

**VERMONT MEDICAID FRAUD AND
RESIDENTIAL ABUSE UNIT**

2017 ANNUAL REPORT



July 1, 2016 - June 30, 2017

**Office of the Vermont Attorney General
Honorable Thomas J. Donovan**

2017 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 2017.

I. EVALUATION OF THE UNIT'S PERFORMANCE

A. *Overview*

During the reporting period the Unit was successful in diversifying its mix of cases, both in terms of provider types and increasing its civil enforcement under Vermont False Claims Act (which became retroactive on March 15, 2016). The Unit was able to successfully prosecute eight criminal cases, while moving a several larger criminal cases towards prosecution in the second half of 2017. The Unit completed a civil settlement with a urinalysis laboratory during this reporting period which is the largest Vermont-only Medicaid fraud recovery in the history of Vermont. Considerable progress has been made in the investigation of several other important civil enforcement cases. The Unit also continued to make significant progress in increasing its efficiency and effectiveness and more quickly resolving cases. The case aging profile of the Unit's open matters has been trending towards newer cases, which allows for more effective investigations and results. The Unit has focused more attention on complex investigations and prosecutions that are most likely to protect the fiscal integrity of the Vermont Medicaid program and the welfare of vulnerable adults.

B. *Statistical Summary*

Across both civil and criminal cases, the Unit obtained settlements and restitution judgment orders totaling \$7,455,536, for Medicaid overpayments and additional recoveries. This total includes \$7,316,421, from Vermont-only fraud cases. The unit collected \$2,052,071 this year from these settlements, restitution judgment orders, and payments related to settlements and orders from previous years. The Unit completed a \$6.75M settlement with a urinalysis laboratory that will be collected over a seven-year period. The settlements and judgments obtained this Reporting Period represent a record for Vermont-only frauds, and are one of the better years ever for the Unit despite there being extremely modest global case recoveries during the reporting period. 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 Burlington Laboratories matter. The Unit investigated the case after one of the Unit's auditors noted an anomaly in Burlington Lab's Medicaid reimbursements while completing a comparative analysis in the investigation of a separate urinalysis laboratory matter that had been previously referred by the single state agency. Following the issuance of a civil investigative demand by the Unit, Burlington Laboratories indicated a desire to negotiate a settlement. Those negotiations resulted in the largest Medicaid fraud settlement in Vermont history (for non-global cases). The remainder of the fraud recoveries represents recoveries the Unit obtained as a direct result of its criminal and civil enforcement actions, and any global settlements completed this year. This year's Vermont only recoveries were made possible by passage of the Vermont False Claims Act in 2015, with retroactivity in 2016. The Unit has now fully established its mechanism for civil enforcement efforts and hopes to continue this momentum into future years.

During the reporting period, the Unit received 76 complaints and opened 61 new investigations, with a total of 66 investigations open at the end of the year. The majority of the

Unit's current investigations (80%) involve Vermont provider fraud; a smaller percentage of the remaining investigations involve patient abuse and neglect (15%) or multi-state fraud cases (5%). 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 five criminal informations leading to arraignments during the reporting period. In another matter, Unit investigators jointly investigated, with OIG, a provider who was indicted in U.S. District Court by the United States Attorney's Office (USAO). Three of the cases charged by the Unit, and the case indicted by the USAO, involved allegations of Medicaid billing fraud by home health care providers. One case involved fraudulent billing by a mental health counselor and the final case involved a nursing home care attendant diverting narcotics from a patient.

Additionally, Unit attorneys obtained eight criminal convictions during the reporting period, and an additional case investigated by the Unit led to a conviction in federal court after a prosecution by the USAO. The Unit also concluded three significant civil settlements. One settlement resolved a False Claims Act suit filed by the Unit, and the other two resolved matters prior to the filing of the civil suit.

Significant case resolutions and developments included:

- Pre-litigation civil settlement of \$6,750,000.00 with a urinalysis laboratory that had submitted false claims for drug screenings and confirmatory tests. The laboratory had effectively unbundled services by using multiple "Usual & Customary Charges" for the same service in claims submitted to Vermont Medicaid. The settlement allowed for recovery of over \$5,000,000.00 in damages and more than \$1,650,000.00 in civil penalties.
- Felony Medicaid Fraud conviction (two counts) and restitution judgment order in excess of \$160,000.00 in a case where a mental health counselor submitted fraudulent billings for counseling sessions that did not occur, were upcoded, or lacked proper documentation.
- Felony Medicaid Fraud convictions for employer of record and a personal care aid for filing false claims for services for multiple recipients when the services were not provided. The scheme involved multiple perpetrators who were convicted in separate actions. Total restitution ordered in the cases was in excess of \$96,000.00.
- Civil settlement of approximately \$66,000 to resolve allegations that a pediatric group practice had inappropriately upcoded after-hours visits to obtain additional reimbursement.
- Conviction of nursing home care aid for abuse of a vulnerable adult following a physical assault on a nursing home resident suffering from dementia. The resident had been pushed to the ground and suffered significant bruising and trauma.

The Unit committed significant resources during the Reporting Period to the investigation of a matter involving fraudulent billing by a physician operating a drug treatment practice. The

fraudulent claims at issue in the case exceed \$600,000.00. Charges were filed in the matter shortly after the end of the Reporting Period as part of the 2017 Healthcare Fraud Takedown.

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.

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

The Unit has not had any problems fulfilling its required procedures or agreements during the Reporting Period.

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**

2017 ANNUAL REPORT - APPENDIX

A. MATTERS RECEIVED

Matter Type	Matters Received	Investigated by Unit	Referred Out	Declined
Abuse and Neglect & Exploitation	15	11	3	1
Vermont Fraud	57	46	6	5
Multi-State Fraud	4	4	0	0
TOTAL	76	61	9	6

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	6	11	2	5	10
Vermont Fraud	29	40	7	20	42
Multi-State Fraud	0	0	0	0	0
Patient Funds	0	0	0	0	0
<i>Subtotal</i>	35	51	9	25	52
Civil Cases					
Patient Abuse & Neglect	0	0	0	0	0
Vermont Fraud	11	6	0	6	11
Multi-State Fraud	13	5	0	15	3
Patient Funds	0	0	0	0	0
<i>Subtotal</i>	24	11	0	21	14
TOTAL	59	62	9	46	66

{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

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	0	0	0	1
Developmental Disability Facility (Residential)	0	0	0	0	0
Hospice	0	0	0	0	0
Hospitals	1	1	0	0	2
Inpatient Psychiatric Services (Under Age 21)	0	0	0	0	0
Nursing Facilities	0	3	0	1	2
Other Inpatient Mental Health Facility	0	2	0	0	2
Other Long Term Care Facility	0	0	0	0	0
TOTAL	2	6	0	1	7
FRAUD: Facility Based Medicaid Providers and Programs - Outpatient and/or Day Services					
Adult Day Center	0	0	0	0	0
Ambulatory Surgical Center	0	0	0	0	0
Developmental Disability Facility (Non-Resid.)	0	0	0	0	0
Dialysis Center	0	0	0	0	0
Mental Health Facility (Non-Residential)	1	0	0	0	1
Substance Abuse Treatment Center	0	1	0	0	1
Other Facility (Non-Residential)	2	0	0	1	1
Total	3	1	0	1	3
FRAUD: Physicians (MD/DO) by Medical Specialty					
Allergist/Immunologist	0	0	0	0	0
Cardiologist	0	0	0	0	0
Emergency Medicine	0	0	0	0	0
Family Practice	2	1	0	0	3
Geriatrician	0	1	0	0	1
Internal Medicine	0	0	0	0	0
Neurologist	0	0	0	0	0
Obstetrician/Gynecologist	0	0	0	0	0
Ophthalmologist	0	0	0	0	0
Pediatrician	1	0	0	1	0
Physical Medicine and Rehabilitation	0	0	0	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	0	0	0
Radiologist	0	0	0	0	0
Surgeon	0	0	0	0	0
Urologist	0	0	0	0	0
Other MD/DO	2	1	0	3	0
Total	5	3	0	4	4
FRAUD: Licensed Practitioners					
Audiologist	0	0	0	0	0
Chiropractor	0	0	0	0	0
Clinical Social Worker	0	2	0	1	1
Dental Hygienist	0	0	0	0	0
Dentist	2	0	0	0	2
Nurse - LPN, RN, or other licensed	0	0	0	0	0
Nurse Practitioner	0	0	0	0	0
Optometrist	0	0	0	0	0
Pharmacist	0	0	0	0	0
Physician Assistant	0	0	0	0	0
Podiatrist	0	0	0	0	0
Psychologist	0	0	0	0	0
Therapist (Non-Mental Health; PT, ST, OT, RT)	0	0	0	0	0
Other Practitioner	3	0	1	1	1
Total	5	2	1	2	4
FRAUD: Other Individual Providers					
EMTs or Paramedics	0	0	0	0	0
Nurse's Aide - CNA or other	0	0	0	0	0
Optician	0	0	0	0	0
Personal Care Services Attendant	19	26	6	14	25
Pharmacy Technician	0	0	0	0	0
Unlicensed Counselor (Mental Health)	0	0	0	0	0
Unlicensed Therapist (Non-Mental Health)	0	0	0	0	0
Other	0	1	0	0	1
Total	19	27	6	14	26

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	0	0	0
Billing services	0	0	0	0	0
DME, Prosthetics, Orthotics and Supplies	3	1	0	2	2
Home Health Agency	0	1	0	0	1
Lab (Clinical)	2	1	0	2	1
Lab (Radiology and Physiology)	0	0	0	0	0
Lab (Other)	2	0	0	1	1
Medical Device Manufacturer	0	0	0	0	0
Pain Management Clinic	0	0	0	0	0
Personal Care Services Agency	0	0	0	0	0
Pharmaceutical Manufacturer	8	3	0	10	1
Pharmacy (Hospital)	0	1	0	0	1
Pharmacy (Institutional Wholesale)	1	0	0	1	0
Pharmacy (Retail)	1	2	0	1	2
Transportation (Non-Emergency)	1	0	0	1	0
Other	0	0	0	0	0
Total	18	9	0	18	9
FRAUD: Program Related					
Managed Care Organization (MCO)	0	0	0	0	0
Medicaid Program Administration	1	2	0	0	3
Other	0	1	0	1	0
Total	1	3	0	1	3
ABUSE AND NEGLECT:					
Assisted Living Facility	0	1	0	0	1
Developmental Disability Facility (Residential)	0	1	0	1	0
Hospice	0	0	0	0	0
Non-Direct Care	0	0	0	0	0
Nurse's Aide (CNA or Other)	1	1	1	0	1
Nursing Facilities	2	4	0	3	3
PCA or Other Home Care Aide	1	0	0	0	1
Registered/Licensed Nurse/PA/NP	0	1	0	1	0
Other	2	3	1	0	4
Total	6	11	2	5	10
TOTAL	59	62	9	46	66

D. AGE OF OPEN CASES

Age	# of Cases
0 – 6 Months	28
7 – 12 Months	16
13 – 24 Months	15
24 – 36 Months	3
36+ Months	4
TOTAL	66

E. MFRAU CASE OUTCOMES

Case Outcomes	SFY '13	SFY '14	SFY '15	SFY '16	SFY '17
Criminal Investigations/Prosecutions					
Plea agreement	4	9	11	12	9
Dismissed	0	0	0	0	0
Conviction at trial (some charges)	0	1	0	0	0
Acquitted at trial (all charges)	0	0	0	0	0
Close Prior to Prosecution	27	33	60	45	25
Other	0	0	8	0	0
Subtotal	31	43	79	57	34
Civil Investigations/Litigation					
Settled prior to trial	15	13	36	12	17
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	8	4
Other	0	0	0	0	0
Subtotal	15	13	36	20	21
TOTAL	46	56	115	77	55

F. RECOUPMENTS BY AGENCY

Agency	Recovery Actions Initiated	Referred to Another Agency	Overpayments Identified {4}	Overpayments Collected {4}	Overpayments to be Collected {5}
MFRAU	NA	NA	\$7,455,536	\$2,052,071	\$5,681,220
DVHA/PIU under agreement with Unit {5}	NA	NA	NA	NA	NA
TOTAL			\$7,455,536	\$2,052,071	\$5,681,220

{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 collected by MFRAU.

G. MFRAU RECOUPMENTS BY CASE TYPE

Case Type	Overpayments Collected SFY'13	Overpayments Collected SFY'14	Overpayments Collected SFY'15	Overpayments Collected SFY'16	Overpayments Collected SFY'17
Multi-State	\$10,118,597	\$4,111,630	\$567,539	\$6,805,293	\$83,911
Vermont Civil	\$4,912,590	\$286,881	\$168,127	\$809,053	\$1,932,245
Vermont Criminal	\$51,120	\$3,126	\$2,587	\$71,377	\$35,916
TOTAL	\$15,082,307	\$4,401,637	\$738,253	\$7,685,723	\$2,052,072

H. MFRAU RECOUPMENTS BY CASE SHARE

Case Share	Overpayments Collected SFY'13	Overpayments Collected SFY'14	Overpayments Collected SFY'15	Overpayments Collected SFY'16	Overpayments Collected SFY'17
Federal Share	\$8,739,577	\$2,543,287	\$391,581	\$4,030,875	\$1,938,244
State-Only Share	\$6,342,730	\$1,858,350	\$346,672	\$3,654,848	\$113,828
TOTAL	\$15,082,307	\$4,401,637	\$738,253	\$7,685,723	\$2,052,072

I. STATE-ONLY SHARE BREAKDOWN

Case Share	Overpayments Collected SFY'13	Overpayments Collected SFY'14	Overpayments Collected SFY'15	Overpayments Collected SFY'16	Overpayments Collected SFY'17
Restitution to DVHA	\$5,462,820	\$1,473,357	\$299,895	\$3,136,987	\$95,263
MFRAU's Share of "additional recoveries"	\$879,910	\$384,994	\$46,777	\$517,861	\$18,565
TOTAL	\$6,342,730	\$1,858,350	\$346,672	\$3,654,848	\$113,828

J. MFRAU COSTS

Expense Category	SFY'14	SFY' 15	SFY '16	SFY '17	Projected FFY'18
Personnel	\$651,238	\$662,826	\$624,218	\$739,572	\$964,255
Non-Personnel	\$193,955	\$91,983	\$85,830	\$98,315	\$151,660
Indirect Costs	\$97,198	\$90,577	\$85,206	\$105,574	\$140,605
TOTAL	\$942,391	\$845,386	\$795,254	\$943,461	\$1,256,520

K. MFRAU TOTAL BUDGET EXPENDITURES VS. STATE FUNDING

State Fiscal Year	MFRAU Deposits to State Special Fund	Distribution to MFRAU by State Legislature
2017	\$24,566	\$291,553
2016	\$517,068	\$291,533
2015	\$46,777	\$254,434
2014	\$384,482	\$247,751
2013	\$379,940	\$318,455

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	10	15	3	5	5	12
Vermont Fraud	53	60	9	25	20	59
Multistate Fraud	3	12	0	12	0	3
TOTAL	66	87	12	42	25	74

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
Facility Based Providers & Programs	14	10	2	6	4	12
Physicians & Lic/Other Providers	40	60	9	21	20	50
Medical Support	9	15	1	12	1	10
Program Related	3	2	0	3	0	2
TOTAL	66	87	12	42	25	74

Press Releases Relating to MFRAU Cases

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

Vermont's lobbyist registration and disclosure law applies to certain communications with and activities directed at the Attorney General. Prior to any interactions with the Office of the Vermont Attorney General, you are advised to review Title 2, Sections 261-268 of the Vermont Statutes Annotated, as well as the Vermont Secretary of State's most recent guide to compliance, available at <https://www.sec.state.vt.us/elections/lobbying.aspx>.

Four Women Convicted In Franklin County Medicaid Fraud Scheme

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

August 19, 2016

Karen Tucker, of Swanton, Vermont, Pauline Gaboury of Essex Junction, Vermont, Christy Richard of St. Albans, Vermont, and Katherine Tucker of Milton, Vermont were all recently convicted of charges related to a Medicaid Fraud scheme orchestrated by Karen Tucker in Franklin County that resulted in over \$100,000 in losses to Vermont Medicaid Program over a nearly five-year period.

Each of Karen Tucker, Pauline Gaboury, Christy Richard, and Katherine Tucker, admitted to participation in a scheme to submit false timesheets to ARIS Solutions, the payroll facilitator contracted by the State of Vermont to process payments under the Children's Personal Care Program, a Vermont Medicaid program. Karen Tucker was the employer-of-record, and each of the other women were purported caregivers for three child beneficiaries. The State alleged that the children were not under Tucker's supervision for large portions of the time related to the claims, and that each of the four convicted defendants admitted that they did not provide care as indicated on the timesheets.

Karen Tucker, entered guilty pleas and was convicted of four counts of Medicaid Fraud on August 17, 2016. She was sentenced to 4-8 years of incarceration, suspended except for two years to serve with a preapproved furlough for a court approved treatment program after 12 months of incarceration. She was additionally sentenced to 5 years of probation and ordered to pay restitution of \$96,932.40 to the Vermont Medicaid Program. Pauline Gaboury pled guilty and was convicted of two misdemeanor counts of False Pretenses on May 3, 2016. She was sentenced to 9-18 months of incarceration, all suspended, with 18 months of probation. Ms. Gaboury was also ordered to pay \$11,642.40 in restitution. Christy Richard pled guilty on June 7, 2016, and was convicted on one misdemeanor count of False Pretenses. Richard was sentenced to 6 to 12 months incarceration, all suspended with 12 months of probation, and ordered to pay restitution of \$5672.40. Katherine Tucker pled guilty and was convicted of one misdemeanor count of False Pretenses on April 26, 2016. She was sentenced to 0-12 months of incarceration, all suspended with 12 months of probation. Katherine Tucker was also ordered to pay \$4,495.00 in restitution to the Vermont Medicaid Program. As a consequence of their convictions, each of the four defendants 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: Aug 19, 2016

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Franklin County Woman Convicted For Medicaid Fraud Scheme

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

September 8, 2016

Julie Bushey of Highgate, Vermont was convicted on September 6, 2016 on two felony counts of Medicaid Fraud. The charges were related to a personal care services scheme in Franklin County that resulted in over \$100,000 in losses to the Vermont Medicaid Program over a nearly five-year period. Karen Tucker, who was convicted last month on four counts of Medicaid fraud, orchestrated the scheme and enlisted Bushey and three other women to submit false timesheets. All participants in the fraud have now been convicted and sentenced in connection with the fraudulent conduct.

Bushey pled no contest and admitted that the State could have proven at trial her participation in a scheme to submit false timesheets for personal care services under the Children's Personal Care Services Program (CPCS). CPCS is a program operated by the Vermont Department of Health with funding from Vermont Medicaid to provide personal care services for children with physical or developmental difficulties. Karen Tucker was the employer-of-record in charge of approving timesheets, and timesheets were submitted that purported to show Bushey as a caregiver for three child beneficiaries. The State alleged, and Bushey admitted the State could prove, that for large portions of the claims paid to Bushey no care was delivered to the beneficiaries.

Bushey was sentenced to three to five years of incarceration, all suspended with 5 years of probation. Bushey was also ordered to pay \$64,633.86 in restitution to the Vermont Medicaid Program and to provide 500 hours of community service. As a consequence of her convictions, she 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: Sep 8, 2016

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Attorney General's Office Agrees To Settlement With Burlington Laboratories On Medicaid Fraud Investigation

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

October 10, 2016

The State of Vermont, and Burlington Laboratories, Inc. and Burlington Labs, LLC (together "Burlington Labs"), have reached an agreement settling an investigation by the Medicaid Fraud and Residential Abuse Unit of the Office of the Attorney General into whether Burlington submitted false claims or received overpayments from the Vermont Medicaid Program. Burlington Labs will pay \$6.75 million to settle potential claims under the Vermont False Claims Act. "This settlement balances the ongoing needs for drug testing services in Vermont with ensuring proper billings for services rendered and safeguarding of state and federal monies," said Attorney General William H. Sorrell. Burlington Labs is an independent toxicology laboratory, headquartered in Burlington, Vermont. The settlement resolves an investigation into Burlington Labs' Medicaid claims related to drug screening and certain confirmatory tests. The investigation revealed that from January 1, 2015, through June 30, 2015, Burlington Labs violated a number of Medicaid rules regarding such tests including by varying the charged amount submitted to Vermont Medicaid depending on the number of drugs tested. As a result of this practice, Burlington Labs received more than \$12 million from the Vermont Medicaid program in calendar year 2015, after only receiving approximately \$10 million over the previous five years combined. The increase in 2015 was not proportional to an increase in patients screened by Burlington Labs during that time period.

Under the settlement agreement, Burlington Labs will pay \$6.75 million to the Vermont Medicaid program. The settlement agreement allows Burlington Labs to make payments over a seven-year period. The extended payment terms are intended to maximize Burlington Labs' ability to continue operations, fulfill its mission, and properly compensate the Medicaid Program.

Pursuant to the settlement agreement, Burlington Labs has entered into a Corporate Integrity Agreement with the State that requires enhanced compliance measures, including independent review of a sample of its claims for up to five years. Burlington Labs will be required to return to Vermont Medicaid any overpayment identified 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.

[Settlement Agreement](#)

[Corporate Integrity Agreement](#)

Published: Oct 10, 2016

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Caregiver Sentenced For Abuse Of A Vulnerable Adult

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

November 4, 2016

Marissa Flagg, age 21, of Rutland, Vermont was sentenced on November 3, 2016, in the Vermont Superior Court, Rutland Criminal Division, on one misdemeanor count of abuse of a vulnerable adult. Ms. Flagg previously pled guilty at a hearing in June, after admitting the charge against her.

According to documents filed with the Court, Flagg was working as an overnight caregiver at a residential care facility for dementia patients in Rutland from September through December 2015. Testimony and video evidence established that in the early morning hours of December 31, 2015, Ms. Flagg became agitated when interacting with a dementia patient, and verbally abused and pushed the 78 year-old woman causing her to fall to the ground and injure her hip. Testimony also indicated that Ms. Flagg subsequently left the facility without rendering aid to the patient.

Ms. Flagg was sentenced to 6-18 months in jail, all suspended, except 30 days to be served on work crew, and placed on two years of probation. The Court imposed special conditions of probation, ordering Ms. Flagg to participate in a restorative justice program and to complete mental health and anger management counseling as directed by her probation officer.

The case was investigated and prosecuted by the Medicaid Fraud and Residential Abuse Unit within the Vermont Attorney General's Office. The Vermont Department of Aging and Independent Living-Adult Protective Services and the Rutland City Police Department also assisted in the investigation.

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Website consulting provided by The National Association of Attorneys General.

Attorney General's Office Agrees To Settlement With Mousetrap Pediatrics On False Claims Investigation

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

November 18, 2016

The State of Vermont and Mousetrap Pediatrics PC, have reached an agreement settling an investigation into whether Mousetrap submitted false claims or received overpayments from the Vermont Medicaid Program.

Mousetrap operated as a pediatric physician group for over twenty-five years in the Franklin County area, until its dissolution in January 2016. The settlement resolves an investigation into Mousetrap's Medicaid claims related to after-hours office visits. The investigation revealed that from January 28, 2013, through December 7, 2015, Mousetrap submitted claims to Medicaid using an improper billing code for services provided during regularly scheduled extended office hours. Mousetrap received \$51,553.65 more from the Vermont Medicaid program than it would have been entitled had the claims been properly submitted. The improper use of the billing code was caused by a change in Mousetrap's business practices regarding extended office hours, and not due to any intentional fraudulent behavior. MFRAU found that Mousetrap's use of the code prior to January 28, 2013 did not violate any Medicaid or coding rules.

Mousetrap will pay \$66,553.65 to settle potential claims under the Vermont False Claims Act. Under the settlement agreement, Mousetrap will repay the Medicaid Program the \$51,553.65 it improperly received and a \$15,000.00 civil penalty. The settlement followed an investigation by the Medicaid Fraud and Residential Abuse Unit of the Office of the Attorney General and the Program Integrity Unit of the Department of Vermont Health Access.

A copy of the Settlement Agreement is available via the link below.

[Settlement Agreement](#)

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Website consulting provided by [The National Association of Attorneys General](#).

Bennington Family Convicted Of Multiple Counts Of Medicaid Fraud

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December 27, 2017

Patrick Morse, 64, Ellie May Morse, 43, and Donald Morse, 23, of Bennington, Vermont, were convicted in Vermont Superior Court, Windsor Criminal Division, of multiple felony counts of Medicaid Fraud arising out of their scheme to defraud the Vermont Medicaid Children's Personal Care Services ("PCS") Program. Patrick Morse was convicted on nine counts, Ellie May Morse was convicted on six counts, and Donald Morse was convicted on three counts.

Patrick Morse and Ellie May Morse submitted claims, as the employers of record, for payments from the PCS Program, for services purportedly rendered to three recipients when those services were not actually rendered. For over five years, Patrick and Ellie May Morse falsified timesheets to document the purported services and submitted the timesheets to the PCS Program for payment. They hired their son, Donald Morse, and another family member and an acquaintance purportedly to provide personal care services to the three recipients. Frequently no services were rendered. Patrick and Ellie May submitted the false claims to the PCS Program knowing that the services were not rendered. Indeed, in many cases the other family member and the acquaintance were not aware that the timesheets had been submitted in their names. Medicaid funded checks, issued in the names of the providers, including Donald Morse, were mailed directly to Patrick and Ellie-May Morse's post office box and were cashed or deposited by the Morses for their own benefit. Donald Morse was convicted because of his knowledge that false timesheets for services not rendered were submitted in his name as an employee for his parents. The payments for claims submitted by Patrick and Ellie May Morse totaled over \$100,000 during the five-year period.

All three Morses entered guilty pleas to the charges. Patrick Morse was sentenced on December 20, 2016 to two to six years of imprisonment. Ellie May Morse was sentenced on June 29, 2016, to a suspended sentence of one to three years, and placed on three years of probation subject to standard conditions along with the special condition that she complete 200 hours of community service. She was also ordered to pay \$28,747 in restitution to the Vermont Medicaid Program. Donald Morse was sentenced on September 6, 2016, to a suspended sentence of one to two years and placed on two years of probation subject to standard conditions along with the special condition that he completed 100 hours of community service. Donald was also ordered to pay \$9,329 in restitution to Vermont Medicaid. The Court will determine the amount of restitution to be paid by Patrick Morse at a later hearing. As a consequence of their convictions, the Morses are likely to be excluded from participation as providers or employers 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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