A 101 ON THE VERMONT FALSE CLAIMS ACT

Office of the Vermont Attorney General
Medicaid Fraud and Residential Abuse Unit

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WHAT ARE OUR OBJECTIVES FOR TODAY?

After the end of this session, you will be able to:

- Recognize the main statutory components of Vermont False Claims Act and the value of the FCA in stopping fraud against the State.
- Describe who can bring an FCA case and what protections whistleblowers receive.
- Identify tools and strategies to assess whether an FCA case brought by a relator has merit.
- Identify when a referral can be made to the Attorney General's Office for investigation of potential FCA violations.

WHO IS IN THE AUDIENCE TODAY?

I work in:

- Healthcare
- Education
- Business & Finance
- Environmental
- Other

THE MEDICAID FRAUD AND RESIDENTIAL ABUSE UNIT

MFRAU is a law-enforcement investigation and prosecution unit within the Criminal Division of the Vermont Attorney General's Office. We are one of 53 national units, MFRAU receives 75 percent of its funding from the U.S. Department of Health and Human Services under a grant award totaling $1,229,616 for Federal fiscal year 2024. The remaining 25 percent, totaling $409,870 for FFY 2024, is funded by the State of Vermont.

Unit within the Criminal Division of the VT AGO, part of a national framework

Unit is comprised of:

- three Assistant Attorney Generals
- two sworn law enforcement officers
- two fiscal analysts,
- one civil investigator
- one paralegal

Member of the National Association of Medicaid Fraud Control Units (NAMFCU) who host specialized trainings several times per year and assist with the organization of global healthcare fraud teams.

- Team approach, integrating AAGs, Investigators, Analysts for every case which is accepted.
- Joint / Parallel investigations with DLP, APS, OIG/USAO-VT, DCF, OPR and others
- Statewide jurisdiction and coverage

WHAT DO WE DO?

Medicaid Provider Fraud: Includes individuals or businesses that have a provider agreement permitting them to submit claims to Vermont Medicaid and who bill fraudulently. Some examples: MD, DDS, DC, APRN, LADC/LCMHC, Designated Agencies, Etc.

Facility - Fraud (Failure to provide care billed for). For example: Hospitals, Nursing homes, Etc.

Long Term Care Facilities - Abuse/Neglect/ Exploitation Jurisdiction: MFRAU investigates abuse, neglect and exploitation of Vulnerable Adults Long-Term Care Facilities and investigates related abuse, neglect and exploitation of vulnerable adults when they are also Medicaid recipient, and if the crime occurred in “connection with the provision of Medicaid services.

HOW DO WE DO THIS?

One the main tools MFRAU uses to stop Medicaid Fraud is the Vermont False Claims Act,

32 V.S.A. § 630 *et al.*

BUT we aren't the only ones who can use the Vermont False Claims Act to stop fraud being committed against the State.

QUI TAM

"WHO PURSUES THIS ACTION ON OUR LORD THE KINGS BEHALF AS WELL AS HIS OWN"

Whistle Blower lawsuit filed **UNDER SEAL**

Under the *qui tam* provisions of the Federal False Claims Act (FCA) and Vermont's FCA Statute, private persons ("relators") may file suit in Federal or State court on behalf of the Government or States against individuals and/or entities that have presented false or fraudulent claims to the United States and/or States

The Relator
Who can be a relator? Anyone!

The qui tam provisions of the FCA are meant to encourage insiders with “inside information” to uncover and report fraud schemes that might otherwise remain undetected. Relators are often past or present employees, contractors, vendors, auditors, consultants, or associates of a defendant organization. But, because the FCA allows anyone claiming to have inside knowledge of false claims or statements being submitted to the government to file a qui tam suit, relators also can be competitors or others in the marketplace.

Why be a relator?

To stop fraud against the Federal Government and State and be apart of the recovery of stolen government funds.

False Claims Act Settlements and Judgments Exceed $2.68 Billion in Fiscal Year 2023.
Source: https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-268-billion-fiscal-year-2023

MFRAU RECOVERIES UNDER THE FCA

In the past five years, MFRAU has recovered approximately $17,000,000.

32 V.S.A. § 631. Prohibition; penalties
(b) Any person who violates a provision of subsection (a) of this section shall be liable to the State for:
(1) a **civil penalty of not less than $5,500.00 and not more than $11,000.00** for each act constituting a violation of subsection (a) of this section, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. § 2461);
(2) **three times the amount of damages that the State sustains because of the act of that person**; and
(3) the costs of the investigation and prosecution of such violation.

There is also a monetary incentive for relators:

Under 32 V.S.A. § 635 Payments to relators; limitations
(a) If the Attorney General proceeds with an action brought by a relator under subsection 632(b) of this chapter, the relator shall, subject to subsection (b) of this section, receive at least 15 percent but not more than 25 percent of the proceeds recovered and collected in the action or in settlement of the claim, depending upon the extent to which the relator substantially contributed to the prosecution of the action.

Recent National FCA Cases

Lincare Holdings Inc. agreed to pay $29.0 million to resolve allegations that it fraudulently billed Medicare Advantage plans and Medicare Part B for oxygen equipment rental payments. While many Medicare Advantage plans and Medicare Part B "capped" oxygen equipment rental payments at 36 months, Lincare admitted that it improperly billed government health care plans for oxygen equipment rental payments and co-payments after it had already received three years of payments. Lincare not only admitted to improperly billing Medicare for oxygen equipment rentals, but also admitted to improperly collecting co-pays from beneficiaries and, as part of the settlement, agreed to timely identify and refund all beneficiary co-pays that it had improperly collected, and to implement additional corrective actions in order to ensure appropriate billing going forward. Source: https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-268-billion-fiscal-year-2023

Mallinckrodt ARD LLC, paid $260 million to resolve separate allegations relating to its drug H.P. Acthar Gel, which is approved to treat, among other things, acute exacerbations of multiple sclerosis and infantile spasms. The government alleged that the company knowingly underpaid rebates to the Medicaid program by improperly designating Acthar as a "new drug" as of 2013, as opposed to a preexisting drug for which Mallinckrodt had significantly raised the price in years prior. Source: https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-2-billion-fiscal-year-2022

Whistleblower Protections

Understanding the risks taken by whistleblowers, the FCA prohibits workplace retaliation while offering the prospect of a monetary reward. But profiting from a FCA claim is not guaranteed, and the process usually takes years.

To protect relators, Under 32 V.S.A. § 638 of the FCA, employers are prohibited from discriminating against employees, contractors, and agents “because of lawful acts done by the employee, contractor, agent or associated others in furtherance of an action under this section or other efforts to stop one or more violations” of the FCA.

Do you need a relator for to move forward with an FCA Case?

Under 32 V.S.A. § 632 (a) (a) The Attorney General shall investigate violations of subsection 631(a) of this chapter. If the Attorney General finds that a person has violated or is violating subsection 631(a), the Attorney General may bring a civil action in the Civil Division of the Superior Court under this section against the person. The action may be brought in Washington County or in any county where an act prohibited by section 631 occurred.

MFRAU consistently uses the FCA to bring cases against Vermont Medicaid providers who knowingly defraud Medicaid and receive payments based on that fraud.

VERMONT FCA

32 V.S.A. § 631 et al
(mirrors the federal FCA statute)

§ 631. Prohibition; penalties

(a) No person shall:

(1) knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval;

(2) knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim;

(3) knowingly present, or cause to be presented, a claim that includes items or services resulting from a violation of 13 V.S.A. chapter 21 or section 1128B of the Social Security Act, 42 U.S.C. §§ 1320a-7b;

(4) knowingly present, or cause to be presented, a claim that includes items or services for which the State could not receive payment from the federal government due to the operation of 42 U.S.C. § 1396b(s) because the claim includes designated health services (as defined in 42 U.S.C. § 1395nn(h)(6)) furnished to an individual on the basis of a referral that would result in the denial of payment under 42 U.S.C. chapter 7, subchapter XVIII (the "Medicare program"), due to a violation of 42 U.S.C. § 1395nn;

(5) having possession, custody, or control of property or money used, or to be used, by the State, knowingly deliver, or cause to be delivered to the State or its agent, less than all of that property or money for which the person receives a certificate or receipt...

WHAT IS A CLAIM

A demand for money or property made directly to State (or to a contractor, grantee, or other recipient if the money is to spent on the government's behalf) and if the Government provides any of the money demanded or if the Government will reimburse the contractor or grantee.

(1) "Claim" means any request or demand, whether under a contract or otherwise, for money or property, and whether or not the State has title to the money or property, that:

(A) is presented to an officer, employee, or agent of the State; or

(B) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the State's behalf or to advance a State program or interest, and if the State:

(i) provides or has provided any portion of the money or property that is requested or demanded; or

(ii) will reimburse directly or indirectly such contractor, grantee, or other recipient for any portion of the money or property that is requested or demanded. A claim shall not include a request or demand for money or property that the State has paid to an individual as compensation for State employment or as an income subsidy with no restrictions on that individual's use of the money or property. 32 V.S.A. § 630(1).

For example: in Medicaid, providers submit a claim for services provided to the State via Gainwell. Any other examples?

"KNOWINGLY" . . .

The terms "**knowing**" and "**knowingly**" mean that a person has:

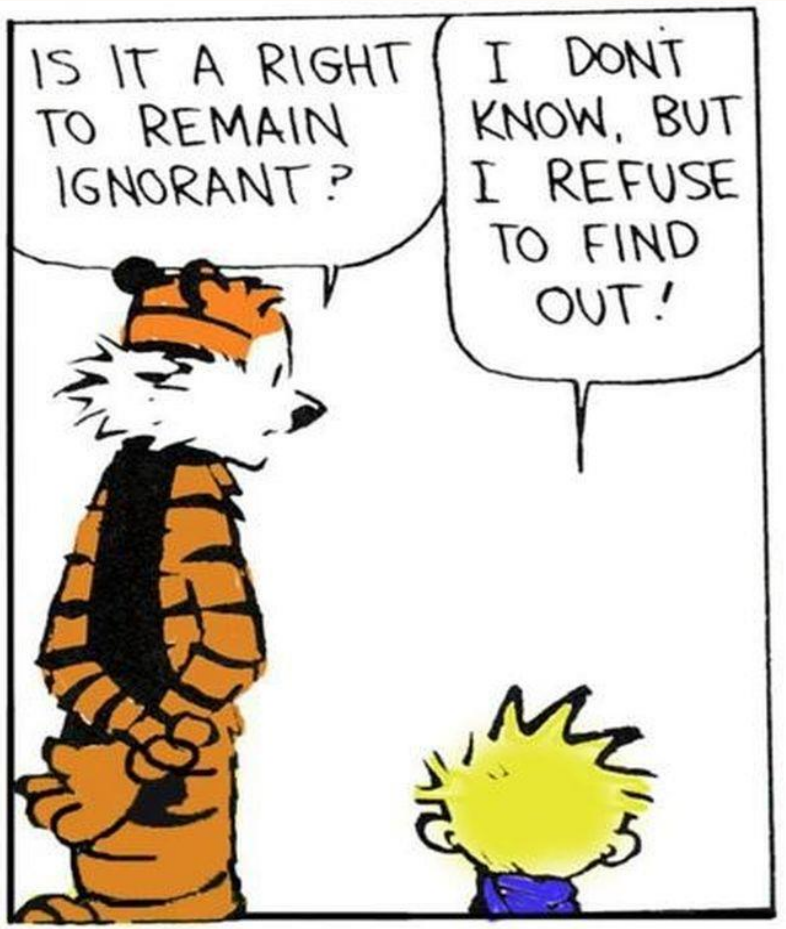
Actual knowledge; or

Acts in deliberate ignorance; or

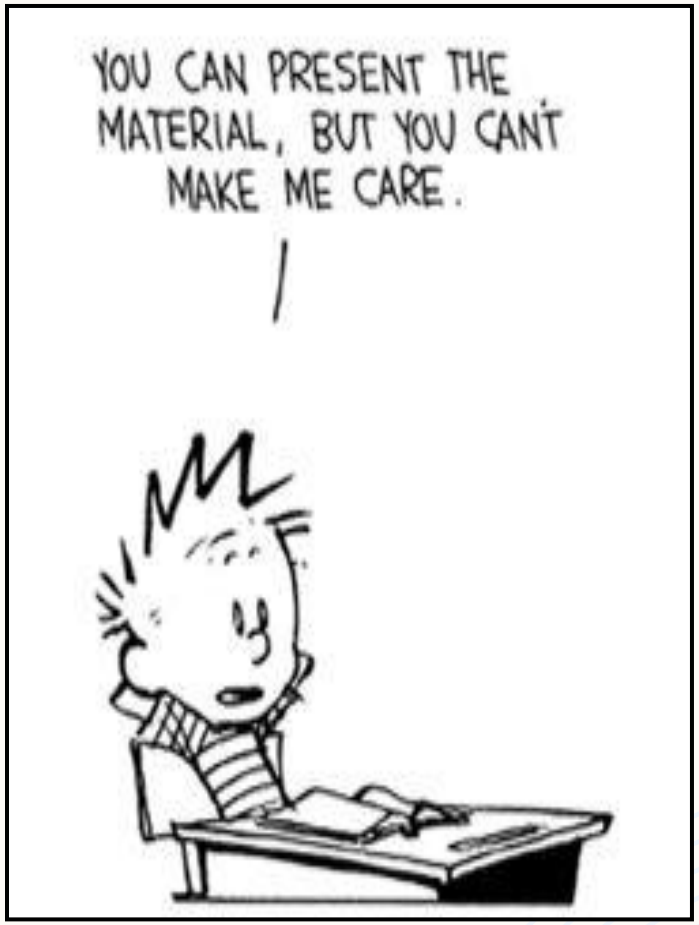
Acts in reckless disregard of truth or falsity

Actual Knowledge

Deliberate Ignorance



Reckless Disregard



THE BASICS

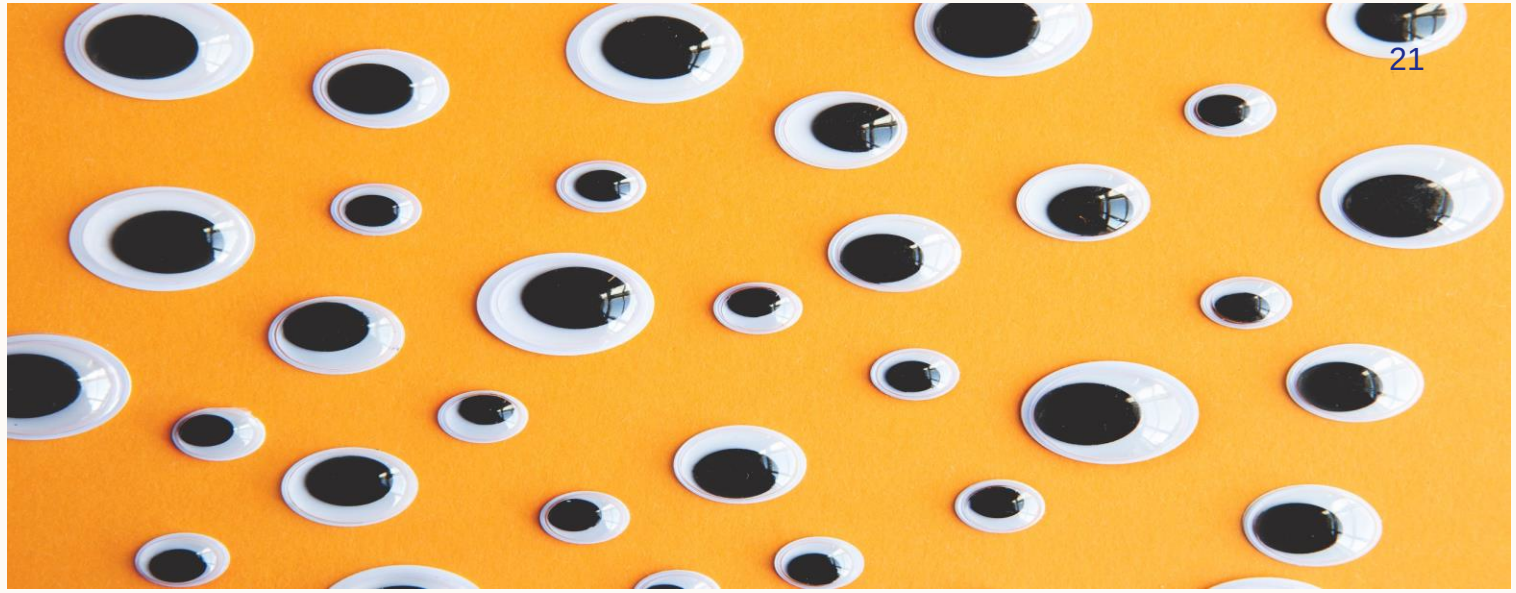
REVIEWING INITIAL FILING

When a relator files an FCA case it remains under seal for automatically for 60 day. Purpose of 60 days is for federal government and named states to investigate and decide whether to take over prosecution of the case, this is called intervention.

How does the State know whether to intervene? We investigate….

THE BASICS

WHAT TO LOOK FOR IN THE COMPLAINT



Is the named defendant in Vermont?

What is the States's Possible Interest in the Case?

Do the allegations seem valid?

Can you determine Vermont's potential utilization? OR determine what State Agency might have that information?

INVESTIGATION OF ALLEGATIONS

Relator Interviews – can be multiple interviews

Civil Investigative Demands to the Defendants

Relator Counsel could request a presentation

Discussion with relevant government agencies

AND DATA, DATA, DATA

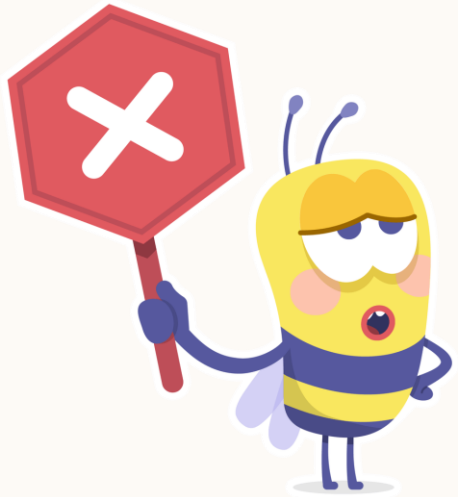
In many healthcare investigation cases what the data show can be most important:

Data can lead us to somebody that is potentially committing fraudulent activity OR in the case of FCA case where we have whistleblower come tell them that they suspect fraud happening, and we can confirm or dispel those allegations that against the data.

INTERVENTION DECISION

Eventually, all named States and the Federal government will need to decide whether they are intervening in the case or not.

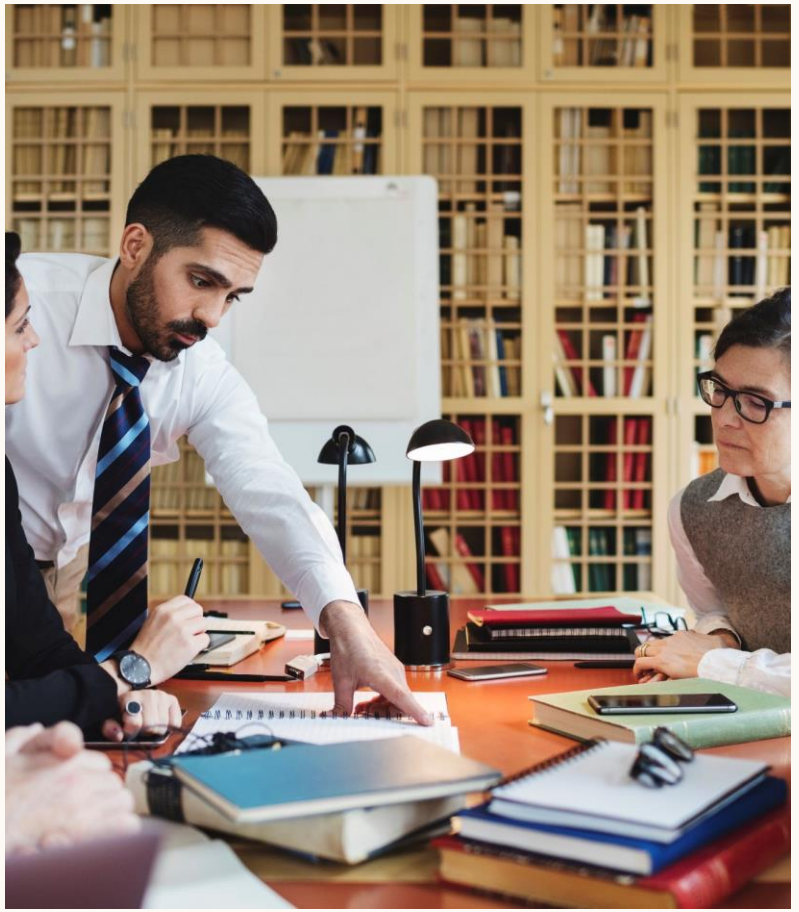
Declination Procedure: If all States and Federal Government all decide to not intervene than typically Notice of Declination is filed by the federal government and name states.



INTERVENTION

What generally happens when the States and Federal Government decide to intervene after investigation?

- Notice of Intervention is filed by intervening parties.
- AAG for each intervening state will be admitted to the District Court *Pro Hoc Vice*.
- Each state separately or in a joint filing file a complaint-in-intervention



EXAMPLES OF USE OF FALSE CLAIMS ACT IN VERMONT

December 2023, MFRAU entered a civil settlement with Green Mountain Support Services (GMSS), a state-designated special service agency that provides crucial support to developmentally disabled Vermont Medicaid recipients. The settlement resolved the State's allegations that GMSS made fraudulent Medicaid claims under the False Claims Act. As a result of the settlement agreement, GMSS will make organizational improvements and pay the State of Vermont $459,190 in civil damages and penalties.

False Claims Act Allegations:

- GMSS billed Medicaid for seven hours per week, or approximately 365 hours per year, to support their service coordination for a client who they consistently provided substantially less service coordination
- GMSS billed Vermont Medicaid for services to a client from August 2022 through April 2023, despite disenrolling the client from services in August 2022; and
- GMSS instructed some of their direct support staff in 2019 to set aside up to an hour each week to complete paperwork, potentially causing GMSS clients to receive less direct care per week, while GMSS represented and billed Medicaid for the full number of hours in violation of Medicaid Rules and Regulations.

EXAMPLES OF USE OF FALSE CLAIMS ACT IN VERMONT

Theory of worthless services: holds that a provider is in violation of the False Claims Act (FCA) if they submit a claim for services that are of such low quality that they are essentially equivalent to no services at all. In other words, if the State new how bad/poor the services were being provided we would not have paid for them at all.

February 2020, MFRAU entered into a civil settlement with three Genesis Healthcare subsidiary-operated nursing homes in Vermont – Burlington Health & Rehab, St. Johnsbury Health & Rehab, and Berlin Health & Rehab – resolving allegations of neglect that resulted in serious injury to three residents and the death of a fourth. Each of these incidents was related to inadequate staff training and orientation, the use of visiting or third-party contractors, and the failure to adequately document and monitor the delivery of resident care services. The settlement requires the Centers to pay $740,143 in damages and penalties to the State of Vermont, create a new Patient Care Coordinator position, and engage the services of an independent monitor to review the quality of care provided by each facility.

Questions?

Contact Information

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You can also fraud report to us at:

ago.mfraureport@vermont.gov or

https://ago.vermont.gov/medicaid-fraud-report-form/