfer Cards to Buy Nearly $3,000 in Food for Herself

On June 9, 2009, Teah Bender, formerly a community skills counselor at The Rehabilitation Center-Moss Apartments, pleaded guilty to petit larceny for using electronic benefit transfer ("EBT") cards to buy food for herself, rather than residents. On September 15, 2009, a judge sentenced Bender to three years' probation and, as a condition of probation, ordered her to pay restitution in the amount of $2,920.

The Rehabilitation Center-Moss Apartments, located in Amsterdam, housed ten residents with a variety of mental health disorders. Eight of these residents had electronic benefit transfer cards ("EBT cards") through which New York provides monthly stipends for certain government benefits like food stamps. Part of Bender's job required her to use the EBT cards and make purchases on behalf of residents. Instead, the NYMFCU's audit revealed that on seven occasions from December 2005 to July 2008, Bender used the residents' EBT cards to buy $2,920 in food for herself. In addition, she made false entries into the business records of The Rehabilitation Center to conceal the thefts.

Court Jailed Certified Nurse Aide Who Stole $2,400 Using 90 Year-old Resident's Credit Card and Submitted False Application for Government Benefits

A 90 year-old resident of Blossom South Nursing Home, of Rochester, gave her credit card to CNA Latoya Harding, so that Harding could buy toiletries for the resident. Instead, Harding used the credit card to pay telephone, utility, cable, and furniture bills, and purchase goods from Walmart. Harding returned the card to the resident without even bothering to buy the toiletries the resident requested. When the nursing home discovered the thefts, which totaled approximately $2,400, it suspended Harding while it continued to investigate.

Following her suspension, Harding applied for government assistance and in August 2009, submitted a form to the Monroe County Department of Human Services in which she

falsely stated that she had been laid off. Additionally, the form Harding submitted contained the forged signature of Blossom South's director of human resources.

On November 13, 2009, the NYMFCU charged Harding with grand larceny in the fourth degree, offering a false instrument for filing in the first degree, and criminal possession of a forged instrument in the second degree. Harding pleaded guilty to the felony larceny charge on December 17, 2009. On January 29, 2010, the court sentenced Harding to time served (31 days in jail), five years' probation, and ordered her to pay restitution of $2,435.

APPENDIX

Investigations

Table A-1[5]

Investigations Opened and Closed by Provider Category 2009				
	Investigations Opened		Investigations Closed	
Provider Category	*Number*	*Percent of Total*	*Number*	*Percent of Total*
Facilities—Hospitals	31	9%	35	10%
Facilities—Nursing Facility	17	5%	36	10%
Facilities—Other Long-term Care	3	1%	2	1%
Facilities—Substance Abuse Treatment Center	3	1%	3	1%
Facilities—Other	11	3%	10	3%
Physicians—Doctors of Medicine or Osteopathy	11	3%	17	5%
Dentists	2	1%	10	3%
Podiatrists	0	0%	0	0%
Optometrist/Optician	0	0%	0	0%
Counselor/Psychologist	7	2%	6	2%
Chiropractors	0	0%	0	0%
Practitioners—Other	2	1%	0	0%
Pharmacy	22	7%	16	4%
Pharmaceutical Manufacturer	38	11%	16	4%
Durable Medical Equipment and/or Supplies	6	2%	6	2%
Lab	3	1%	3	1%
Transportation Services	15	4%	17	5%
Home Health Care Agency	37	11%	30	8%
Home Health Care Aides	19	6%	11	3%
All Nurses, Physician Assistants, and Nurse Practitioners, including Certified Nurse Aides	22	7%	32	9%
Radiology	2	1%	0	0%
Medical Support—Other	19	6%	41	11%
Managed Care	1	0%	0	0%
Medicaid Program Administration	0	0%	0	0%
Billing Company	0	0%	2	1%
Program Related—Other	15	4%	13	4%
Subtotal Fraud Investigations	**286**	**85%**	**306**	**86%**
Abuse and Neglect—Nursing Facility	2	1%	1	0%
Abuse and Neglect—Other Long-term Care	1	0%	1	0%
Abuse and Neglect—Registered/Licensed Nurse/PA/NP	13	4%	12	3%
Abuse and Neglect—Certified Nurse Aides	25	7%	25	7%
Abuse and Neglect—Other Practitioner	3	1%	3	1%
Subtotal Abuse and Neglect Investigations	**44**	**13%**	**42**	**12%**
Patient Funds—Non-direct Care	4	1%	2	1%
Patient Funds—Registered/Licensed Nurse/PA/NP	1	0%	0	0%
Patient Funds—Certified Nurse Aides	2	1%	3	1%
Patient Funds—Other Practitioner	0	0%	4	1%
Subtotal Patient Fund Investigations				
Patient Funds Investigations	**7**	**2%**	**9**	**3%**
Total All Investigations	**337**	**100%**	**357**	**100%**

[5] Statistics for the NYMFCU 2009 Annual Report have been updated and may not, as a result, mirror the totals of the four 2009 quarterly statistical reports the NYMFCU previously submitted to Department of Health and Human Services' Office of the Inspector General.

Table A-2

Investigation Closures 2009					
	Closed by Prosecution	**Closed by Civil Action**	**Closed Due to Insufficient Evidence**	**Closed by Referral**	**Total**
Fraud Investigations	53	161	83	9	**306**
Patient Abuse and Neglect Investigations	24	0	14	4	**42**
Patient Fund Investigations	7	0	2	0	**9**
Total Completed Investigations	**84**	**161**	**99**	**13**	**357**

Patient Abuse Complaints[6]

Table A-3

Patient Abuse Complaints Received, Investigated and Referred 2009	
	Total
Patient Crimes Complaints Received	1002
Patient Crimes Investigations Opened	51
Patient Crimes Referrals to Other State Agencies	16

Prosecutions

Table A-4

Criminal Prosecution Closures by Defendant 2009			
	Fraud	**Patient Abuse and Neglect (including Patient Fund Cases)**	**Total**
Criminal prosecutions filed	111	28	**139**
Convictions	113	35	**148**
Acquittals	0	5	**5**
Dismissals	4	0	**4**
Total Prosecutions Completed	**117**	**40**	**157**
Conviction Rate	**97%**	**88%**	**94%**

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

Monetary Recoveries[7]

Table A-5

Monetary Recoveries 2009			
	Criminal	**Civil**	**Total**
Number of Recovery Actions Initiated (and Resolved with Order or Settlement)	90	197	**287**
Medicaid Overpayments Identified	$8,921,082	$274,321,934	**$283,243,016**
Penalties Imposed	$181,897	-	**$181,897**
Non-Medicaid Restitution Due to Third Parties	$189,782	$353	**$190,135**
Medicaid Overpayments Collected by the NYMFCU	$1,558,664	$228,732,753	**$230,291,417**
Non-Medicaid Restitution Due to Third Parties Collected by the NYMFCU	$132,245	$5,500	**$137,745**
Penalties Collected by the NYMFCU	$177,274	-	**$177,274**

[7] 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 2009					
Provider Category	**Medicaid Restitution**	**Penalties**	**Fines**	**Non-Medicaid Restitution Due to Third Parties**	**Total**
Facilities—Hospitals	5,169,541				5,169,541
Facilities—Nursing Facility	346,287				346,287
Facilities—Child Foster Care Agencies	2,089,985				2,089,985
Facilities—Clinics	3,591,533				3,591,533
Facilities—Other	850,984				850,984
Physicians—Doctors of Medicine or Osteopathy	1,727,278		500		1,727,778
Dentists	16,599,735				16,599,735
Counselor/Psychologist	26,840		2,000	1,285	30,125
Pharmacy	3,515,121				3,515,121
Pharmaceutical Manufacturer	188,559,524				188,559,524
Durable Medical Equipment and/or Supplies	1,462,813		21,000		1,483,813
Transportation Services	154,707				154,707
Home Health Care Agency	26,096,684	109,623		24,183	26,230,490
Home Health Care Aides	1,088,537			2,823	1,091,360
All Nurses, Physician Assistants, and Nurse Practitioners, including Certified Nurse Aides	1,374,978	72,274	1,000	19,507	1,467,759
Laboratories	611,049				611,049
Therapists					
Drug Diversion	29,670,100				29,670,100
Program Related—Other	304,400			118,167	422,567
Subtotal Fraud Monetary Recoveries	**283,240,096**	**181,897**	**24,500**	**165,965**	**283,612,458**
Patient Abuse—Nursing Facility					
Patient Abuse—Certified Nurse Aides			1,395		1,395
Subtotal Abuse and Neglect Recoveries			**1,395**		**1,395**
Patient Funds —Other Practitioner	2,920			1,700	4,620
Patient Funds —Facilities				19,000	19,000
Patient Funds —Certified Nurse Aides				3,470	3,470
Subtotal Patient Fund Recoveries	**2,920**			**24,170**	**27,090**
Total All Monetary Recoveries	**283,243,016**	**181,897**	**25,895**	**190,135**	**283,640,943**

Costs

Table A-7

Expenditures 2009	
Type of Expenditure	**Cost**
Personal Services	$25,306,654
Non-personal Services	$7,773,542
Fringe Benefits	$10,783,462
Total Expenditures	$43,863,658