VERMONT MEDICAID FRAUD AND RESIDENTIAL ABUSE UNIT

2013 ANNUAL REPORT

July 1, 2012 - June 30, 2013

Office of the Vermont Attorney General
Honorable William H. Sorrell

PREFACE

This Annual Report is submitted in support of the State of Vermont's Medicaid Fraud and Residential Abuse Unit's ("MFRAU") Federal Fiscal Year 2013 budget request to the U.S. Department of Health and Human Services, Office of Inspector General ("OIG"), and MFRAU's Application for Recertification under 42 C.F.R. § 1007.15(c).

Pursuant to 42 C.F.R. § 1007.15(c)(1), the State certifies that no changes in the conditions reported pursuant to 42 C.F.R. § 1007.15(a)(1) through (5) have occurred in the last twelve months. Pursuant to 42 C.F.R. § 1007.15(c)(3), the State incorporates by reference the following Annual Report Narrative.

2013 ANNUAL REPORT NARRATIVE

Pursuant to 42 C.F.R. § 1007.17(h), the Vermont Medicaid Fraud and Residential Abuse Unit submits this narrative as part of its annual report to HHS-OIG for State Fiscal Year 2013.

A. Evaluation of the Unit's Performance

The Unit had a very successful year. Notably, the Unit recouped $15M in Medicaid overpayments, including almost $5M in Vermont-only fraud cases – a Unit record. (By comparison, the Unit's recoveries in the previous three years *combined* totaled $8.5M, including $846k in Vermont-only cases). These recoveries derived from the successful resolution of several major cases that the Unit had been working on for some time, including a civil enforcement action against McGregor's Pharmacy for "churning" dispensing fees and other violations, and the criminal prosecution of a Rutland oral surgeon for billing more expensive procedures than he performed. The McGregor's case was settled in December for more than $1M after lengthy and complex negotiations involving a third-party. The Rutland oral surgeon pled guilty to two felony counts of Medicaid fraud and two misdemeanor counts of false pretense. He was sentenced in February to six years imprisonment, all suspended, except 110 days of home confinement, and ordered to pay $50,000 in restitution to the Medicaid program. The Unit is continuing to prosecute this provider in a related matter for lewd and lascivious conduct toward patients.

In addition to these cases, the Unit also worked closely with the Vermont USAO on several matters that resulted in significant settlements, including a civil enforcement action against two jointly owned nursing homes for hiring excluded nurses, and the joint criminal and civil prosecution of several managers at a for-profit residential school for troubled youth for submitting fraudulent information to the state as part of the rate-setting process. The former cases resulted in a $249k settlement with the corporate parent of the nursing homes, and the latter in separate plea agreements and civil settlements with four individuals totaling $4.3M.

While investigating and prosecuting these major cases, the Unit continued to work on a large number of smaller cases, including timesheet fraud by home health/PCA workers (two convictions) and fraudulent schemes by other types of providers. The Unit also devoted considerable resources to resident abuse and neglect cases, convicting a personal care attendant in an assisted living facility for drug diversion, and prosecuting an LNA for the second-degree murder and financial exploitation of an elderly nursing home resident. The latter case is set to go to trial in September.

During the reporting period, the Unit continued to participate actively in NAMFCU global cases. The Director is a member of the litigation team for thirty-six states in the Wyeth "best price" litigation in Boston federal court. He is working closely with AUSAs in Boston and at DOJ on this matter, which is currently in the summary judgment stage. Likewise, the Unit's two analysts responded to more than a dozen data requests from NAMFCU teams in other "global" cases throughout the year. Their work provided the basis for over $10M in recoveries for Vermont.

In terms of case flow and management, the Unit received 125 complaints during the year from a wide variety of referral sources, including 16 from the Program Integrity Unit at the state Medicaid agency. The referrals from the PI Unit were both more numerous and of a higher

quality than the prior year, including one referral resulting from the PI Unit's successful data-mining efforts. The Unit Director is continuing to work with the PI Unit director and other staff to continue this positive trend.

Of the 125 new complaints received during the reporting period, the Unit opened a full investigation on 58, declined 28 for lack of jurisdiction or another reason, and referred 17 to other agencies. The Unit resolved 42 cases during the year, including 4 criminal prosecutions and 15 civil settlements. Of the 143 cases pending at the end of the year, almost half (68) were Vermont-only matters involving provider fraud, and roughly a third (46) were multi-state "global" cases. The remaining twenty-percent of cases involved patient abuse and neglect (25) and patient funds (4).

While maintaining this significant case flow, the Unit also engaged in numerous training and outreach activities, including participating with the USAO and other state and federal agencies in the Vermont Elder Justice Working Group, and co-organizing and hosting the second annual meeting of the Vermont Healthcare Fraud Enforcement Task Force. In preparation for an audit by HHS-OIG, the Unit significantly revised its Policies and Procedures and updated its staff training plan. The Unit is poised to increase the number of prosecutions in the coming year.

B. Description of Problems the Unit Has Had in Connection with Required Procedures and Agreements

The Unit has not experienced any particular problems in connection with the required procedures and agreements. However, as reported in response to the OIG Questionnaire (*see* Response to Question 1c), the Unit faces the following challenges in prosecuting Medicaid fraud and resident abuse cases:

Small Staff Size: The primary challenge facing the VT MFCU is the Unit's small staff size, which only permits us to handle a small number of complex fraud cases at any one time.

Lack of E-Discovery Support: The Unit is responsible for setting up and managing its own e-discovery systems, as well as arranging for e-discovery training by outside vendors. This can create challenges in the Unit's ability to handle complex fraud cases.

Insufficient Statutory Enforcement Authority and Penalties: Vermont has a Medicaid fraud statute that includes a civil monetary penalty provision, however, Vermont does not have a *qui tam* provision, Civil Investigative Demand (CID) authority, civil asset forfeiture authority, and penalties commensurate with those in the federal False Claims Act.

C. Discussion of Other Matters Impairing the Unit's Effectiveness

In addition to the problems identified above, the Unit's effectiveness is constrained by its case management software system, which is slow and not user-friendly, often requiring duplicate data entry. However, in the past year the Attorney General's Office invested in new case management software that is being implemented office-wide. The Director is optimistic that, once this new system is fully functional and customized to the Unit's special reporting requirements, he will be able to more easily monitor the status and progress of all Unit cases, and thereby more effectively target the Unit's limited resources.

APPENDIX

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

2013 ANNUAL REPORT - APPENDIX

A. COMPLAINTS

Complaint Type	Complaints Received	Investigated by Unit	Referred Out	Deferred**	Declined
Patient Abuse & Neglect	30	7	3	6	14
Vermont Fraud	70	32	11	16	11
Multi-State Fraud	13	13	0	0	0
Patient Funds	12	6	3	0	3
TOTAL	**125**	**58**	**17**	**22**	**28**

*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.

** Deferred complaints include those that have been opened for preliminary investigation only, or are awaiting completion of investigation by another agency before further action by the Unit.

B. MFRAU INVESTIGATIONS BY PROVIDER TYPE

Provider Type	Pending at Start of Period	Opened Within Period	Closed Within Period	Pending at End of Period
Institutions				
Hospitals	1	0	1	0
Home Health Care Agencies	2	0	0	2
Nursing Facilities / LTC	14	2	6	10
Substance Abuse Treatment	1	1	0	2
Other Institutions	7	1	3	5
Subtotal	**25**	**4**	**10**	**19**
Practitioners/Individuals				
All Nurse/PA/NP	2	0	1	1
Chiropractors	0	0	0	0
Counselors/Psychologists	2	1	0	3
Dentists	3	0	1	2
Home Health Care Aides	31	23	10	44
Doctors	4	4	4	4
RN/Licensed Nurse/PA/NP	5	1	1	5
CNA	2	0	1	1
Home/PCA	3	1	3	1
Other Practitioner	4	4	2	6
Subtotal	**56**	**34**	**23**	**67**
Medical Support				
DME	3	1	1	3
Transportation	1	3	0	4
Pharmaceutical Manufacturer	36	10	10	36
Laboratories	2	0	0	2
Pharmacy	10	2	2	10
Other Medical Support	2	0	0	2
Subtotal	**54**	**16**	**13**	**57**
TOTAL	**135**	**54**	**46**	**143**

C. AGE OF OPEN CASES

AGE	# OF CASES
0 – 6 Months	32
7 – 12 Months	24
13 – 24 Months	34
24 – 36 Months	14
36+ Months	39
TOTAL	**143**

D. MFRAU CASES

Complaint Type*	Carried Over	Opened	Prosecuted **	Resolved ***	Investigated but Not Prosecuted
Criminal Cases					
Patient Abuse & Neglect	27	7	1	8	25
Vermont Fraud	58	30	3	17	68
Multi-State Fraud	0	0	0	0	0
Patient Funds	2	4	0	2	4
Subtotal	**87**	**41**	**4**	**27**	**97**
Civil Cases					
Patient Abuse & Neglect	0	0	0	0	0
Vermont Fraud	2	0	0	2	0
Multi-State Fraud	46	13	0	13	46
Patient Funds	0	0	0	0	0
Subtotal	**48**	**13**	**0**	**15**	**46**
TOTAL	**135**	**54**	**4**	**42**	**143**

*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.

** "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, or civil enforcement actions.

*** "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.

E. MFRAU CASE OUTCOMES

CASE OUTCOMES	SFY '10	SFY '11	SFY'12	SFY'13
Criminal Investigations/Prosecutions				
Plea agreement	7	9	6	4
Dismissed	0	0	0	0
Conviction at trial	0	0	0	0
Acquitted at trial	0	0	0	0
Close Prior to Prosecution	NA	9	36	27
Other	0	0	1	0
Subtotal	**7**	**18**	**43**	**31**
Civil Investigations/Litigation				
Settled prior to trial	10	11	13	15
Dismissed	0	0	0	0
Resolved on Summary Judgment	0	0	0	0
Judgment for State at trial	0	0	0	0
Judgment for Defendant at trial	0	0	0	0
Other	0	0	0	0
Subtotal	**10**	**11**	**13**	**15**
TOTAL	**17**	**29**	**56**	**46**

F. RECOUPMENTS BY AGENCY

	Recovery Actions Initiated	Referred to Another Agency	Overpayments * Identified	Overpayments * Collected	Overpayments* to be Collected
MFRAU			$7,285,618	$15,082,307	$932,863
DVHA/PIU under agreement with Unit **	NA	NA	NA	NA	NA
TOTAL			**$7,285,618**	**$15,082,307**	**$932,863**

* Overpayments include the total state *and* federal share.

** 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 collected by MFRAU.

G. MFRAU RECOUPMENTS BY CASE TYPE

Case Type	Overpayments Collected SFY'10	Overpayments Collected SFY'11	Overpayments Collected SFY'12	Overpayments Collected SFY'13	Projected SFY'14
Multi-State	$3,143,603	$2,482,403	$2,054,400	$10,118,597	$3,000,000
Vermont Civil	$382,201	$200,990	$262,924	$4,912,590	$500,000
Vermont Criminal	$8,593	$8,286	$7,952	$51,120	$50,000
TOTAL	**$3,534,397**	**$2,691,679**	**$2,325,276**	**$15,082,307**	**$3,550,000**

H. MFRAU RECOUPMENTS BY CASE SHARE

Case Share	Overpayments Collected SFY'10	Overpayments Collected SFY'11	Overpayments Collected SFY'12	Overpayments Collected SFY'13
Federal Share	$2,247,607	$1,651,363	$1,201,307	$8,739,577
State-Only Share	$1,286,790	$1,040,316	$1,123,969	$6,342,730
TOTAL	**$3,534,397**	**$2,691,679**	**$2,325,276**	**$15,082,307**

I. STATE-ONLY SHARE BREAKDOWN

Case Share	Overpayments Collected SFY'10	Overpayments Collected SFY'11	Overpayments Collected SFY'12	Overpayments Collected SFY'13
Restitution to DVHA	$1,039,460	$769,561	$819,028	$5,462,820
MFRAU's Share of "additional recoveries"	$247,330	$270,756	$304,941	$879,910
TOTAL	**$1,286,790**	**$1,040,316**	**$1,123,969**	**$6,342,730**

J. MFRAU COSTS

Expense Category	SFY'10	SFY'11	SFY'12	SFY' 13	Projected FFY'14
Personnel	$572,160	$566,500	$600,965	$677,430	$784,114
Non-Personnel	$155,329	$122,220	$126,532	$163,771	$180,815
Indirect Costs	0	0	$66,289	$96,738	$110,967
TOTAL	**$727,489**	**$688,720**	**$793,786**	**$937,939**	**$1,075,896**

K. MFRAU TOTAL BUDGET EXPENDITURES VS. STATE FUNDING

Fiscal Year	MFRAU Deposits to State Special Fund	Distribution to MFRAU by State Legislature
2013	$879,940	$318,455
2012	$304,801	$208,000
2011	$270,756	$280,000
2010	$247,330	$88,302
2009	$451,260	$195,235

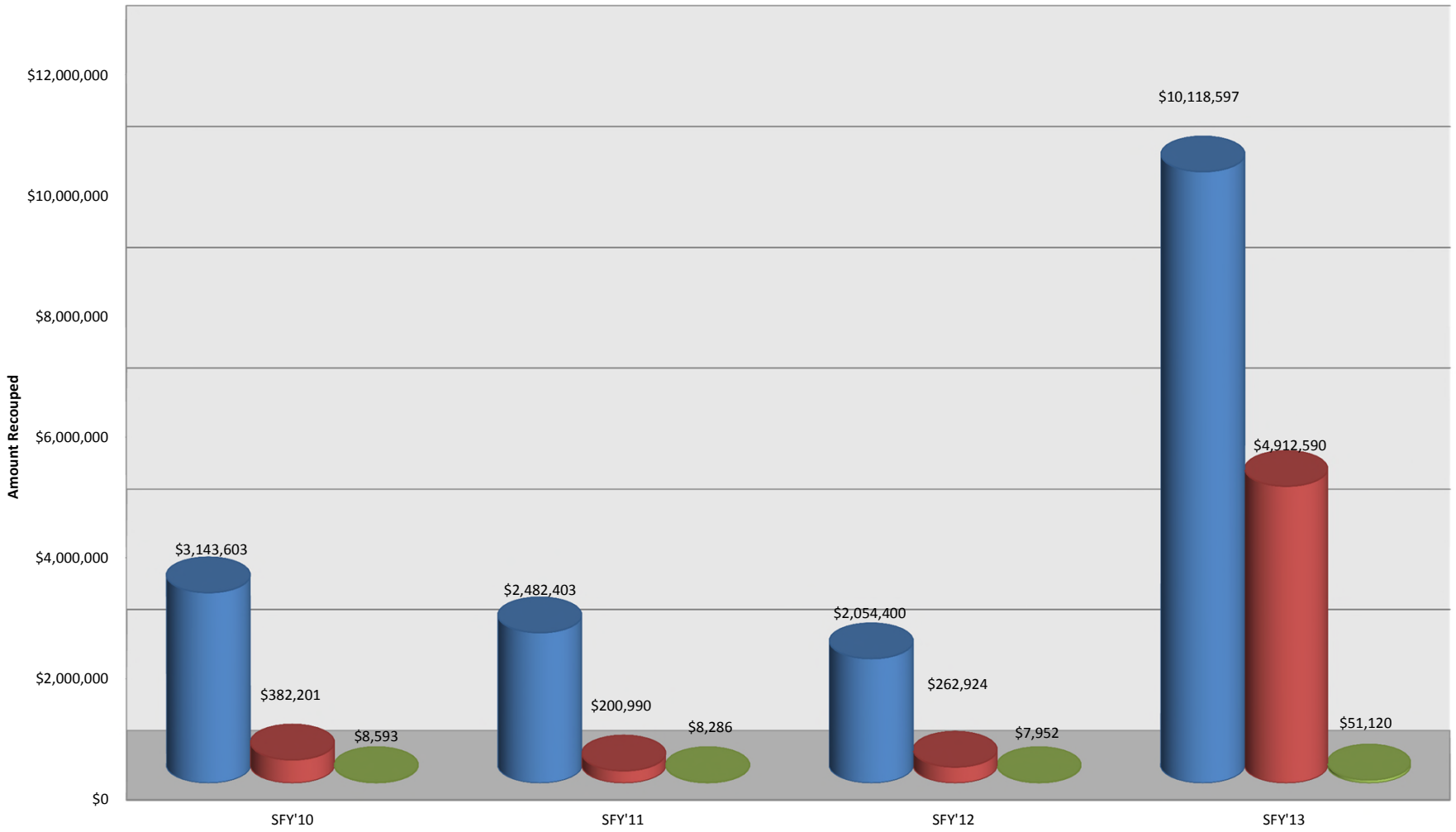
L. MFRAU PROJECTIONS - BY CASE TYPE

Case Type	Pending at Start (7/1/13)	Projected New Complaints	Projected New Investigation	Projected Closed Cases	Projected Prosecuted	Projected Resolved
Patient Abuse & Neglect	25	30	10	15	5	15
Vermont Fraud	68	75	35	50	15	20
Multistate Fraud	46	15	15	10	1	10
Patient Funds	4	15	5	10	5	10
TOTAL	**143**	**135**	**65**	**85**	**26**	**55**

M. MFRAU PROJECTIONS - BY PROVIDER TYPE

Provider Type	Pending at Start (7/1/13)	Projected New Complaints	Projected New Investigation	Projected Closed Cases	Projected Prosecuted	Projected Resolved
Institutions	19	25	10	20	5	10
Practitioner/ Individual	67	80	40	50	18	30
Medical Support	57	30	15	15	3	15
TOTAL	**143**	**135**	**65**	**85**	**26**	**55**

MFRAU Overpayments Collected SFY 2010 - SFY 2013



	SFY'10	SFY'11	SFY'12	SFY'13
Multi-State	$3,143,603	$2,482,403	$2,054,400	$10,118,597
Vermont Civil	$382,201	$200,990	$262,924	$4,912,590
Vermont Criminal	$8,593	$8,286	$7,952	$51,120

Press Releases Relating to MFRAU Cases

Press Releases

Glaxosmithkline To Pay Vermont $2 Million As Part Of Largest Healthcare Fraud Settlement In U.S. History

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

July 2, 2012

Attorney General William H. Sorrell announced today that Vermont will receive approximately $2 million from pharmaceutical manufacturer GlaxoSmithKline (GSK) as part of the largest healthcare fraud settlement in U.S. history. Under the terms of the settlement, GSK will pay to the states and the federal government a total of $3 billion to resolve criminal and civil allegations that GSK unlawfully marketed certain drugs for uses for which the drugs were not approved by the Food and Drug Administration (FDA); made false representations regarding the safety and efficacy of certain drugs; offered kickbacks to medical professionals; and underpaid rebates for various drugs paid for by Medicaid and other federally-funded healthcare programs. Specifically, the states and federal government alleged that, as far back as 1998, GSK engaged in the following activities:

- Marketing the depression drug Paxil for off-label uses, such as use by children and adolescents;
- Marketing the depression drug Wellbutrin for off-label uses, such as for weight loss and treatment of sexual dysfunction, and at higher-than-approved dosages;
- Marketing the asthma drug Advair for off-label uses, including first-line use for asthma;
- Marketing the seizure medication Lamictal for off-label uses, including bipolar depression, neuropathic pain, and various other psychiatric conditions;
- Marketing the nausea drug Zofran for off-label uses, including pregnancy-related nausea;
- Making false representations regarding the safety and efficacy of Paxil, Wellbutrin, Advair, Lamictal, Zofran, and the diabetes drug Avandia;
- Offering kickbacks, including entertainment, cash, travel, and meals, to healthcare professionals to induce them to promote and prescribe Paxil, Wellbutrin, Advair, Lamictan, Zofran, the migraine drug Imitrex, the irritable bowel syndrome drug Lotronex, the asthma drug Flovent, and the shingles and herpes drug Valtrex; and
- Submitting incorrect pricing data for various drugs, thereby underpaying rebates owed to Medicaid and other federal healthcare programs.

In addition, as part of the settlement, GSK will plead guilty to federal criminal charges that it violated the federal Food, Drug, and Cosmetic Act ("FDCA") by introducing certain drugs into interstate commerce without proper labeling, and failed to report clinical data regarding Avandia to the FDA. According to Attorney General Sorrell, this settlement is "further proof that Vermont will not tolerate marketing violations by the pharmaceutical industry, and will work closely with other states, whistleblowers, and the federal government to aggressively investigate reports of industry misconduct as they arise."

109 State Street, Montpelier VT 05609-1001
Phone: (802) 828-3171

Press Releases

Caregiver Charged With Medicaid Fraud

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

November 20, 2012

Attorney General William H. Sorrell announced today that Michelle Forcier, age 42, of Colchester, Vermont, was arraigned on November 20, 2012, in Vermont Superior Court for Windsor County on seventeen counts of Medicaid Fraud. The court imposed conditions of release governing Ms. Forcier's conduct while the case is pending.

According to papers filed in court, Ms. Forcier is accused of submitting claims for payments in excess of $1,300 for care under the Vermont Developmental Services Medicaid waiver program that was not provided. Ms. Forcier pleaded 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.

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Phone: (802) 828-3171

Press Releases

Vermont To Receive $1,000,000 From Mcgregor's Pharmacy To Settle Medicaid And Consumer Fraud Allegations

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

December 17, 2012

Attorney General William H. Sorrell announced today that Vermont will receive $1,000,000 as part of a settlement with McGregor's Pharmacy, which has pharmacies in both Winooski and South Hero, Vermont. The settlement resolves a civil lawsuit filed in March 2010 in which the State alleged that, between April 2004 and December 2011, McGregor's Pharmacy obtained excessive payments from the Vermont Medicaid program by submitting Medicaid claims for dispensing drugs more frequently than instructed by physicians and permitted under the Medicaid rules, and by charging Medicaid beneficiaries illegal administrative fees and co-payments.

As part of the settlement, which will be shared with the federal government, McGregor's Pharmacy has made a payment to the State of $250,000, with the remaining settlement amount, plus interest, to be paid over seven years. In addition, with State oversight, McGregor's Pharmacy will reimburse Medicaid beneficiaries for any co-payments and administrative fees, plus interest, that the beneficiaries overpaid between 2004 and 2012. Eligible Medicaid beneficiaries will be contacted by the State. The State expects that, over the next two years, reimbursements to these individuals will total approximately $111,000. McGregor's Pharmacy has also agreed to heightened monitoring of its Medicaid claims by the State for at least the next five years. The pharmacy's owner, Audrey McGregor-Reardon, has been removed from any operational or ownership role in the pharmacy, and will be placed on the State's Medicaid provider exclusion list.

According to Attorney General Sorrell, "this settlement achieves a hard-fought victory both for Vermont and for individual consumers, and helps protect the integrity of the Medicaid program." The Attorney General's Office worked in close collaboration throughout the investigation and litigation of this matter with members of the Program Integrity Unit within the Department of Vermont Health Access. The State was also assisted by agents with the U.S. Department of Health and Human Services, Office of the Inspector General, and the United States Attorney's Office for the District of Vermont.

109 State Street, Montpelier VT 05609-1001
Phone: (802) 828-3171

U.S. Department of Justice

United States Attorney
District of Vermont

United States Courthouse and Federal Building
Post Office Box 570 *(802) 951-6725*
Burlington, Vermont, 05402-0570 *Fax: (802) 951-6540*

PRESS RELEASE
BURLINGTON, VERMONT JANUARY 24, 2013

UNITED STATES AND STATE OF VERMONT SETTLE WITH TWO NURSING HOMES OVER EMPLOYMENT OF BANNED PERSONS

The United States Attorney for the District of Vermont and the Attorney General for the State of Vermont have settled potential enforcement litigation against Burlington Health and Rehabilitation Center and St. Johnsbury Health and Rehabilitation Center relating to their employment of nurses who had been prohibited from participating in federal health care programs by the Office of the Inspector General of the United States Department of Health and Human Services ("HHS OIG"). Both nursing homes are owned by Revera Health Systems, a corporation with its principal place of business in Connecticut. Revera Health Systems is affiliated with Revera Inc., a Canadian corporation. As part of the settlements, the homes together paid more than $249,000, and agreed to follow procedures intended to prevent employing excluded persons in the future.

HHS OIG has the authority to exclude persons from participating in various federal health care programs, such as Medicare and Medicaid. The HHS OIG will exercise its exclusion authority for various reasons, including certain convictions and state licensing board actions. Once an individual is excluded, Medicare, Medicaid, and other Federal health care programs shall not pay for services provided by that individual, and it is unlawful to bill those programs for services provided by such individuals. Health care providers can easily determine whether an employee, or applicant for employment, has been excluded by HHS OIG by accessing the publicly available on-line database through http://exclusions.oig.hhs.gov/.

The United States and the State of Vermont contended that both facilities employed an excluded nurse and billed various federal health care programs for services provided by those nurses. As part of their respective settlements, Burlington Health and Rehabilitation paid more than $66,900 and St. Johnsbury Health and Rehabilitation paid more than $182,100. The different amounts reflect the amount of time the excluded nurses worked at each facility.

Burlington Health and Rehabilitation and St. Johnsbury Health and Rehabilitation were represented by Michael Kogut, of Springfield, Massachusetts. The matter was investigated by the Office of the Inspector General of the United States Department of Health and Human Services. The United States was represented by Assistant United States Attorney Nikolas Kerest. The State of Vermont was represented by Assistant Attorney General Edward Baker.

Press Releases

Personal Care Attendant Convicted of Unlawful Possession of Narcotic Drugs

CONTACT: Steven J. Monde, Assistant Attorney General,

February 5, 2013

Attorney General William H. Sorrell announced today that Cassandra Bashaw, age 24, of St. Johnsbury, Vermont was convicted on February 4, 2013, in Vermont Superior Court for Caledonia County, on a misdemeanor charge of unlawfully possessing a Narcotic. The conviction stems from Ms. Bashaw's employment as a personal care attendant at the Canterbury Inn, an assisted living facility, in St. Johnsbury, Vermont. Ms. Bashaw admitted to unlawfully possessing the narcotic, Vicodin.

Ms. Bashaw was sentenced to 0-12 months in jail, all suspended, and placed on one year of probation. In addition to standard conditions of probation, the Court imposed special conditions, ordering Ms. Bashaw to perform 100 hours of community service; to submit to urinalysis testing; to complete substance abuse counseling as directed by her probation officer; and to participate in the St. Johnsbury Community Justice Center's restorative justice program. Ms. Bashaw is also prohibited from working in any setting providing care to vulnerable adults or where there is access to regulated drugs.

109 State Street, Montpelier VT 05609-1001
Phone: (802) 828-3171

Press Releases

Former Oral Surgeon Sentenced For Medicaid Fraud

CONTACT: Linda A. Purdy, Assistant Attorney General, (802) 828-5332

February 28, 2013

Attorney General William H. Sorrell announced today that Peter B. Gray, age 54, of Dorset, Vermont, was sentenced on February 28, 2013, in Vermont Superior Court for Rutland County, on two felony counts of Medicaid fraud and two misdemeanor counts of false pretense. Gray, a former oral surgeon who practiced in Rutland, Vermont, was convicted on January 9, 2013, for fraudulently billing the Vermont Medicaid program for more expensive procedures than the procedures that he actually performed.

Judge Theresa S. DiMauro sentenced Gray to six months to six years imprisonment, all suspended, except Gray will be incarcerated for 110 days in home confinement. Gray was also placed on four years of probation. In addition to standard conditions of probation, the Court imposed a special condition requiring Gray to participate in substance abuse and mental health counseling. Gray will also make restitution to the Vermont Medicaid program in the amount of $50,000. As a collateral consequence of his Medicaid fraud convictions, Gray will be prohibited from participating as a provider in the Medicaid program for at least five years. Gray's dental license is currently under suspension by the Office of Professional Regulation.

"The Medicaid program plays a critical role in the delivery of quality health care to Vermont citizens," said Attorney General William Sorrell. "Provider fraud costs us all money with no benefit to anyone's health. We hope this case serves as a strong deterrent to those providers who would take advantage of the system and lie about the care that they provide to Vermont Medicaid beneficiaries."

109 State Street, Montpelier VT 05609-1001
Phone: (802) 828-3171

Press Releases

Caregiver Convicted For Falsely Obtaining Money From The Vermont Medicaid Program

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

March 27, 2013

Attorney General William H. Sorrell announced today that Michelle Forcier, age 42, of Colchester, Vermont, was convicted on March 26, 2013 in Vermont Superior Court for Windsor County of five misdemeanor counts of False Pretenses. The convictions stemmed from Ms. Forcier's submission of falsified timesheets in order to obtain payment for services that were not provided while she was employed as a personal caregiver under a Vermont Medicaid program.

Ms. Forcier was sentenced to two to five years in jail, all suspended, and placed on probation for two-and-a-half years subject to standard conditions and a special condition that she not work as a home-based care provider or serve as the employer-of-record under any Medicaid waiver program for a period of five years. Ms. Forcier was also ordered to pay $1,369.50 in restitution to Vermont Medicaid.

109 State Street, Montpelier VT 05609-1001
Phone: (802) 828-3171

Press Releases

Caregiver Convicted For Falsely Obtaining Money From The Vermont Medicaid Program

CONTACT: Ed Baker, Assistant Attorney General, 802 828-5511

March 29, 2013

Attorney General William H. Sorrell announced today that Beverly Whittemore, age 49, of Rutland, Vermont, was convicted on March 28, 2013 in Vermont Superior Court for Windsor County of five misdemeanor counts of False Pretenses. The convictions stemmed from Ms. Whittemore' s submission of falsified timesheets in another person's name in order to obtain payment for services that were not provided under a Vermont Medicaid program.

Ms. Whittemore was sentenced to two-and-one-half to five years in jail, all suspended, and placed on probation for two years subject to standard conditions and a special condition that she not work as a home-based care provider or serve as the employer-of-record under any Choices for Care waiver program. Ms. Whittemore was also ordered to pay $7,230.00 in restitution to Vermont Medicaid.

The investigation and prosecution of this matter was handled by the Medicaid Fraud and Residential Abuse Unit within the Vermont Attorney General's Office, with assistance from Special Agent Frank Puleo of the U.S. Department of Health and Human Services, Office of the Inspector General.

109 State Street, Montpelier VT 05609-1001
Phone: (802) 828-3171

U.S. Department of Justice

United States Attorney
District of Vermont

United States Courthouse and Federal Building
Post Office Box 570
Burlington, Vermont, 05401-0570

(802) 951-6725
Fax: (802) 951-6540

PRESS RELEASE
Burlington, Vermont May 7, 2013

THE UNITED STATES AND THE STATE OF VERMONT ENTER INTO GLOBAL RESOLUTION WITH FORMER OFFICERS OF BENNINGTON SCHOOL, INC. RELATING TO TAX AND HEALTH CARE FRAUD VIOLATIONS

The Office of the United States Attorney for the District of Vermont and the Office of the Vermont Attorney General stated today that they have entered into global resolution of criminal and civil investigative matters concerning alleged tax and health care fraud by former officers of Bennington School, Inc. (BSI). Defendant, Matthew Merritt, Jr., age 81, the President and Trustee of BSI, along with his son, Defendant Matthew Merritt III, age 54, BSI's Plant Manager, and his son-in-law, Defendant Raymond Crowley, age 58, who served as CFO of BSI, have agreed to plead guilty to one charge each of federal tax fraud. In addition, Matthew Merritt, Jr., will plead guilty to a federal charge of engaging in a scheme to defraud a health care program. To resolve potential civil health care fraud liability, the three Merritt family members have agreed to pay a total of $3,000,000.00 to the United States and the State of Vermont. Defendant Jeffrey LaBonte, age 59, the Executive Director of BSI, has also agreed to plead guilty to a federal tax fraud charge, and will pay $1,300,000.00 to resolve his potential civil health care fraud liability. Of the total $4.3 Million recovery, the State of Vermont will receive $2,113,708.00 and the United States will receive $2,186,292.00.

Until 2013, BSI, a for-profit, closely-held corporation, operated a residential program in Bennington, Vermont that offered therapeutic and educational services for socially and emotionally challenged boys and girls. Over the course of the last two decades, the State of Vermont placed many students at BSI, and was responsible for their tuition and other expenses. The funding for these placements came from the Vermont Medicaid program (approximately 60% federal funding and 40% state funding) and from several Vermont state agencies, including the Agency of Education, the Department of Mental Health, and the Department for Children and Families. This funding was based on a per diem rate for each student, determined on an annual basis by the Division of Rate Setting (DRS), within the Vermont Agency of Human Services. The annual rate set by DRS was determined upon a review of BSI's application materials, including various

accounting reports and budgets. In particular, the formula for the rate calculated by DRS for Medicaid and Education payments to BSI was based upon the school's reported allowable expenses. The higher the allowed expenses, the higher the per diem rate for each student. However, not all of BSI's claimed allowable expenses were in fact allowable for the rate calculation. For example, BSI President, Matthew Merritt, Jr. and Executive Director Jeffrey LaBonte, with the assistance of CFO Raymond Crowley and Plant Manager Matthew Merritt III, implemented a system of compensating certain employees of BSI, in addition to their salary amounts, by providing personal benefits, such as cars, gasoline, oil for personal residences, payments of personal expenses on credit card accounts, salaries for family members who did not work at BSI, and reimbursements for various personal expenses. These forms of compensation were never reported on the individuals' tax returns. In addition, these unallowable expenses were embedded in the books and records of BSI, which were used to create the reports, budgets and other financial documents that BSI presented to DRS as accurate and allowable for rate setting.

The Government's investigation arose in 2011 following a request by BSI for a rate change due to reduced enrollment. In processing that request, DRS auditors took a close look at some of the financial information submitted and determined an on-site audit should be performed. The audit, completed in 2012, resulted in a recalculation of the rate BSI received during the years 2003-2012. DRS calculated the total amount of overpayment by the State during those years to be over $3.6 Million. Under the False Claims Act, 31 U.S.C. § 3729, and potential state law remedies, should the Government prevail at a trial, the defendants would be liable for treble damages as well as mandatory penalties up to $11,000 per claim. The defendants dispute DRS's calculation, and the parties have settled to avoid further investigation and litigation.

For his federal health care fraud conviction, Matthew Merritt, Jr. faces a maximum term of imprisonment of ten years under 18 U.S.C. § 1347. For his federal tax fraud conviction Matthew Merritt, Jr., faces a maximum prison term of three years under 26 U.S.C. § 7206. Pursuant to a written plea agreement, the parties have agreed that Matthew Merritt Jr.'s total term of imprisonment should not exceed 24 months.

For their federal tax fraud convictions, Matthew Merritt III and Raymond Crowley each face a maximum prison term of three years under 26 U.S.C. § 7206. Pursuant to a written plea agreement, the parties have agreed that Matthew Merritt III and Raymond Crowley's prison terms should not exceed 18 months.

For his federal tax fraud conviction, Jeffrey Labonte faces a maximum prison term of three years under 26 U.S.C. § 7206. Pursuant to a written plea agreement, the government has agreed to make the nature and extent of Jeffrey Labonte's cooperation known to the federal court and, as a result of his cooperation, request that the court sentence Jeffrey Labonte to a term of imprisonment below that recommended by the advisory sentencing guidelines.

Tristram J. Coffin, United States Attorney, noted that "schemes such as the one employed by these former BSI officials exact a significant toll on federal and state programs. Top officials at a for-profit organization that held itself out as serving an important public mission engaged in a fraud scheme involving government health care program payments. In addition, these same individuals filed false income tax returns. The prosecution of health care fraud offenses is a top priority for the Department of Justice, and coupling such fraud with tax violations make these types of crimes even more egregious. Our office will continue to vigorously pursue and prosecute individuals who engage in such conduct. The American taxpayer deserves no less."

The United States and the State of Vermont acknowledge that the scheme at issue here did not impact the quality of services offered to students at BSI. The school continues to operate as a fully-licensed residential treatment program. However, as of January 1, 2013, management and ownership of the programs at Bennington School were transferred to Vermont Permanency Initiative Inc., which is part of the Becket Family of Services. Matthew Merritt, Jr., has resigned as President and Trustee of BSI, and Jeffrey LaBonte, Matthew Merritt III and Raymond Crowley have left the school's employ.

This matter was investigated by the United States Attorney's Office, the Medicaid Fraud and Abuse Unit of the Vermont Attorney General's Office, the Internal Revenue Service, the Federal Bureau of Investigation, and the Office of Inspector General, U.S. Department of Health and Human Services. United States Attorney Coffin commends the investigative agencies for their hard work on this criminal and civil investigation.

On the criminal matters, the United States was represented by First Assistant U.S. Attorney Paul Van de Graaf and Assistant United States Attorney Timothy C. Doherty, Jr. The civil investigation was handled by Civil Chief, Carol L. Shea. The State of Vermont was represented by Assistant Attorney General Edward Baker. Matthew Merritt, Jr. is represented by David V. Kirby of O'Connor and Kirby in Burlington, Vermont. Jeffrey LaBonte is represented by John Pucci of Buckley Richardson in Springfield, Massachusetts. Matthew Merritt III is represented by Richard Berne in Portland, Maine. Raymond Crowley is represented by Maryanne E. Kampmann of Stetler, Allen & Kampmann in Burlington, Vermont.