VERMONT MEDICAID FRAUD AND RESIDENTIAL ABUSE UNIT

2016 ANNUAL REPORT

July 1, 2015 - June 30, 2016

Office of the Vermont Attorney General
Honorable William H. Sorrell

2016 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 2016.

I. EVALUATION OF THE UNIT'S PERFORMANCE

A. Overview

During the reporting period the Unit's performance increased in efficiency and effectiveness from the recent historical trends. The Unit exceeded last year's record number of criminal convictions, had a record amount of criminal restitution ordered and collected, and had one of its best years of Vermont specific civil recoveries. The Unit also continued to make significant progress 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 focus additional attention on 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. The Unit added a civil investigator position during the past year that allowed it to utilize the state false claims act, enacted in May 2015, to increase civil enforcement and recoveries.

B. Statistical Summary

Through civil settlements and restitution judgment orders in criminal cases, the Unit recovered $7,756,113 in state and federal Medicaid overpayments, including $880,430 from Vermont-only fraud cases. The unit collected $7,685,723 this year from these settlements, restitution judgment orders, and payments related to settlements and orders from previous years. These recovery figures are more than 10 times the recoveries from last year and one of the best years ever for the Unit. Over the past five years, the Unit's total recoupments exceed $30 million.

The state and federal recoupment figure largely derives from the settlement of the Wyeth multi-state case coordinated through the National Association of Medicaid Fraud Units (NAMFCU). The Unit intervened in the case and actively participated in the cases through the NAMFCU global case process, providing responses to data requests, and participating on the litigation team. The "Vermont-only" fraud figure represents recoveries the Unit obtained as a direct result of its criminal and civil enforcement actions. This year's Vermont only recoveries were a significant increase from the historical averages, and was in part the result of the new Vermont False Claims Act. The Unit was able to negotiate a settlement of over $460,000 with a DME provider as a result of the new law. The Unit has also stepped up its efforts to obtain civil recoveries and hopes to continue this momentum into future years.

During the reporting period, the Unit received 91 complaints and opened 57 new investigations, with a total of 60 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 and 76 at the conclusion of SFY15. The majority of the Unit's current investigations (68%) involve Vermont provider fraud; a smaller percentage of the remaining investigations involve patient abuse and neglect (10%) or multi-state fraud cases (22%). In comparison with past years, the distribution of the Unit's investigations has made a modest shift to include a greater percentage of Vermont provider fraud cases. However, the Unit has and will continue to place an emphasis on both Vermont provider fraud, and the abuse, neglect and exploitation of vulnerable adults in Vermont.

Following the completion of investigations, Unit attorneys filed thirteen criminal informations leading to arraignments during the reporting period. Twelve of the criminal informations involved allegations of Medicaid billing fraud by home health care providers. The additional information charged neglect of a vulnerable adult.

Additionally, Unit attorneys obtained twelve criminal convictions during the reporting period, which represents a record number of convictions in a single year for the Unit, one more than last year's then record eleven convictions. The Unit also concluded two significant civil settlements. One settlement resolved a civil enforcement action filed in SFY 2015 and the other resolved a matter prior to the filing of the civil suit.

Significant case resolutions and developments included:

- Criminal conviction and restitution judgment order in excess of $41,000 in a case where the guardian of a nursing home resident had diverted the patient's funds for personal use.
- Pre-litigation civil settlement in excess of $460,000 and a three-year corporate integrity agreement with a durable medical equipment provider in connection with inappropriate billing for oximetry and other respiratory treatment supplies.
- Civil settlement in excess of $80,000 to resolve litigation with a former podiatry provider related to improper billing for custom orthotics, where the provider had charged Medicaid approximately double that charged to other payers for the same services.
- Conviction of an employer of record for personal care attendant services on five felony counts of Medicaid Fraud for filing false claims for services not actually rendered to beneficiaries. The Unit secured restitution judgment orders exceeding $28,000 in the matter.
- Felony Medicaid Fraud conviction 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 all of the care claimed and were not aware of the filing of claims. The employer retained all of the payments in excess of $30,000.
- Conviction of respite and community services attendant on six misdemeanor counts of false pretenses for filing claims for community support services purportedly delivered in the middle of the night. The Unit also secured a restitution judgment order in excess of $12,000.

The Unit continued to aggressively pursue prosecutions of home health aides for 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 nine 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. These cases include timesheet fraud cases against two defendants involving more than $100,000 in allegedly fraudulent billings. Three co-defendants have already been convicted in connection with their roles in the fraud. The Unit is also continuing the prosecution of a significant fraud and neglect case involving a shared living provider who failed to provide or obtain adequate care for a beneficiary who suffered an untimely death as a result. That case is expected to go to trial in April 2017.

II. DESCRIPTION OF PROBLEMS THE UNIT HAS HAD IN CONNECTION WITH REQUIRED PROCEDURES AND AGREEMENTS

A key finding by OIG during the Unit's last audit was that "large caseloads hinder the Unit's ability to investigate and prosecute fraud and abuse in a timely manner." In response to this finding, the Unit Director conducted a formal assessment of the Unit's staffing levels and worked with the Chief of the Criminal Division, the Deputy Attorney General, and the Attorney General to obtain an additional investigator position. The Unit was able to fill that additional position initially but the applicant has since left the Unit and we are seeking to fill the vacancy. In the meantime, the Unit's made significant efforts to more efficiently handle matters and process matters to conclusion so that they may be prosecuted or closed more promptly. Those efforts have been largely successful, and in the two years since the audit the overall case load for the Unit has been decreased by 50%, while increasing the number of convictions and amount of recoveries. Through the greater efficiencies and the additional investigator position, the Unit is confident that this problem will be resolved in the upcoming year.

III. DISCUSSION OF OTHER MATTERS IMPAIRING THE UNIT'S EFFECTIVENESS

There are no other matters currently impairing the Unit's effectiveness.

Appendices

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

2016 ANNUAL REPORT - APPENDIX

A. MATTERS RECEIVED

Matter Type	Matters Received	Investigated by Unit	Referred Out	Declined
Abuse and Neglect & Exploitation	13	2	8	3
Vermont Fraud	70	46	14	10
Multi-State Fraud	8	8	0	0
TOTAL	**91**	**56**	**22**	**13**

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	10	10	0	14	6
Vermont Fraud	46	47	11	50	32
Multi-State Fraud	0	0	0	0	0
Patient Funds	3	0	1	2	0
Subtotal	**59**	**57**	**12**	**66**	**38**
Civil Cases					
Patient Abuse & Neglect	0	0	0	0	0
Vermont Fraud	5	13	0	9	9
Multi-State Fraud	17	8	0	12	13
Patient Funds	0	0	0	0	0
Subtotal	**22**	**21**	**0**	**21**	**22**
TOTAL	**81**	**78**	**12**	**87**	**60**

{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.

{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 **Per Formula**

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

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				0
Radiologist	0				0
Surgeon	0				0
Urologist	0				0
Other MD/DO	0	3			3
Total	1	6	0	1	**6**
FRAUD: Licensed Practitioners					
Audiologist	0				0
Chiropractor	0				0
Clinical Social Worker	0				0
Dental Hygienist	0				0
Dentist	1	2		1	2
Nurse - LPN, RN, or other licensed	1			1	0
Nurse Practitioner	0				0
Optometrist	0				0
Pharmacist	0				0
Physician Assistant	0				0
Podiatrist	1			1	0
Psychologist	0				0
Therapist (Non-Mental Health; PT, ST, OT, RT)	1			1	0
Other Practitioner	0	3			3
Total	4	5	0	4	**5**
FRAUD: Other Individual Providers					
EMTs or Paramedics	0				0
Nurse's Aide - CNA or other	0				0
Optician	0				0
Personal Care Services Attendant	32	31	11	33	19
Pharmacy Technician	0				0
Unlicensed Counselor (Mental Health)	0				0
Unlicensed Therapist (Non-Mental Health)	0				0
Other	2	4		6	0
Total	**34**	**35**	**11**	**39**	**19**

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				0
Billing services	0				0
DME, Prosthetics, Orthotics and Supplies	3	3		3	3
Home Health Agency	0	1		1	0
Lab (Clinical)	0	3		1	2
Lab (Radiology and Physiology)	0				0
Lab (Other)	1	1			2
Medical Device Manufacturer	1			1	0
Pain Management Clinic	0				0
Personal Care Services Agency	0	1		1	0
Pharmaceutical Manufacturer	10	5		7	8
Pharmacy (Hospital)	0				0
Pharmacy (Institutional Wholesale)	2			1	1
Pharmacy (Retail)	3			2	1
Transportation (Non-Emergency)	2	1		2	1
Other	1			1	0
Total	**23**	**15**	**0**	**20**	**18**
FRAUD: Program Related					
Managed Care Organization (MCO)	0				0
Medicaid Program Administration	0	2		1	1
Other	1			1	0
Total	**1**	**2**	**0**	**2**	**1**
ABUSE AND NEGLECT:					
Assisted Living Facility	0	1		1	0
Developmental Disability Facility (Residential)	1			1	0
Hospice	0				0
Non-Direct Care	0				0
Nurse's Aide (CNA or Other)	0	3		2	1
Nursing Facilities	1	1			2
PCA or Other Home Care Aide	2	1		2	1
Registered/Licensed Nurse/PA/NP	2			2	0
Other	6	4	1	7	2
Total	**12**	**10**	**1**	**15**	**6**
TOTAL	**81**	**78**	**12**	**87**	**60**

D. AGE OF OPEN CASES

Age	# of Cases
0 – 6 Months	25
7 – 12 Months	17
13 – 24 Months	4
24 – 36 Months	7
36+ Months	7
TOTAL	**60**

E. MFRAU CASE OUTCOMES

Case Outcomes		SFY '12	SFY '13	SFY '14	SFY '15	SFY '16
Criminal Investigations/Prosecutions						
Plea agreement		6	4	9	11	12
Dismissed		0	0	0	0	0
Conviction at trial (some charges)		0	0	1	0	0
Acquitted at trial (all charges)		0	0	0	0	0
Close Prior to Prosecution		36	27	33	60	45
Other		1	0	0	8	0
Subtotal		**43**	**31**	**43**	**79**	**57**
Civil Investigations/Litigation						
Settled prior to trial		13	15	13	36	12
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
Closed Prior to Litigation		0	0	0	0	8
Other		0	0	0	0	0
Subtotal		**13**	**15**	**13**	**36**	**20**
TOTAL		**56**	**46**	**56**	**115**	**77**

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	$7,752,376	$7,685,722	$231,839
DVHA/PIU under agreement with Unit {6}	NA	NA	NA	NA	NA
TOTAL			**$7,752,376**	**$7,685,722**	**$231,839**

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

{5} 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 Collected SFY'16
Multi-State	$2,054,400	$10,118,597	$4,111,630	$567,539	$6,805,293
Vermont Civil	$262,924	$4,912,590	$286,881	$168,127	$809,053
Vermont Criminal	$7,952	$51,120	$3,126	$2,587	$71,377
TOTAL	**$2,325,276**	**$15,082,307**	**$4,401,637**	**$738,253**	**$7,685,723**

H. MFRAU RECOUPMENTS BY CASE SHARE

Case Share	Overpayments Collected SFY'12	Overpayments Collected SFY'13	Overpayments Collected SFY'14	Overpayments Collected SFY'15	Overpayments Collected SFY'16
Federal Share	$1,201,307	$8,739,577	$2,543,287	$391,581	$4,030,875
State-Only Share	$1,123,969	$6,342,730	$1,858,350	$346,672	$3,654,848
TOTAL	**$2,325,276**	**$15,082,307**	**$4,401,637**	**$738,253**	**$7,685,723**

I. STATE-ONLY SHARE BREAKDOWN

Case Share	Overpayments Collected SFY'12	Overpayments Collected SFY'13	Overpayments Collected SFY'14	Overpayments Collected SFY'15	Overpayments Collected SFY'16
Restitution to DVHA	$819,028	$5,462,820	$1,473,357	$299,895	$3,136,987
MFRAU's Share of "additional recoveries"	$304,941	$879,910	$384,994	$46,777	$517,861
TOTAL	**$1,123,969**	**$6,342,730**	**$1,858,350**	**$346,672**	**$3,654,848**

J. MFRAU COSTS

Expense Category	SFY'13	SFY' 14	SFY '15	SFY '16	Projected FFY'17
Personnel	$677,430	$651,238	$662,826	$624,218	$883,630
Non-Personnel	$163,771	$193,955	$91,983	$85,830	$154,290
Indirect Costs	$96,738	$97,198	$90,577	$85,206	$130,778
TOTAL	**$937,939**	**$942,391**	**$845,386**	**$795,254**	**$1,168,698**

K. MFRAU TOTAL BUDGET EXPENDITURES VS. STATE FUNDING

State Fiscal Year	MFRAU Deposits to State Special Fund	Distribution to MFRAU by State Legislature
2016	$513,373	$205,081
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 Cases Closed with No Investigation	Projected Open at End of Period
Patient Abuse & Neglect	6	15	3	5	5	8
Vermont Fraud	41	60	15	25	15	46
Multistate Fraud	13	30	0	15	0	28
TOTAL	**60**	**105**	**18**	**45**	**20**	**82**

M. MFRAU PROJECTIONS - BY PROVIDER TYPE

Case Type	Current Open at Start of Period	Projected New Complaints	Projected Prosecuted Cases	Projected Resolved Cases	Projected Cases Closed with No Investigation	Projected Open at End of Period
Institutions	9	11	3	4	6	7
Practitioner/ Individual	33	63	15	6	21	54
Medical Support	18	27	1	12	11	21
TOTAL	**60**	**101**	**19**	**22**	**38**	**82**

Press Releases Relating to MFRAU Cases

Rutland Man Convicted For Falsely Obtaining Monies From The Vermont Medicaid Program

CONTACT: Steven J. Monde, Assistant Attorney General, (802) 828-5512

January 7, 2016

Hal Curtis, age 64, of Rutland, Vermont, was convicted on January 5, 2016, in Vermont Superior Court, Windsor Criminal Division, on six misdemeanor counts of False Pretenses. The convictions stemmed from Mr. Curtis' submission of false timesheets in order to obtain payment for services that were not provided to a recipient of benefits under the Developmental Services waiver program, a Vermont Medicaid program. Specifically, the State alleged that Mr. Curtis filed timesheets purporting to show that he had delivered community support services in the middle of the night and small hours of the morning while the recipient of benefits was sleeping.

Curtis was sentenced to three to six years of imprisonment, all suspended, and placed on two years of probation subject to standard conditions and the special condition that he complete 400 hours of community service. The Court also ordered Curtis to pay $12,938 in restitution to the Vermont Medicaid program. As a collateral consequence of his conviction, Curtis will likely be excluded from participation as a provider in Medicaid, Medicare and other federally-funded healthcare programs for five 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: Jan 7, 2016

Attorney General's Office Agrees To Settlement And Corporate Integrity Agreement With Keene Medical Products On Medicaid Fraud Investigation

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

February 9, 2016

The State of Vermont and Keene Medical Products, Inc. have reached an agreement settling a multi-year investigation by the Medicaid Fraud and Residential Abuse Unit of the Attorney General's Office and the Program Integrity Unit of the Department of Vermont Health Access regarding whether Keene submitted false claims or received overpayments from the Vermont Medicaid Program. Keene will pay in excess of $460,000 to settle potential claims, under the Vermont False Claims Act and Vermont Medicaid Fraud Statute, that Keene received improper payments from the Vermont Medicaid Program.

Keene Medical Products, Inc. is a durable medical equipment supplier that offers numerous services, medical devices, and medical supplies to patients. The settlement resolves an investigation examining whether Keene filed improper claims related to oximetry equipment (measuring blood oxygen saturations) and supplies, and other medical supplies. An investigation identified that Keene's claims to Medicaid for oximetry probes were improper because Keene also billed for rental of the oximeter. Medicaid rules required that supplies necessary to the operation of rented equipment, such as oximetry probes, be included in the rental rate and prohibits separate billing for the necessary supply. The investigation also determined that Keene had overbilled Medicaid for sterile water used in the treatment of Medicaid beneficiaries receiving respiratory services.

Under the settlement agreement, Keene will repay $451,621.09 to the Vermont Medicaid program and also pay $10,000.00 in additional recoveries to the State. Pursuant to the settlement agreement, Keene has also entered into a Corporate Integrity Agreement with the State of Vermont that will require enhanced compliance activities for up to three years. The Corporate Integrity Agreement includes provisions requiring an independent review of Keene's claims for the prior two years, and up to three years following the execution of the agreement. Keene will be required to return

to Vermont Medicaid any overpayment identified by those reviews and must also establish a compliance program designed to prevent or limit future false claims. Copies of the Settlement Agreement and the Corporate Integrity Agreement are available via the links below. 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: Feb 9, 2016

Ludlow Woman Convicted Of Medicaid Fraud And False Pretenses

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

June 27, 2016

Jennifer Newsome, age 50, of Ludlow, Vermont, was convicted on June 23, 2016, in Vermont Superior Court for Windsor County on a felony count of Medicaid Fraud and a misdemeanor count of False Pretenses.

The convictions arose from Newsome's submission of claims, as the employer of record, for payments from the Vermont Medicaid's Children's Personal Care Services Program, for services purportedly rendered to two recipients by an acquaintance of Newsome when those services were not actually rendered. The acquaintance was not aware that the claims were filed, and Newsome received and deposited the checks for payment of those services herself.

Newsome entered no contest pleas to the charges. She was sentenced to 3 to 5 years in jail, all suspended, and placed on four years of probation subject to standard conditions and the special condition that she complete 100 hours of community service. The Court also ordered Newsome to pay $7,075.83 in restitution to the Vermont Medicaid program. As a consequence of her convictions, Newsome is likely to be excluded from participation as a provider in Medicaid, Medicare and other federally-funded healthcare programs for five 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: Jun 27, 2016

Attorney General Obtains Settlement From Wyeth Pharmaceuticals

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

July 6, 2016

Pharmaceutical manufacturer Wyeth, Inc., a wholly owned subsidiary of Pfizer, Inc., has paid $6,029,003.35 to Vermont to resolve allegations that it knowingly underpaid drug rebates to the Vermont Medicaid Program. The payment is part of a joint multistate and federal settlement totaling $784.6 million. The settlement primarily reimburses the Medicaid Program for the overpayments made to Wyeth, but also included nearly $900,000 in civil penalties and additional recoveries.

The settlement resolves claims that Wyeth knowingly engaged in a scheme to reduce the amount of rebates it was required to pay to state Medicaid programs between 2001 and 2006 for the sales of its products Protonix Oral and Protonix IV. The drugs are in a class of drugs called Proton Pump Inhibitors that are used to treat symptoms of acid reflux.

Under the Medicaid Prescription Drug Rebate Program, participating pharmaceutical manufacturers are required to pay quarterly rebates to state Medicaid programs for drugs sold to pharmacies and subsequently paid for by Medicaid. The amount of the quarterly rebate is based in part upon the manufacturer's reported "best price," the lowest retail price available for the drug in a particular calendar quarter. The government plaintiffs alleged that Wyeth falsely reported its best prices, resulting in a substantial reduction of the rebate amounts it paid to the state Medicaid programs.

The investigation of the allegations began after two whistleblower lawsuits were filed in the U.S. District Court for the District of Massachusetts. The United States, Vermont and 34 other states intervened in the lawsuits in 2009. Vermont's involvement in the case was handled by the Medicaid Fraud & Residential Abuse Unit of the Vermont Attorney General's Office.

Published: Jul 6, 2016

East Corinth Woman Arraigned On Charges Of Financial Exploitation Of A Vulnerable Adult

CONTACT: Steven J. Monde, Assistant Attorney General, (802) 828-5511

July 16, 2015

Carmen Gross, age 40, of East Corinth, Vermont, was arraigned on two felony counts of Financial Exploitation of a Vulnerable Adult on July 8, 2015, in the Vermont Superior Court, Orange Criminal Division, in Chelsea. According to court documents, in 2012-13, while acting as power of attorney for a vulnerable adult, Ms. Gross spent more than $40,000 of the vulnerable adult's U.S. Treasury and Social Security income and funds held in two bank accounts for her own personal benefit.

Ms. Gross pleaded not guilty to the charges. The court imposed conditions of release governing her conduct while the case is pending. The financial exploitation charges carry a maximum penalty of up to ten years imprisonment and/or a fine of not more than $10,000. The Medicaid Fraud and Residential Abuse Unit of the Office of the Vermont Attorney General investigated and is prosecuting the case with assistance from the U.S. Department of Veterans Affairs, Office of Inspector General, Criminal Investigations Division.

Published: Jul 16, 2015

Three Charged With Participation In Medicaid Fraud Scheme

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

July 30, 2015

Gloria Relation, age 70, of Williamstown, Vermont, and Jamie LaFountain, age 27, of East Montpelier, Vermont, were each arraigned on July 30, 2015, in Vermont Superior Court for Washington County on one felony count of Medicaid fraud. Additionally, Chris Relation, age 43, of Barre, Vermont, was arraigned on one felony count each of Medicaid Fraud, False Pretenses, and Identity Theft. The Court imposed conditions of release governing the parties' conduct while the case is pending.

According to papers filed in court, Gloria Relation is accused of submitting claims for payments in excess of $29,000 for providing care to a disabled adult under the Developmental Services Medicaid waiver program, when, in fact, she did not provide the care. It is alleged that the care was actually provided by Chris Relation, who was excluded from providing care under the Medicaid program and to whom payments were not authorized. According to affidavits filed with the Court, Mr. Relation impersonated another individual to health care providers and state inspectors in order to perpetrate the scheme. Gloria Relation is alleged to have cashed the checks from ARIS Solutions, the payroll processor for the Medicaid Program, for the fraudulent services and provided the amounts in cash to Chris Relation.

According to the charging documents filed with the Court, Ms. LaFountain is also accused of submitting claims for payments for providing care to the same disabled adult under the Developmental Services Medicaid waiver program, when, in fact, she did not provide the care. According to affidavits filed with the Court, Ms. LaFountain submitted timesheets to the Medicaid program for times she was actually working for a different employer.

All three individuals pled not guilty to the charges. The Medicaid Fraud charge carries 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. The Identity Theft charge carries a maximum penalty of up to three years imprisonment and/or a fine of up to $5,000.

Published: Jul 30, 2015

East Corinth Woman Convicted On Charges Of Financial Exploitation Of A Vulnerable Adult

CONTACT: Jason Turner, Assistant Attorney General, (802) 828-5511

September 3, 2015

Carmen Gross, age 40, of East Corinth, Vermont, was convicted yesterday on two misdemeanor counts of Financial Exploitation of a Vulnerable Adult in Vermont Superior Court, Orange Criminal Division, in Chelsea. The convictions stemmed from Ms. Gross' abuse of her authority as power of attorney for a vulnerable adult, spending more than $40,000 of the vulnerable adult's income and savings for her own personal benefit.

Ms. Gross was sentenced to one to two years in jail, all suspended, and placed on two years of probation subject to certain conditions, including 40 hours of community service. Ms. Gaudette was also ordered to pay $41,567 in restitution.

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 Veterans Affairs, Office of Inspector General, Criminal Investigations Division.

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Barre Town Man Charged With Medicaid Fraud, False Pretenses, Neglect Of A Vulnerable Adult, And Obstruction Of Justice

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Octobere 15, 2015

Cody LaFountain, age 33, of Barre Town, Vermont, was arraigned on October 15, 2015, in the Vermont Superior Court, Washington Criminal Division, on three felony counts of Medicaid Fraud, one felony count of False Pretenses, two felony counts of Neglect of a Vulnerable Adult, five misdemeanor counts of Neglect of a Vulnerable Adult, one felony count of Obstruction of Justice, and one misdemeanor count of False Information to Law Enforcement. Mr. LaFountain entered pleas of not guilty to the charges and was released by the court on conditions governing his conduct while the case is pending.

The seven counts of Neglect of a Vulnerable Adult related to Mr. LaFountain's care of a thirty-two year old disabled adult who was found deceased at Mr. LaFountain's residence on November 2, 2014. According to the affidavit filed with the Court, Mr. LaFountain was the shared living provider for the disabled adult through a program managed by the Community Access Program of Rutland Mental Health Services. The State alleges that Mr. LaFountain failed to provide proper supervision to the disabled individual, who suffered from cerebral palsy and was non-verbal, by leaving the individual in the home unattended although care plans required 24-hour supervision. Mr. LaFountain is also alleged to have failed to properly clothe the individual and to obtain proper medical treatment for injuries suffered by the individual. As a result of Mr. LaFountain's failure to provide proper care to the disabled adult consistent with the terms of shared living provider contract, the State alleges that Mr. LaFountain committed Medicaid Fraud in seeking and receiving payments of Medicaid funds under the shared living provider program.

Additionally, according to the affidavit filed in court, Mr. LaFountain is accused of participating in a scheme with three other individuals, arraigned previously, to submit claims for payments in excess of $30,000 for providing care to the disabled adult under the Developmental Services Medicaid Waiver Program, when the care was not

actually provided by the person indicated on the claim. It is alleged that in certain instances the care was actually provided by a person, Chris Relation, who was excluded from providing care under the Medicaid program and to whom payments were not authorized. According to the State's affidavit, Mr. Relation impersonated another individual to health care providers and state inspectors and had the checks made out in the name of his mother, Gloria Relation, in order to perpetrate the scheme. According to the charging documents filed with the Court, Mr. LaFountain is also accused of submitting or aiding and abetting in the submission of claims on behalf of his sister, Jamie LaFountain, for payments to provide care to the disabled adult under the Medicaid waiver program, when, in fact, the care was not provided. The documents further allege that Cody and Jamie LaFountain submitted timesheets to the Medicaid program for times she was actually working for a different employer. According to the affidavit and the charges filed, Jamie LaFountain would cash the checks from the Medicaid payment agency and provide cash to Cody LaFountain related to the improper claims.

Mr. LaFountain is also charged with Obstruction of Justice and Providing False Information to Law Enforcement related to false statements made to Barre Town Police and Vermont State Police during the investigation immediately after the death of the disabled adult. The State's charging documents allege that Mr. LaFountain made false statements, related to events in the hours immediately preceding the death of the vulnerable adult, to investigators, as well as inducing another individual to provide a false statement.

Mr. LaFountain pled not guilty to all of the charges. Each Medicaid Fraud charge carries 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. Each felony charge for Abuse of a Vulnerable Adult carries a maximum penalty of not more than fifteen years imprisonment and/or a fine of not more than $10,000.00. Each misdemeanor charge for Abuse of a Vulnerable Adult has a maximum penalty of imprisonment for not more than eighteen months and/or a fine of not more than $10,000.00. The charge for Obstruction of Justice carries a maximum penalty of up to five years imprisonment and/or a fine of $5,000. The charge of False Report/Information to Law Enforcement has a maximum penalty of not more than one year imprisonment and/or a fine of up to $1,000.

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Two Springfield Women Convicted For Falsely Obtaining Monies From The Vermont Medicaid Program

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October 15, 2015

Jessica Wood, age 38, and Angela Martin, age 35, of Springfield, Vermont, were each convicted on October 13, 2015, in Vermont Superior Court, Windsor Criminal Division, on three misdemeanor counts of False Pretenses. The convictions stemmed from the submission of false timesheets in order to obtain payment for services that were not provided under the Children's Personal Care program, a Vermont Medicaid program, while Wood was the employer-of-record, and Martin was the purported caregiver, for a child beneficiary.

Wood and Martin were each sentenced to 18 to 36 months in jail, all suspended, and placed on two years of probation subject to standard conditions and the special condition that Wood and Martin each complete 80 hours of community service. The Court also ordered Wood and Martin to jointly pay $13,715 in restitution to the Vermont Medicaid program. As a consequence of their convictions, Wood and Martin are likely to be excluded from participation as providers in Medicaid, Medicare and other federally-funded healthcare programs for five 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.

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Attorney General's Office Reaches Settlement With Rutland Podiatrist On Medicaid Fraud Allegations

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October 16, 2015

A Rutland podiatrist will pay the State of Vermont in excess of $83,678 to settle claims that he obtained payments from the Vermont Medicaid Program to which he was not entitled. The provider, Dr. Frank Buggiani, offers podiatry services and orthotic devices to patients. The settlement resolves a civil complaint filed in Rutland Superior Court, Civil Division in December 2014 by the Medicaid Fraud and Residential Abuse Unit of the Office of the Attorney General. The complaint related to the submission of Medicaid claims by Dr. Buggiani for custom orthotic devices. An investigation identified that Dr. Buggiani's claims to Medicaid for custom orthotic devices were at a rate that exceeded the rate that he charged to other insurers. Medicaid rules and provider contracts require that providers bill Medicaid their "usual & customary rate" that is not to exceed the lowest rate charged to other insurers or patients. The higher rates submitted by Dr. Buggiani resulted in the Vermont Medicaid Program making overpayments to Dr. Buggiani. Dr. Buggiani cooperated with the investigation.

Under the settlement agreement, Buggiani will repay $67,643.46 to the Vermont Medicaid program and also pay $16,035.51 in additional recoveries to the State. A copy of the settlement is available via the link below. 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.

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Franklin County Women Charged With Medicaid Fraud

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October 29, 2015

Karen Tucker, age 40, of Swanton, Vermont, and Julie Bushey, age 44, of Highgate, Vermont were each arraigned on October 27, 2015, in Vermont Superior Court, Criminal Division, Windsor Unit, on five felony counts of Medicaid Fraud. Ms. Tucker and Ms. Bushey both pled not guilty to the charges and the court imposed conditions of release governing their conduct while the cases are pending.

According to papers filed in court, the State alleges that the women submitted false timesheets to ARIS Solutions, the payroll facilitator contracted by the State of Vermont to process payments to care providers under various Medicaid waiver programs. The women are alleged to have submitted the false timesheets in order to obtain payment for services that were not provided under the Children's Personal Care Program, a Vermont Medicaid program, while Tucker was the employer-of-record, and Bushey was the purported caregiver for three child beneficiaries. The State's affidavit alleges that the children were not under Tucker's supervision for large portions of the time related to the claims, and that those persons who were in charge of overseeing the children's care have stated that Bushey did not provide care as indicated on the timesheets.

Each count of Medicaid Fraud carries 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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