VERMONT MEDICAID FRAUD AND RESIDENTIAL ABUSE UNIT

2015 ANNUAL REPORT

July 1, 2014 - June 30, 2015

Office of the Vermont Attorney General
Honorable William H. Sorrell

2015 ANNUAL REPORT NARRATIVE

In compliance with 42 C.F.R. § 1007.17(h), the Vermont Medicaid Fraud and Residential Abuse Unit (Unit) submits this narrative as part of its annual report to HHS-OIG for State Fiscal Year 2015.

I. Evaluation of the Unit's Performance

A. Overview

The Unit's performance was strong during the reporting period. Despite the departure of the Unit's director early in the year, and attorney turnover, the Unit obtained a record number of criminal convictions. It also made great strides in increasing its efficiency and effectiveness by eliminating a backlog of older investigations through appropriate resolutions and referrals and reducing its overall caseload. This, in turn, permitted the Unit to dedicate its resources to more complex cases and investigations and prosecutions that are most likely to protect the fiscal integrity of the Vermont Medicaid program and the welfare of vulnerable adults. With the addition of a new assistant attorney general in October 2014, enhanced enforcement tools in the form of a state false claims act enacted in May 2015, and improved case intake and prioritization procedures, the Unit enters SFY16 with an experienced team of investigators, analysts and prosecutors and a good case mix of provider fraud, and abuse and neglect investigations, that are expected to result in significant criminal prosecutions and civil enforcement actions in the coming fiscal year.

B. Statistical Summary

Through civil settlements and restitution orders in criminal cases, the Unit recovered $738,253 in state and federal Medicaid overpayments, including $170,714 from Vermont-only fraud cases. These recovery figures are similar to those in SFY14, not including last year's $3.7 million Risperdal multi-state settlement. Over the past five years, the Unit's total recoupments exceed $25 million.

The state and federal recoupment figure largely derives from settlements of multi-state pharmaceutical cases coordinated through the National Association of Medicaid Fraud Units (NAMFCU). The Unit actively participates in these cases through the NAMFCU global case process, providing responses to data requests, reviewing settlement agreements, and participating on litigation teams. The "Vermont-only" fraud figure represents recoveries the Unit obtained as a direct result of its criminal and civil enforcement actions.

During the reporting period, the Unit received 67 complaints and opened 52 new investigations, with a total of 76 investigations open at the end of the year. The number of open cases at year-end was reduced from a high of 139 at the conclusion of SFY14. The majority of the Unit's current investigations (60%) involve Vermont provider fraud; a smaller percentage of the remaining investigations involve patient abuse and neglect (14%) or multi-state cases against pharmaceutical companies (26%). Consistent with past years, the distribution of the Unit's investigations by case type remained largely unchanged, with a continued emphasis on Vermont provider fraud, and abuse, neglect and exploitation of vulnerable adults.

Following the completion of investigations, Unit attorneys filed five criminal informations leading to arraignments during the reporting period and one civil enforcement

action. The five arraignments all involved allegations of Medicaid billing fraud by home health care aides. Four additional informations charging Medicaid fraud, abuse and neglect and financial exploitation of vulnerable adults were filed within 30 days of the close of the fiscal year.

Additionally, Unit attorney's obtained eleven criminal convictions during the reporting period, which represents a record number of convictions in a single year for the Unit. Significant case resolutions and developments included:

- Criminal conviction of an oral surgeon, previously convicted of Medicaid fraud, for groping a female patient while she was sedated for surgery.
- Pre-litigation civil settlement in excess of $70,000 with a laboratory provider in connection with inappropriate billing for urinalysis testing and qualitative drug screening.
- Criminal conviction of a pharmacist related to drug diversion.
- Pre-litigation civil settlement in excess of $90,000 with a former pharmacy provider related to the failure to bill primary insurers, resulting in fraudulent Medicaid claims.
- Arraignment of employer of record for recipient of personal care services for filing claims for services in the names of family and friends who did not provide care and were not aware of the filing of claims. The employer retained all of the payments in excess of $30,000. Litigation continues on the charges.
- Filed civil enforcement action against podiatrist related to Medicaid billings in excess of the usual and customary charges.

The Unit also continued to aggressively pursue prosecutions of home health aides for so-called time-sheet fraud. The Vermont Medicaid program provides benefits through various waiver programs to recipients to provide in-home care by personal care, respite and community support aides. These programs are critical component of Medicaid funded services that benefit thousands of Vermonters. The Unit acts to protect these programs by prosecuting individuals who file timesheets for payment in excess of the services actually delivered or when services were not delivered at all. In addition to the prosecutions described above, the Unit obtained eight convictions of home health aides for Medicaid fraud or false pretenses during the reporting period.

The Unit reported all convictions that it obtained to HHS-OIG for purposes of exclusion. The Unit continues to actively prosecute the remaining charged cases, including a timesheet fraud case against two defendants involving more than $70,000 in allegedly fraudulent billings. This case is expected to go to trial this fall.

C. Legislative Initiatives and Program Recommendations

The Unit played a lead role in two legislative initiatives during the fiscal year. First, Assistant Attorney General Jason Turner worked closely with legislative council in refining draft legislation for a state false claims act, proposed but not passed in the previous legislative session, and testified before committees in both houses of the legislature. This work culminated in May 2015 with the enactment of the Vermont False Claims Act. The Act provides the Unit with

additional enforcement tools, including authority to issue civil investigative demands, a reduced scienter standard to establish liability in civil enforcement cases, and enhanced monetary penalties for violations, to protect the fiscal integrity of the Vermont Medicaid program.

Second, the Unit, working in conjunction with partners from the State Ombudsman for Long Term Care, the Office of the Chief Medical Examiner and Adult Protective Services, among others, proposed legislation to create a Vulnerable Adult Fatality Review Team. The purpose of the team is to improve the understanding of the risk factors involved in untimely deaths, increase communication among key state entities and to make recommendations related to oversight and the delivery of services. Although the legislation was not passed, it will be considered again in the next legislative session.

Finally, the Unit was successful in advancing program recommendations related to personal care and respite providers working under the Development Services waiver program.

D. Partnerships

The Unit maintains an excellent and close working relationship with the Program Integrity Unit (PIU) of the Department of Vermont Health Access (DVHA). During the reporting period, PIU referred ten new complaints to the Unit. The quality of PIU's referrals, particularly with respect to cases involving allegations of complex provider, were exceptionally high, resulting in the filing of charges or pre-litigation settlements in several matters, and the continued investigation of others.

Strengthening the partnership and collaboration with PIU in the coming fiscal year is a top priority with the ultimate goal of advancing the missions of both entities by increasing referrals to the Unit, and PIU opportunities to recover for waste and abuse in provider claims. The Unit hopes to achieve this by learning and borrowing from successful models of MFCU-PIU cooperation in other jurisdictions, particularly the cooperative model established in Ohio which has led to a significant increase in referrals.

During the reporting period, the Unit also developed a strong relationship with the Development Disabilities Services Division within the Agency of Human Services, Department on Aging and Independent Living. The Unit and DDS began meeting quarterly to discuss case developments and shared programmatic concerns. This relationship resulted in improved communication, case referrals and the adoption of program recommendations to reduce fraud, waste and abuse.

The success of the Unit's work with DDS highlights the importance of maintaining strong relationships with all stakeholders that share an interest in protecting the integrity of the Medicaid program and the safety and well-being of vulnerable adults. With this goal in mind, another top priority for the Unit in the coming year is the re-cultivation of its relationship with Adult Protective Services and the Division of Licensing and Protection which traditionally have been critical sources of referrals related to abuse, neglect and exploitation of vulnerable adults.

The Unit continues to enjoy a strong relationship with its federal counterparts. In 2012, the Unit and prosecutors from the United States Attorney's Office established the Vermont Health Care Fraud Enforcement Task Force. Among others, the task force consists of representatives from MFRAU, USAO, OIG and PIU, as well as private partners including BCBS

of Vermont. The task force meets quarterly to discuss cases, trends and developments in provider fraud, and to coordinate the most effective use of resources. Unit investigators also frequently work with the federal agent assigned to Vermont by the U.S. Department of Health and Human Services, Office of Inspector General on cases involving Medicare and Medicaid fraud.

E. Outreach

In the on-going effort to increase the visibility of the Unit and its mission, Unit personnel engaged in outreach and education programs, including participation in a HHS-OIG community awareness panel discussion in Brattleboro, two presentations on abuse of vulnerable adults at the Vermont State Police Academy, a presentation to a nursing home operator on drug diversion, and a presentation at the NAMFCU Annual Meeting on information sharing systems. Unit members also received additional training designed to enhance the Unit's effectiveness and expertise, attending NAMFCU's Fraud 101 training and a joint Department of Justice and NAMFCU training on nursing home failure to care cases.

F. Conclusion

The Unit is well positioned to build on the success of the past year. With a manageable caseload, and skilled and experienced personnel, the Unit is now able to focus its resources on major cases of fraud in critical areas of the delivery of Medicaid services and systemic abuse and neglect of vulnerable adults.

APPENDIX

VERMONT ATTORNEY GENERAL'S OFFICE
MEDICAID FRAUD AND RESIDENTIAL ABUSE UNIT

2015 ANNUAL REPORT - APPENDIX

A. MATTERS RECEIVED

Matter Type	Matters Received	Investigated by Unit	Referred Out	Declined
Abuse and Neglect & Exploitation	17	10	3	4
Vermont Fraud	45	37	1	7
Multi-State Fraud	5	5	0	0
TOTAL	**67**	**52**	**4**	**11**

B. MFRAU CASES

Complaint Type {1}	Open at Start of Period	Opened Within the Period	Prosecuted {2}	Resolved {3}	Open at End of Period
Criminal Cases					
Patient Abuse & Neglect	20	5	0	17	8
Vermont Fraud	65	38	0	64	39
Multi-State Fraud	0	0	0	0	0
Patient Funds	2	3	0	2	3
Subtotal	**87**	**46**	**0**	**83**	**50**
Civil Cases					
Patient Abuse & Neglect	0	0	0	0	0
Vermont Fraud	7	0	0	1	6
Multi-State Fraud	45	6	0	31	20
Patient Funds	0	0	0	0	0
Subtotal	**52**	**6**	**0**	**32**	**26**
TOTAL	**139**	**52**	**0**	**115**	**76**

{1} Complaints of mixed type--involving both fraud and abuse/neglect elements--are categorized as either fraud or abuse/neglect at the Unit Director's direction.

{2} "Prosecuted" complaints include all and only those cases that have been closed by the Unit following criminal prosecution. It does not include criminal cases still in active prosecution and/or successfully resolved and merely awaiting a closing memo, or civil enforcement actions. The Unit criminally arraigned 19 individuals during the reporting period.

{3} "Resolved" complaints include all and only those cases that the Unit has closed following a full (as opposed to a preliminary) investigation, but excluding criminal cases closed following prosecution.

C. OPEN MATTERS - BY PROVIDER CATEGORY AND TYPE

Provider Type {4}	Open at Start of Period {4}	Opened Within the Period {4}	Prosecuted {4}	Resolved {4}	Open at End of Period
FRAUD: Facility Based Medicaid Providers and Programs - Inpatient and/or Residential					
Assisted Living Facility					1
Developmental Disability Facility (Residential)					0
Hospice					0
Hospitals					0
Inpatient Psychiatric Services (Under Age 21)					0
Nursing Facilities					0
Other Inpatient Mental Health Facility					1
Other Long Term Care Facility					0
TOTAL					**2**
FRAUD: Facility Based Medicaid Providers and Programs - Outpatient and/or Day Services					
Adult Day Center					0
Ambulatory Surgical Center					0
Developmental Disability Facility (Non-Resid.)					0
Dialysis Center					0
Mental Health Facility (Non-Residential)					1
Substance Abuse Treatment Center					0
Other Facility (Non-Residential)					2
Total					**3**
FRAUD: Physicians (MD/DO) *by Medical Specialty*					
Allergist/Immunologist					0
Cardiologist					0
Emergency Medicine					0
Family Practice					1
Geriatrician					0
Internal Medicine					0
Neurologist					0
Obstetrician/Gynecologist					0
Ophthalmologist					0
Pediatrician					0
Physical Medicine and Rehabilitation					0

{4} New OIG Categories and Types, effective 10/01/2015. Data to be tracked in subsequent years.

C. OPEN MATTERS - BY PROVIDER CATEGORY AND TYPE (Continued)

Provider Type {4}	Open at Start of Period {4}	Opened Within the Period {4}	Prosecuted {4}	Resolved {4}	Open at End of Period
Psychiatrist					0
Radiologist					0
Surgeon					0
Urologist					0
Other MD/DO					1
Total					**2**
FRAUD: Licensed Practitioners					
Audiologist					0
Chiropractor					0
Clinical Social Worker					0
Dental Hygienist					0
Dentist					1
Nurse - LPN, RN, or other licensed					1
Nurse Practitioner					0
Optometrist					0
Pharmacist					0
Physician Assistant					0
Podiatrist					0
Psychologist					0
Therapist (Non-Mental Health; PT, ST, OT, RT)					1
Other Practitioner					0
Total					**3**
FRAUD: Other Individual Providers					
EMTs or Paramedics					0
Nurse's Aide - CNA or other					0
Optician					0
Personal Care Services Attendant					29
Pharmacy Technician					0
Unlicensed Counselor (Mental Health)					1
Unlicensed Therapist (Non-Mental Health)					0
Other					4
Total					**34**

{4} New OIG Categories and Types, effective 10/01/2015. Data to be tracked in subsequent years.

C. OPEN MATTERS - BY PROVIDER CATEGORY AND TYPE (Continued)

Provider Type {4}	Open at Start of Period {4}	Opened Within the Period {4}	Prosecuted {4}	Resolved {4}	Open at End of Period
FRAUD: Medical Services					
Ambulance					0
Billing services					0
DME, Prosthetics, Orthotics and Supplies					3
Home Health Agency					0
Lab (Clinical)					0
Lab (Radiology and Physiology)					0
Lab (Other)					1
Medical Device Manufacturer					1
Pain Management Clinic					0
Personal Care Services Agency					0
Pharmaceutical Manufacturer					10
Pharmacy (Hospital)					0
Pharmacy (Institutional Wholesale)					2
Pharmacy (Retail)					3
Transportation (Non-Emergency)					2
Other					1
Total					**23**
FRAUD: Program Related					
Managed Care Organization (MCO)					0
Medicaid Program Administration					0
Other					1
Total					**1**
ABUSE AND NEGLECT:					
Assisted Living Facility					0
Developmental Disability Facility (Residential)					1
Hospice					0
Non-Direct Care					0
Nurse's Aide (CNA or Other)					0
Nursing Facilities					1
PCA or Other Home Care Aide					2
Registered/Licensed Nurse/PA/NP					1
Other					3
Total					**8**
TOTAL					**76**

{4} New OIG Categories and Types, effective 10/01/2015. Data to be tracked in subsequent years.

D. AGE OF OPEN CASES

Age	# of Cases
0 – 6 Months	12
7 – 12 Months	13
13 – 24 Months	29
24 – 36 Months	11
36+ Months	11
TOTAL	**76**

E. MFRAU CASE OUTCOMES

Case Outcomes	SFY '11	SFY '12	SFY '13	SFY '14	SFY '15
Criminal Investigations/Prosecutions					
Plea agreement	9	6	4	9	11
Dismissed	0	0	0	0	0
Conviction at trial (some charges)	0	0	0	1	0
Acquitted at trial (all charges)	0	0	0	0	0
Close Prior to Prosecution	9	36	27	33	60
Other	0	1	0	0	8
Subtotal	**18**	**43**	**31**	**43**	**79**
Civil Investigations/Litigation					
Settled prior to trial	11	13	15	13	36
Dismissed	0	0	0	0	0
Summary Judgment	0	0	0	0	0
Judgment for State at trial	0	0	0	0	0
Judgment for Defendant at trial	0	0	0	0	0
Other	0	0	0	0	0
Subtotal	**11**	**13**	**15**	**13**	**36**
TOTAL	**29**	**56**	**46**	**56**	**115**

F. RECOUPMENTS BY AGENCY

Agency	Recovery Actions Initiated	Referred to Another Agency	Overpayments Identified {5}	Overpayments Collected {5}	Overpayments to be Collected {5}
MFRAU	NA	NA	$773,626	$738,253	$298,662
DVHA/PIU under agreement with Unit {6}	NA	NA	NA	NA	NA
TOTAL			**$773,626**	**$738,253**	**$298,662**

{5} Overpayments include the total state *and* federal share.

{6} DVHA/PIU figures are limited to cases referred by MFRAU to PIU (per Section IV.F.4 of the MOU), and exclude any amounts reported as

G. MFRAU RECOUPMENTS BY CASE TYPE

Case Type	Overpayments Collected SFY'12	Overpayments Collected SFY'13	Overpayments Collected SFY'14	Overpayments Collected SFY'15	Overpayments Projected SFY'16
Multi-State	$2,054,400	$10,118,597	$4,111,630	$567,539	$750,000
Vermont Civil	$262,924	$4,912,590	$286,881	$168,127	$500,000
Vermont Criminal	$7,952	$51,120	$3,126	$2,587	$5,000
TOTAL	**$2,325,276**	**$15,082,307**	**$4,401,637**	**$738,253**	**$1,255,000**

H. MFRAU RECOUPMENTS BY CASE SHARE

Case Share	Overpayments Collected SFY'12	Overpayments Collected SFY'13	Overpayments Collected SFY'14	Overpayments Collected SFY'15
Federal Share	$1,201,307	$8,739,577	$2,543,287	$391,581
State-Only Share	$1,123,969	$6,342,730	$1,858,350	$346,672
TOTAL	**$2,325,276**	**$15,082,307**	**$4,401,637**	**$738,253**

I. STATE-ONLY SHARE BREAKDOWN

Case Share	Overpayments Collected SFY'12	Overpayments Collected SFY'13	Overpayments Collected SFY'14	Overpayments Collected SFY'15
Restitution to DVHA	$819,028	$5,462,820	$1,473,357	$299,895
MFRAU's Share of "additional recoveries"	$304,941	$879,910	$384,994	$46,777
TOTAL	**$1,123,969**	**$6,342,730**	**$1,858,350**	**$346,672**

J. MFRAU COSTS

Expense Category	SFY'12	SFY'13	SFY' 14	SFY '15	Projected FFY'16
Personnel	$600,965	$677,430	$651,238	$662,826	$854,403
Non-Personnel	$126,532	$163,771	$193,955	$91,983	$152,325
Indirect Costs	$66,289	$96,738	$97,198	$90,577	$120,807
TOTAL	**$793,786**	**$937,939**	**$942,391**	**$845,386**	**$1,127,535**

K. MFRAU TOTAL BUDGET EXPENDITURES VS. STATE FUNDING

State Fiscal Year	MFRAU Deposits to State Special Fund	Distribution to MFRAU by State Legislature
2015	$46,777	$254,434
2014	$384,482	$247,751
2013	$379,940	$318,455
2012	$304,801	$208,000
2011	$270,756	$280,000
2010	$247,330	$88,302
2009	$451,260	$195,235

L. MFRAU PROJECTIONS - BY CASE TYPE

Case Type	Current Open at Start of Period	Projected New Complaints	Projected Prosecuted Cases	Projected Resolved Cases	Projected Closed Cases	Projected Open at End of Period
Patient Abuse & Neglect	8	15	3	5	5	10
Vermont Fraud	45	50	13	25	20	37
Multistate Fraud	20	10	0	10	10	10
Patient Funds	3	5	0	2	3	3
TOTAL	**76**	**80**	**16**	**42**	**38**	**60**

M. MFRAU PROJECTIONS - BY PROVIDER TYPE

Case Type	Current Open at Start of Period	Projected New Complaints	Projected Prosecuted Cases	Projected Resolved Cases	Projected Closed Cases	Projected Open at End of Period
Institutions	11	8	3	4	6	6
Practitioner/ Individual	42	59	12	26	21	42
Medical Support	23	13	1	12	11	12
TOTAL	**76**	**80**	**16**	**42**	**38**	**60**

Press Releases Relating to MFRAU Cases

Bradford Woman Convicted For Submitting False Timesheets And Falsely Obtaining Monies

CONTACT: Micaela Tucker, Assistant Attorney General, (802) 828-5511

August 6, 2014

Crystal Hathaway-Therrien, age 31, of Bradford, Vermont, was convicted on August 5, 2014, in the Windsor Criminal Division of the Vermont Superior Court, of five misdemeanor counts of False Pretenses. The convictions stemmed from Ms. Hathaway-Therrien's submission of false timesheets in order to obtain payment for services that were not provided to a child enrolled in the Children's Personal Care program, a Vermont Medicaid program. Ms. Hathaway-Therrien signed and submitted the timesheets in her capacity as the employer-of-record and received the proceeds.

Ms. Hathaway-Therrien was sentenced to two-and-a-half to five years in jail, all suspended, and placed on two years of probation subject to certain conditions, including 100 hours of community service. Ms. Hathaway-Therrien was also ordered to pay $7,150 in restitution to the Vermont Medicaid program. The conviction will be referred to the federal Office of Inspector General which may exclude Ms. Hathaway-Therrien from participation as a provider in Medicaid/Medicare for 5 years.

The case was investigated and prosecuted by the Medicaid Fraud and Residential Abuse Unit within the Vermont Attorney General's Office with assistance from the U.S. Department of Health and Human Services, Office of the Inspector General.

Published: Aug 6, 2014

Omnicare To Pay Vermont $81,708 To Resolve Pharmacy Kickback Allegations

CONTACT: Edward Baker, Assistant Attorney General, (802) 828-5511

September 8, 2014

Vermont will collect $81,708 in restitution and other recoveries as its share of a national $16.5 million settlement with Omnicare Inc., the nation's largest provider of pharmaceuticals and pharmacy services to nursing homes. The civil settlement resolves allegations that Omnicare offered improper financial incentives to skilled nursing facilities ("SNFs"), in the form of commercially unreasonable contracts to supply pharmaceutical drugs, in return for the SNFs continued selection of Omnicare to supply drugs to Medicaid recipients. The whistleblower, a former nursing home owner, and the federal government alleged this incentive arrangement violated the Federal Anti-Kickback Statute and analogous state statutes, which are intended to ensure that the selection of health care providers and suppliers is not compromised by improper financial incentives but is instead based on the best interests of the patient.

Published: Sep 8, 2014

Attorney General Obtains $73,500 Medicaid Recoupment From Michigan Drug Testing Company

CONTACT: Steven J. Monde, Assistant Attorney General, (802) 828-5518

September 18, 2014

A Michigan-based company will pay the State of Vermont in excess of $73,500 to settle claims that it obtained payments from the Vermont Medicaid Program to which it was not entitled, according to Vermont Attorney General William H. Sorrell. The provider, Physicians Toxicology, LLC offers laboratory services to clinicians. The civil settlement resolves an investigation conducted by the Medicaid Fraud and Residential Abuse Unit of the Office of the Attorney General into Medicaid claims for urinalysis drug testing made by Physicians Toxicology. The investigation identified five categories of billing improprieties and errors that resulted in the Vermont Medicaid program making overpayments to the company. Physicians Toxicology cooperated with the investigation.

Urinalysis drug testing is an important tool for clinicians in the treatment and monitoring of drug addiction and chronic pain. Costs to the Medicaid program for urinalysis testing have risen sharply over the past several years. Eliminating improper and unnecessary testing will ensure that these services remain available and affordable for Vermont Medicaid recipients.

Under the settlement agreement, Physicians Toxicology repaid $73,648 to the Vermont Medicaid program and agreed to take the necessary measures to ensure future compliance with the Medicaid rules and guidelines related to urinalysis testing. The Medicaid Fraud and Residential Abuse Unit was assisted by the Program Integrity Unit of the Department of Vermont Health Access in obtaining this settlement

Published: Sep 18, 2014

Shire Pharmaceuticals To Pay Vermont $79,878 To Resolve Marketing Allegations Involving Drugs For ADHD

CONTACT: Edward Baker, Assistant Attorney General, (802) 828-5511

September 30, 2014

Vermont will collect $79,878 in restitution and other recoveries as its share of a national $56.5 million civil settlement with Shire Pharmaceuticals, LLC to resolve allegations that the company unlawfully marketed five of its drugs, Adderall XR, Vyvance, Daytrana, Lialda and Pentasa, resulting in overpayments by Vermont Medicaid and other government healthcare programs. Specifically, it is alleged that Shire:

- promoted Adderall XR, approved for the treatment of Attention Deficit Hyperactivity Disorder (ADHD), as clinically superior to other ADHD drugs despite a lack of clinical data to support such claims and for the treatment of Conduct Disorder, an indication not approved by the FDA;
- promoted Vyvanse, approved for the treatment of ADHD, as preventing certain negative consequences of ADHD and as less abuseable than Adderrall XR or other ADHD medications despite a lack of clinical data to support such claims;
- promoted Daytrana, approved for the treatment of ADHD, as less abuseable than pill-based medications despite a lack of clinical data to support such claims; and was aware that Daytrana, a patch applied product, demonstrated difficulty in sticking to the patient's body, making it therapeutically less effective;
- promoted Lialda, approved for the treatment of ulcerative colitis, for the prevention of colorectal cancer, an indication not approved by the FDA and marketed Lialda as having greater efficacy than other medications, despite a lack of clinical data sufficient to support such a claim;
- promoted Pentasa, approved for the treatment of ulcerative colitis, for the treatment of indeterminate colitis and Crohn's Disease, indications for which it had not been approved by the FDA.

As a condition for the settlement, Shire has entered into a Corporate Integrity Agreement (CIA) with the United States Department of Health and Human Services, Office of the Inspector General, which will closely monitor the company's future

marketing and sales practices. The settlement resulted from two lawsuits originally filed by whistleblowers in Pennsylvania and Illinois under the federal False Claims Act and various state false claims statutes.

Published: Sep 30, 2014

Organon Pharmaceuticals To Pay Vermont $75,455 To Resolve Marketing Allegations Involving Antidepressants

CONTACT: Edward Baker, Assistant Attorney General, (802) 828-5511

October 17, 2014

Vermont will receive $75,455 in restitution and other recoveries as its share of a national $31 million civil settlement with Organon Pharmaceuticals USA Inc. ("Organon") to resolve allegations that the drug manufacturer, which is now owned by Merck & Co., Inc., engaged in various marketing violations. Specifically, whistleblowers in two federal lawsuits filed in Massachusetts and Texas alleged that Organon underpaid rebates and misrepresented drug prices to state Medicaid programs, offered improper financial incentives to nursing home pharmacy companies, and promoted its antidepressants Remeron and Remeron SolTab for unapproved uses in children and adolescents. The lawsuits were filed under the federal False Claims Act and various State false claims statutes.

Published: Oct 17, 2014

Perkinsville Woman Convicted For Falsely Obtaining Monies From The Vermont Medicaid Program

CONTACT: Jason M. Turner, Assistant Attorney General, (802) 828-5332

October 28, 2014

Magen Hill of Perkinsville, Vermont, was convicted on October 23, 2014, in Vermont Superior Court, Windsor Criminal Division, of three misdemeanor counts of False Pretenses. The convictions stemmed from Ms. Hill's submission of falsified timesheets in order to obtain payment for services that were not provided while she was employed as a home-based health care worker under the Developmental Disability Services program, a Vermont Medicaid program.

Ms. Hill was sentenced to 18 to 36 months in jail, all suspended, and placed on 18 months of probation subject to standard conditions. Ms. Hill was also ordered to pay $4,485 in restitution to Vermont Medicaid.

The case was investigated and prosecuted by the Medicaid Fraud and Residential Abuse Unit within the Vermont Attorney General's Office with assistance from the U.S. Department of Health and Human Services, Office of the Inspector General.

Published: Oct 28, 2014

Pharmacist Convicted Of Unlawful Possession of Narcotic Drugs

CONTACT: Steven J. Monde, Assistant Attorney General, (802) 828-5518

January 15, 2015

Brandon Cigana, age 33, of Whitehall, New York, was convicted on January 15, 2015, in the Vermont Superior Court, Rutland Criminal Division, on two misdemeanor charges of unlawful possession of narcotic drugs. The convictions stem from Mr. Cigana's employment as a pharmacist at the Walgreens Pharmacy in Rutland, Vermont. Mr. Cigana admitted to unlawfully possessing the narcotic drug Hydrocodone.

Mr. Cigana was sentenced to 1-2 years in jail, all suspended, and placed on two years of probation. In addition to the standard conditions of probation, the Court imposed special conditions ordering Mr. Cigana to perform 80 hours of community service, to complete substance abuse counseling as directed by his probation officer, and to abide by licensing conditions imposed by the Vermont Board of Pharmacy.

The case was investigated and prosecuted by the Medicaid Fraud and Residential Abuse Unit within the Vermont Attorney General's Office.

Published: Jan 15, 2015

Theresa Ambrose Conviction Press Release

CONTACT: Jason M. Turner, Assistant Attorney General, 802.828.5332

March 24, 2015

SPRINGFIELD WOMAN CONVICTED FOR FALSELY OBTAINING MONIES FROM THE VERMONT MEDICAID PROGRAM

Theresa Ambrose of Springfield, Vermont, was convicted on March 16, 2015, in Vermont Superior Court, Windsor Criminal Division, of two misdemeanor counts of False Pretenses. The convictions stemmed from Ms. Ambrose's submission of false timesheets in order to obtain payment for services that she did not provide while she was employed as a home-based health care worker under the Choices for Care program, a Vermont Medicaid program.

Ms. Ambrose was sentenced to 12 to 24 months in jail, all suspended, and placed on 24 months of probation subject to standard conditions, and the additional conditions that she complete 40 hours of community service and not work as a care provider under any Vermont Medicaid waiver program. Ms. Ambrose was also ordered to pay $4,841 in restitution to Vermont Medicaid.

The case was investigated and prosecuted by the Medicaid Fraud and Residential Abuse Unit within the Vermont Attorney General's Office.

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Attorney General Distributes Settlement Funds To Former Medicaid Beneficiary Customers Of Mcgregor's Medicine-On-Time Pharmacy

CONTACT: Steven J. Monde, Assistant Attorney General, (802) 828-5518

April 24, 2015

The Office of the Attorney General is distributing over $118,000 in settlement funds to more than 1300 Vermonters who were Medicaid beneficiary customers of McGregor's Medicine-on-Time pharmacy in Winooski, Vermont, from 2004 through 2012. The average distribution is $85.00.

The distribution is the result of a settlement agreement between the State and McGregor's that resolved allegations of Medicaid fraud. The State set aside a portion of the settlement funds to distribute to McGregor's former Medicaid beneficiary customers who may have been improperly charged a monthly service fee or excessive copayments. The amount distributed to each beneficiary was determined based on the number of Medicaid pharmacy claims that McGregor's submitted in the beneficiary's name from 2004 through 2012.

Individuals receiving correspondence from the Office of the Attorney General should open the letter immediately as it may contain a check.

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Ludlow Woman Charged With Medicaid Fraud And False Pretenses

CONTACT: Jason Turner, Assistant Attorney General, (802) 828-5332

June 26, 2015

Attorney General William H. Sorrell announced today that Jennifer Newsome, age 50, of Ludlow, Vermont, was arraigned on June 23, 2015, in Vermont Superior Court for Windsor County on two felony counts of Medicaid Fraud and three felony counts of False Pretenses. The court imposed conditions of release governing Ms. Newsome's conduct while the case is pending.

According to papers filed in court, Ms. Newsome is accused of submitting claims for payments in excess of $30,000 for providing care under Vermont Medicaid's Children's Personal Care Services Program waiver program, as the employer of record, in the name of two individuals when, in fact, the individuals were unaware of the claims and did not provide all of the claimed care. Court papers also state that Ms. Newsome allegedly caused those individuals' signatures to be signed on these claims, for the claims to reference addresses for those individuals that were the same as the address listed for Ms. Newsome, and that Ms. Newsome wrongfully obtained the payments for the claims. Ms. Newsome pled not guilty to the charges. The Medicaid Fraud charges carry a maximum penalty of up to ten years imprisonment and/or fines equal to twice the amount of payments wrongfully obtained. The False Pretense charge carries a maximum penalty of up to ten years imprisonment and/or a fine of up to $2,000.

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