Medicaid Fraud, Waste and Abuse Curator: Volume 1

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Waste

Billions In 'Questionable Payments' Went To California's Medicaid Insurers And Providers

SourceURL: https://californiahealthline.org/news/billions-in-questionable-payments-went-to-californias-medicaid-insurers-and-providers/

Billions In 'Questionable Payments' Went To California's Medicaid Insurers And Providers

California's Medicaid program made at least $4 billion in questionable payments to health insurers and medical providers over a four-year period because as many as 453,000 people were ineligible for the public benefits, according to a state audit released Tuesday.

In one case, the state paid a managed-care plan $383,635 to care for a person in Los Angeles County who had been dead for more than four years, according to California State Auditor Elaine Howle.

She said she found "pervasive discrepancies" in Medicaid enrollment in which state and county records didn't match up from 2014 to 2017, leading to other errors that persisted for years. The bulk of the questionable payments, or $3 billion, went to health plans that contract with the state to care for 80 percent of enrollees in California's Medicaid program, known as Medi-Cal.

The program for low-income residents is the nation's largest and funded by both the federal and state governments. The state findings echo similar problems cited by federal officials and come at a time when the Trump administration has applied extra scrutiny to California's spending on Medicaid.

In the report, the state auditor said it's critical for the state to have accurate information on eligibility "because it pays managed care plans a monthly premium for an increasing number of Medi-Cal beneficiaries regardless of whether beneficiaries receive services."

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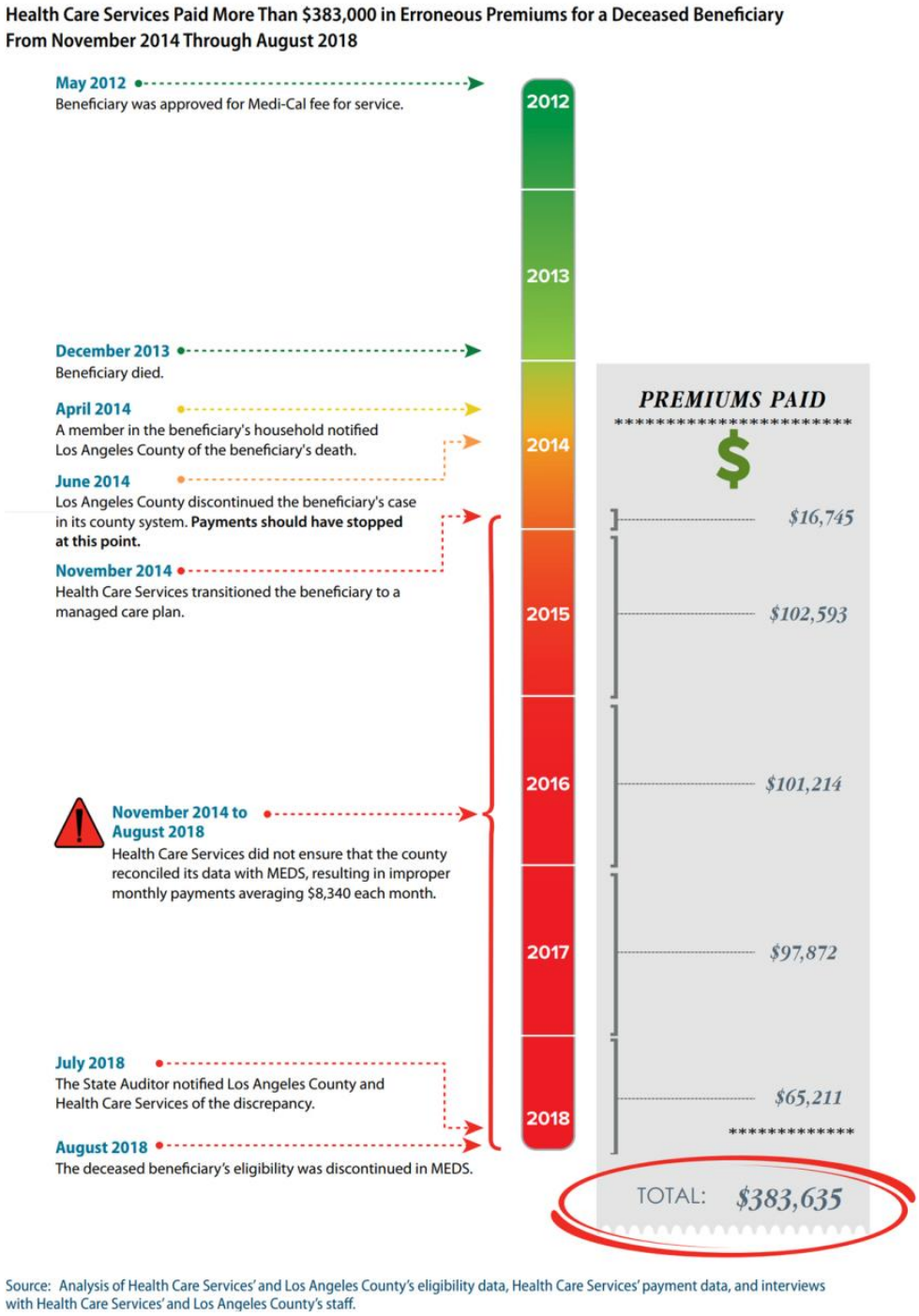

California paid a managed-care plan $383,635 to care for a person in Los Angeles County who had been dead for more than four years.(Courtesy of California State Auditor)

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California's Medicaid program has 13.2 million enrollees, covering about 1 in 3 residents. It has an annual budget of $107 billion, counting federal and state funds. Nearly 11 million of those enrollees are in managed care plans, in which insurers are paid a monthly fee per enrollee to coordinate care.

The state's Medicaid enrollment soared by more than 50 percent since 2013 due to the rollout of the Affordable Care Act and the expansion of Medicaid. Enrollment grew from 8.6 million in December 2013 to more than 13 million in December 2017, according to the audit report.

In the case of the dead patient, a family member had notified the county of the enrollee's death in April 2014. However, the person's name remained active in the state system, and California officials assigned the patient to a managed-care plan in November of that year.

From then on, the state kept making monthly payments of about $8,300 to the health plan until August 2018, shortly after the auditor alerted officials of the error. Auditors didn't identify the health plan.

There also were costly mistakes in cases in which Medi-Cal pays doctors and hospitals directly for patient care – a program known as "fee for service."

For instance, the state auditor found that Medi-Cal paid roughly $1 million in claims for a female patient in Los Angeles County from June 2016 to December 2017 even though the county office had determined in 2016 that she was ineligible.

In a written response to the auditor, the California Department of Health Care Services said it agreed with the findings and vowed to implement the auditor's recommendations. However, the agency warned it may not meet the auditor's timeline, which called for the main problems to be addressed by June 2019.

In a statement to California Healthline, the agency said it is implementing a quality control process and "where appropriate, DHCS will recover erroneous payments."

Early on in 2014, as the ACA rolled out, the state struggled to clear a massive backlog of Medi-Cal applications, which reached about 900,000 at one point. There were widespread computer glitches and consumer complaints amid the increased workload at the county and state level.

In addition to questionable payments for care of ineligible enrollees, Howle and her audit team also discovered some patients who may have been denied benefits improperly. The state auditor identified more than 54,000 people who were deemed eligible by county officials but were not enrolled at the state level. As a result, those people may have had trouble getting medical care.

In February, a federal watchdog estimated that California had signed up 450,000 people under Medicaid expansion who may not have been eligible for coverage.

The inspector general at the U.S. Department of Health and Human Services said California made $1.15 billion in questionable payments during the six-month period it reviewed, from Oct. 1, 2014, to March 31, 2015.

In August, Seema Verma, administrator of the U.S. Centers for Medicare and Medicaid Services, told a U.S. Senate committee that she was closely tracking California to ensure the state "returns a significant amount of funding owed to the federal government related to the state's Medicaid expansion."

Verma expressed concern that states had overpaid managed-care plans during the initial years of Medicaid expansion, resulting in "significant profits for insurance companies." By year's end, she said she expects the federal government to recoup about $9.5 billion from California's Medicaid program, covering overpayments from 2014 to 2016.

Tony Cava, a spokesman for Medi-Cal, said the state has already returned about $6.9 billion to the federal government and expects more than $2 billion more to be sent back by December.

Measure

Measure

Audit: Ohio Medicaid paid $90.5 million to deceased people; owes feds $38 million

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SourceURL: https://www.watchdog.org/ohio/audit-ohio-medicaid-paid-million-to-deceased-people-owes-feds/article_553dd7ca-dbbe-11e8-9dae-3f80e219c750.html

Ohio Medicaid paid out $90.5 million in coverage to individuals who had already been deceased, an audit by the Office of the Inspector General claims.

After the federal audit analyzed a random sample size, it estimated that Ohio Medicaid failed to recover $51.3 million of those funds; $38 million of which were part of the federal share, which Ohio Medicaid owes back to the federal government.

Ohio Medicaid, however, is refuting the claims, saying that no provider paid for services for a deceased person.

According to the audit, Ohio Medicaid did not always process a beneficiary's death information to ensure that payments stopped, which caused the improper payments.

The Office of the Inspector General recommended that Ohio Medicaid do four things: pay back the federal share to the federal government; recover improper payments found in the audit; identify improper payments conducted before and after the audit, and pay back the federal share; and record the proper dates of death in a timely manner to prevent future improper payments.

Thomas Betti, the press secretary for the Ohio Department of Medicaid told Watchdog.org that the department disagrees with the inspector general's audit and will be appealing.

"No provider was paid for services for a deceased person, and nearly a year ago, as part of ongoing work to modernize the system, safeguards went online that prevent it from happening," Betti said. "We can assure Ohio taxpayers that there were no services paid for individuals after their death."

Betti objected to the auditors' methodology and said that the report fails to account for per member per month rate setting procedures and that no provider has been paid for services to a deceased person.

"Nearly a year ago, we fixed the reporting issue by implementing a monthly process to update records," he said.

Additionally, Betti said that Ohio Medicaid has a "robust program integrity unit." Ohio Medicaid also works with the Ohio Attorney General, the Attorney General's Medicaid fraud control unit, the Ohio Auditor of State and federal partners.

The audit was conducted by reviewing 100 random payments to individuals who had died and found that, out of this hundred, 37 payments were properly covered, while the other 63 were not. This amounted to $113,405 total and $74,495 from the federal share. However, when using the sample size to estimate the total cost, the audit estimated that more than $51 million had been improperly paid without being recovered and $38 million was in the federal share, and owed back to the federal government. The audit reviewed payments between July 1, 2014 and June 30, 2016.

Provider Fraud

Suffolk doctor charged in drug-testing scam, state AG's office says

State AG charges doctor in drug-testing scam

SourceURL: https://www.newsday.com/long-island/crime/suffolk-doctor-arrest-fraud-1.22659633

Officials: Edwardo M. Yambo pocketed money by submitting bills for drug testing that his laboratory did not or could not perform and for services not medically necessary.

By Ellen Yan ellen.yan@newsday.com @NewsdayAtNite Updated October 30, 2018 10:24 PM

Print Share

A Suffolk doctor who owns a laboratory cheated state Medicaid out of nearly $1 million in a four-year drug-testing scam, the state attorney general's office said Tuesday.

Edwardo M. Yambo, 70, of Lake Grove, stole $939,000 between 2012 and 2016 by "routinely" submitting bills for drug testing services that his laboratory did not or could not perform and for services that were not medically necessary, according to Attorney General Barbara D. Underwood. For example, instead of charging for one test on a patient, he often charged the state's healthcare program for low-income residents for 11 nonexistent tests, said agency spokesman Jordan Carmon.

Yambo, who has offices in Deer Park and Bay Shore, also operated his laboratory without a director, which is required under state and federal regulations, authorities said.

The doctor and his company, which is named after him, were each charged with one count of second-degree larceny. In a negotiated surrender, the doctor was arrested Tuesday, arraigned in Suffolk County District Court and released on his own recognizance. He gave up his controlled-substance-prescribing privileges to the federal Drug Enforcement Administration, officials said, and could lose his license to practice medicine.

Yambo's attorney declined to comment.

The alleged false charges were discovered by the attorney general's Medicaid fraud control unit when it examined doctors' billing patterns, Carmon said. He had about six schemes, officials said. In one of them, Zambo billed Medicaid for tests that his laboratory did not have equipment to handle. In another, he charged for testing four drugs: powerful pain medications fentanyl and tramadol, the muscle relaxant carisoprodol, and the sedative zolpidem, popularly known under the brand name Ambien, court papers said.

“Billing New York’s Medicaid program for unnecessary or made-up procedures amounts to stealing from New York taxpayers, while wasting critical resources on which our most vulnerable neighbors depend,” Underwood said.

Bridgeport Woman Pleads Guilty To Medicaid Fraud

Bridgeport Woman Pleads Guilty To Medicaid Fraud

SourceURL: https://patch.com/connecticut/bridgeport/bridgeport-woman-pleads-guilty-medicaid-fraud

She agreed to pay back more than $1.3 million.

BRIDGEPORT, CT — A woman accused of defrauding the state through identity theft of Medicaid patients.

Nikkita Chesney, 45, of Bridgeport pleaded guilty to one count of health care fraud and one count of aggravated identity theft. She admitted to stealing the identity information of 150 Medicaid clients from her employer and using about half that information to file false billings to Medicaid, according to the U.S. Attorney District of Connecticut. She said her co-conspirators also falsely billed Medicaid.

She faces up to 10 years for health care fraud and a mandatory two year sentence for aggravated identity theft. She also agreed to pay more than $1.3 million in restitution.

Her co-conspirator Juliet Jacob was ordered to pay $2.7 million in restitution and she faces up to 10 years in prison when sentenced. Five other individuals have been charged and convicted of fraud offenses as part of the investigation.

Johnson County nurse pleads guilty to Medicaid fraud, drug charges

Johnson County nurse pleads guilty to Medicaid fraud, drug charges

SourceURL: https://www.kctv5.com/news/johnson-county-nurse-pleads-guilty-to-medicaid-fraud-drug-charges/article_98a17bee-d8a7-11e8-a2ff-e35a5a4a513c.html

(Associated Press)

OLATHE, KS (KCTV) -- A Johnson County nurse pleaded guilty on Thursday to Medicaid fraud and related charges, according to the Kansas Attorney General.

Jeremy Keith Bailey, a 41-year-old from Gardner, pleaded guilty in Johnson County District Court to one count of Medicaid fraud, one count of theft, and one count of possession of a controlled substance.

The charges stemmed from an investigation by the attorney general's Medicaid Fraud and Abuse Division and the Gardner Police Department, which revealed that Bailey stole prescription medications while working as a registered nurse in a Johnson County nursing facility.

The medication, Percocet, is an opioid classified as a Schedule II Controlled Substance in Kansas. The crimes occurred in February of 2018.

As a condition of the plea, Bailey has agreed to voluntarily surrender his nursing license.

District Judge Brenda Cameron accepted the plea and scheduled sentencing for Dec. 18.

Kansas filed the case as part of a national sweep of Medicaid fraud enforcement actions led by the U.S. Department of Justice, which was announced in July. As part of that national effort, the Kansas attorney general filed criminal charges against six individuals. Three of those individuals have now been found guilty. Three additional cases remain pending.

Two home health agency owners and two employees convicted for roles in $3.7 million home health fraud scheme

Two home health agency owners and two employees convicted for roles in $3.7 million home health fraud scheme

SourceURL: https://www.mdlinx.com/neurology/washington-report/2018/10/31/7548236

Washington, DC, October 30, 2018—A federal jury found two home health owners and two employees guilty today for their roles in a scheme to bill Medicare and Medicaid for over $3.7 million in charges when the owners had previously been excluded from participating in federal health-care benefit programs.

Assistant Attorney General Brian A. Benczkowski of the Justice Department's Criminal Division, US Attorney Erin Nealy Cox of the Northern District of Texas, Special Agent in Charge C.J. Porter of the US Department of Health and Human Services Office of Inspector General's (HHS-OIG) Dallas Region, Special Agent in Charge Eric Jackson of the FBI's Dallas Field Office, and Director of Law Enforcement David Maxwell of the Texas Attorney General's Medicaid Fraud Control Unit (MFCU) made the announcement.

After a 6-day trial, Celestine "Tony" Okwilagwe, 50, of Dallas County, Texas; Paul Emordi, 52, of Collin County, Texas; Adetutu Etti, 60, also of Dallas County; and Loveth Isidaehomen, 49, also of Dallas County, were each convicted of one count of conspiracy to commit health-care fraud. In addition, Okwilagwe and Etti were each convicted of two counts of false statement in connection with a health-care benefit program. Sentencing before US District Judge Jane Boyle of the Northern District of Texas, who presided over the trial, has not yet been scheduled.

According to evidence presented at trial, Okwilagwe and Emordi owned and operated Elder Care, a Medicare and Medicaid provider in Garland, Texas, when both were previously excluded from participating in any federal health-care benefit program. Etti, the administrator of Elder Care, concealed Okwilagwe's ownership and Okwilagwe and Emordi's exclusions from

Medicare and Medicaid. Etti signed false documents that indicated that no one associated with Elder Care was excluded and that another individual owned Elder Care, the evidence showed. The evidence further established that Isidaehomen signed bank documents and wrote employee paychecks to conceal the involvement of her husband, Okwilagwe. The defendants also engaged in a scheme to submit false and fraudulent bills to Medicare for services that were not needed, the evidence showed.

Evidence at trial demonstrated that Elder Care billed Medicare and Medicaid for over $3.7 million for claim reimbursements to which it was not entitled because Okwilagwe and Emordi were excluded from Medicare.

This case was investigated by HHS-OIG, the FBI, and MFCU. Assistant Deputy Chief Adrienne Frazior and Trial Attorney Catherine Wagner of the Criminal Division's Fraud Section and Assistant US Attorney Russell Fusco of the Northern District of Texas are prosecuting the case.

Nursing home settlement involves former owner of Hagerstown facility

Nursing home settlement involves former owner of Hagerstown facility

SourceURL: https://www.heraldmailmedia.com/news/local/nursing-home-settlement-involves-former-owner-of-hagerstown-facility/article_17c8aae4-c99a-5dc8-901f-3b2fa4c44e63.html

NMS Healthcare on Marsh Pike north of Hagerstown.

File photo

BALTIMORE — The former owner of a nursing home north of Hagerstown was the defendant in a lawsuit settled last week with the state attorney general's office.

NMS Healthcare agreed to pay $2.2 million to the attorney general's Medicaid Fraud Control Unit, and the company and its owner, Matthew Neiswanger, are prohibited from operating in Maryland, according to the settlement.

Attorney General Brian Frosh filed suit against NMS in December 2016, alleging NMS had been involved in patient "dumping" and submitting false claims to the state's Medicaid program. At the time, NMS operated the 206-bed facility on Marsh Pike; the Hagerstown operation was among five facilities named in the suit.

NMS closed the Hagerstown unit in June 2017. By that time, the facility no longer was permitted to receive Medicare and Medicaid payments. Delaware-based Cadia Healthcare reopened the facility this past June.

As part of the settlement, the state will dismiss claims against NMS entities, including Marie Costa Nadora, the former administrator at the Hagerstown facility, according to the settlement agreement.

In addition, NMS will drop a suit it filed against four Maryland Department of Health employees in March 2107, alleging they "unlawfully retaliated against the NMS entities for the exercise of their rights under the United States Constitution."

The settlement agreement is "neither an admission of liability nor a concession by any of the parties concerning any of the claims," according to court documents.

When the Hagerstown facility closed last year, about 150 residents had to be relocated, Herald-Mail Media reported.

"NMS and its leadership compromised the health and safety of hundreds of vulnerable people who were in their care," Frosh said in a statement.

"To make more money, NMS issued eviction notices to its residents en masse, unsafely evicted residents who continued to need longterm nursing care, and often exposed frail residents to dangerous conditions by dumping them in homeless shelters and predatory unlicensed facilities. (This) settlement ensures that NMS and its owner will no longer operate nursing facilities in Maryland and sends the message that this conduct is unacceptable."

NMS had denied any wrongdoing and disputed Frosh's allegations.

During the 17-month period from Jan. 1, 2015, to May 31, 2016, NMS issued at least 1,061 eviction notices to residents of its facilities, Frosh's office said.

Maryland's 225 other licensed nursing facilities issued a combined total of less than half that number during that time, Frosh's office said.

Measure

Measure

Austin psychologists convicted in multiple charges after fraud investigation

Austin psychologists convicted in multiple charges after fraud investigation

SourceURL: https://www.kvue.com/article/news/crime/austin-psychologists-convicted-in-multiple-charges-after-fraud-investigation/269-609378370

Dr. William Dubin and his son, Dr. David Dubin, were found guilty in a fraud investigation involving Psychological A.R.T.S.

Author: Drew Knight

Published: 9:07 PM CDT October 29, 2018

Updated: 9:10 PM CDT October 29, 2018

AUSTIN — A federal jury on Monday convicted two Austin-area psychologists on numerous charges after a fraud investigation at their establishment, Psychological A.R.T.S., P.C.

After a three-week-long trial, the jury convicted Dr. William Joseph Dubin, 73, and his son, Dr. David Fox Dubin, 33. William was found guilty of one count of conspiracy to pay and receive health care kickbacks, and two counts of offering to pay and paying illegal kickback, while his son was found guilty of one count of conspiracy to commit health care fraud, one count of health care fraud and aiding and abetting health care fraud, and one count of aggravated identity theft.

Prior to Monday, a third defendant, 68-year-old Glen Elwood McKenzie Jr. of Cedar Park, Texas, pleaded guilty to one count of conspiracy to violate the federal anti-kickback law and one count of receiving an illegal kickback. McKenzie was the president of the board of directors of an emergency shelter house about 80 miles from Austin that provided temporary shelter or crisis intervention and mental health services to children ages five to 17 who had been removed from their homes by the Texas Department of Family and Protective Services.

Based on evidence provided during the trial, Dr. William Dubin paid McKenzie to refer children to Psychological A.R.T.S. for mental health services, which were billed to the Medicaid program. Upon payment for those services, William paid him a 10 percent kickback from the money paid to his facility.

RELATED: Austin-area medical professionals indicted in record-breaking healthcare fraud enforcement

The evidence also revealed that Dr. David Dubin engaged in a conspiracy to commit health care fraud and committed health care fraud by causing at least one fraudulent billing to be submitted to the Medicaid program. He was convicted of engaging in aggravated identity theft when he caused a fraudulent claim to be submitted to Medicaid and unlawfully used a patient's personal information to receive payment of the bill.

Dr. William Dubin faces up to five years in federal prison for each count related to the illegal kickbacks. His son faces up to 10 years for each count related to health care fraud; and a consecutive mandatory two-year term for the count related to aggravated identity theft. The Dubins remains on bond pending sentencing scheduled for 10:30 a.m. on Feb. 19.

Prosecutors dismiss health care fraud charges against Dr. Roland Chalifoux

Prosecutors dismiss health care fraud charges against Dr. Roland Chalifoux

SourceURL: https://www.wtrf.com/news/crimes-and-courts/prosecutors-dismiss-health-care-fraud-charges-against-dr-roland-chalifoux/1564426779

MGN Online

WHEELING, W. Va. (WTRF) - A three and a half year legal battle in West Virginia's Northern District Court has come to an end. In what the U.S. Attorney's office is calling a "rare move," federal prosecutors motioned to dismiss pending charges of health care fraud against Dr. Roland Chalifoux, Jr.

Dr. Chalifoux, 58, was indicted in June 2017 in a 32 count indictment that alleged crimes ranging from health care fraud, wire fraud, and mail fraud. He was alleged to have wrongfully billed insurers, including Medicaid, for visits at which he was not present.

Chalifoux is a Pain Management Physician from McMechen, which his attorneys maintained permitted that manner of management practice.

"We knew from the outset of this case that the prosecution's position was deeply flawed and based on a misunderstanding of healthcare regulations," reads a joint statement from Ronald W. Chapman II and Elgine McArdle, who represented Dr. Chalifoux. "Despite many opportunities

to resolve this case early, we believed in Dr. Chalifoux's innocence and looked forward to presenting his case to the jury."

Chalifoux was outspoken about his belief that this indictment was a culmination of multiple failed allegations dating back to 2014, including one related to a meningitis outbreak of that year.

"I am incredibly relieved that this three and a half year ordeal is over," Dr. Chalifoux said in a statement. "I have always maintained my innocence and look forward to continuning to practice medicine and treat my patients."

Massachusetts Health Care Company Owner Charged with Tax Fraud

Massachusetts Health Care Company Owner Charged with Tax Fraud

SourceURL: https://www.homecaredaily.com/2018/10/26/massachusetts-health-care-company-owner-charged-with-tax-fraud/

By Valerie VanBooven, RN BSN, Editor in Chief of HomeCareDaily.com | October 26, 2018

Two Weymouth, Massachusetts women are facing charges of tax evasion in connection to a home health care company they co-owned in Boston. Sheila O'Connell, 33, and Hannah Holland, 51, were both charged with one count of conspiracy to defraud the United States and three counts of aiding and assisting in the preparation of false tax returns.

The women face up to five years in prison with another three years supervised release and a maximum fine of $250,000 for the conspiracy charge. For filing a false tax return, the sentence could be no greater than three years in prison, one year of supervised release, and a $250,000 fine.

The women apparently received far more money in person then they reported on their tax filings.

As reported by the Weymouth Patch in the news blog, *Weymouth Owner of Healthcare Company Charged [w]ith Tax Fraud*, written by Alex Newman:

"Federal authorities allege the pair, who owned and operated Erin's Own Home Healthcare Inc., cashed over $3.5 million in business checks through nominee accounts controlled by an unnamed person from 2010-2014. During that same time period, Holland also personally cashed over $77,000 in business receipts, according to the U.S. Attorney's office.

None of the funds were reported to the IRS or accounted for in the company's tax filings, and the pair instead provided their tax preparer with a limited set of financial records that did not cover the diverted funds, according to authorities. This caused the IRS to lose $1,126,112, the USAO said."

It is unclear whether this was a conspiracy, but according to anonymous sources, investigators had determined that this was a deliberate act with the main focus of defrauding the IRS and underreporting income.

There was no formal notice about whether the company was still in operation or whether the investigation and subsequent charges may have resulted in clients no longer receiving necessary services. As CMS (the Centers for Medicare and Medicaid Services) has recently implemented new measures to help combat fraud and deception through the system, it has certainly placed increased pressure on home care agencies to maintain paperwork and pay workers out of pocket before reimbursements can be received, but this case does not appear to have anything to do with Medicare or Medicaid fraud but rather tax evasion and it's unclear whether these changes led to some of their actions.

It was not made clear whether these two women had retained legal counsel or if they entered a plea. It was also not noted when the next court date would be held.

Member Fraud

Beshear: Jefferson County Couple Charged with Alleged Neglect/Abuse, Medicaid Fraud

Beshear: Jefferson County Couple Charged with Alleged Neglect/Abuse, Medicaid Fraud

SourceURL: http://www.bereaonline.com/2018/10/beshear-jefferson-county-couple-charged-with-alleged-neglect-abuse-medicaid-fraud/

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ARRESTED

A Jefferson County couple is facing six felony counts of alleged abuse and neglect of a vulnerable Kentuckian, and theft and fraud of the Kentucky Medicaid Program, according to Attorney General Andy Beshear.

Louis Milligan, 46, and **Stacey Milligan**, 49, a Louisville husband and wife, are each charged with one count of theft by deception over $500, a Class D felony; one count of devising or engaging in a scheme to defraud the Kentucky Medical Assistance Program of $300 or more, a Class D felony; and one count of wanton abuse or neglect of an adult, a Class D felony.

A Jefferson County grand jury indicted the couple Oct. 23 on the charges. Stacey Milligan was arraigned Oct. 29 in Jefferson Circuit Court, and her next scheduled appearance is 9 a.m. Dec. 20. Louis Milligan is scheduled to be arraigned at 2 p.m. Nov. 5 in Jefferson Circuit Court.

The indictment alleges the wife, Stacey Milligan, as a family home provider, fraudulently billed Kentucky Medicaid for services that she did not provide and, as a result, received more than $500 in payments from the program.

On one day when Stacey Milligan was not present, one of the adults in her care tried to eat raw chicken, choked and later died.

At the time of this incident, Louis Milligan, the husband, was at the home, but was not approved or trained by the company that administered the program to provide care to this adult.

Beshear's Office of Medicaid Fraud and Abuse investigated this case with the Department of Community Based Services, Cabinet for Health and Family Services.

Beshear's Office of Medicaid Fraud and Abuse is prosecuting the case. A charge is merely an accusation. The defendants are presumed innocent until and unless proven guilty.

The AG's office has seen a significant increase in the number of subpoenas or demand letters issued during Medicaid provider fraud or patient abuse, neglect or exploitation investigations during Beshear's administration.

Since taking office, efforts by Beshear's Office of Medicaid Fraud and Abuse through civil settlements and criminal restitution have resulted in over $74 million in obligations to the state and federal Medicaid program, Medicare, Tricare, commercial payers and other entities.

The Attorney General's tip line for reporting allegations of abuse, neglect or exploitation is 877-ABUSE-TIP (877-228-7384). Reports may be made to Adult Protective Services by calling 800-752-6200. Complaints involving a nursing home may be made by contacting the Office of the Inspector General, which is responsible for licensing nursing homes, by calling 502-564-7963.

Measure

Measure

State Attorney Brings Medicaid Fraud Charges Against Waterbury Man | Connecticut Law Tribune

SourceURL: https://www.law.com/ctlawtribune/2018/10/29/state-attorney-brings-medicaid-fraud-charges-against-waterbury-man/

State Attorney Brings Medicaid Fraud Charges Against Waterbury Man

Authorities have arrested Albert Haddad and charged the Waterbury man with scheming to defraud Medicaid. Haddad allegedly billed the government for caring for an elderly man who was actually in a nursing facility at the time.

By **Robert Storace** | October 29, 2018 at 11:48 AM

Albert Haddad. Courtesy photo

A 49-year-old Waterbury man has been arrested and charged with a scheme to defraud Medicaid of nearly $2,800 by allegedly claiming to provide at-home care to an elderly disabled man who was actually in a nursing home.

Investigators arrested Albert Haddad and charged him Friday with one count each of health insurance fraud and first-degree larceny by defrauding a public community. Haddad was released on a $15,000 bond and is scheduled to appear in Hartford Superior Court Nov. 6. Both charges are Class B felonies punishable by up five years in prison.

According to the arrest warrant affidavit, the Medicaid Fraud Control Unit of the Chief State's Attorneys Office opened up an investigation of Haddad after receiving a complaint from the state Department of Social Services. The investigation found that Haddad allegedly submitted 29 time sheets for payment from Medicaid from August to September 2015. He then allegedly submitted eight more time sheets for payment during the 11-day period between Oct. 1 and Oct. 12, 2015. Authorities said Haddad was paid a total of $2,758 to deliver home health care to a man only identified as "L.S.," who was actually at a skilled nursing facility, Waterbury Nursing and Rehab LLC.

According to the affidavit, L.S. told investigators that "Albert Haddad did not work for him while he was in the hospital or Nursing and Rehab, that he knew better than that." The

investigation also showed that L.S. was not at his home during the time Haddad claimed he was with him and provided at-home personal care assistant services.

The affidavit also states that investigators spoke to Haddad on the telephone on Sept. 27 and he was advised of the investigation. The affidavit says Haddad agreed to meet with authorities on Oct. 1 and never showed up. The same thing, the affidavit said, happened on Oct. 2. He was eventually arrested on Friday.

The case will be prosecuted by the Medicaid Fraud Control Unit, with the investigation assisted by the state Department of Social Services Office of Quality Assurance and the Waterbury Police Department.

As of Monday morning, it could not be determined if Haddad was represented by counsel.

Mark Dupuis, communications officer for the state Division of Criminal Justice, said the press release and arrest warrant affidavit speak for themselves.

Related Stories:

Attorney Speaks on Why His 'Very Likable' Doctor Client Laundered Millions From Medicaid

Newtown Psychologist Charged in Scheme to Defraud Medicaid of Nearly $80,000

Norwich Health Practice Pays $300,000 to Settle False Claims Act Violations

Man pleads guilty to medicaid fraud

Man pleads guilty to medicaid fraud

SourceURL: https://www.wjtv.com/news/local-news/man-pleads-guilty-to-medicaid-fraud/1562902167

Madison Man Sentenced for Misusing Mother's Medical Funds

JACKSON, Miss (WJTV) - Steven Adkins of Madison will spend 10 years in prison after pleading guilty to spending his mother's money instead of paying her medical bills.

Adkins, 62, was sentenced Monday to 10 years on one felony count of exploitation of a vulnerable person by Madison County Circuit Court Judge William Chapman. An investigation by the Attorney General's Medicaid Fraud Control Unit found that Adkins depleted his mother's funds in excess of $30,000 between March and December 2017.

The AG's Office investigation showed that instead of paying for his mother's care, Adkins made numerous cash withdrawals from her account and spent that money on himself.

"As a son who has cared for his own parents, it is beyond angering that a person would selfishly abuse that trust and responsibility," General Hood said.

Judge Chapman ran this sentence consecutive to an eight year sentence Adkins is already serving on an unrelated drug charge, totaling 18 years in prison.

This case was prosecuted by Special Assistant Attorney General Katie Moulds and investigated by Joel Houston, both with the Attorney General's Medicaid Fraud Control Unit.

2 people convicted for million dollar welfare fraud in Louisiana

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SourceURL: https://www.kalb.com/content/news/2-people-convicted-for-million-dollar-welfare-fraud-in-Louisiana-499090141.html

Image Source: MGN

BATON ROUGE, La. (LADOJ) - Two individuals have been convicted for a welfare fraud scheme costing Louisiana over $1 million.

Lanice Stamps, 39 of New Orleans, pled guilty to one count of Felony Theft and was ordered to pay $1,059,709.76 towards restitution for the money stolen and $300,000 to the MFCU in civil monetary penalties. She was also ordered to execute a mortgage to repay the State for Medicaid monies she used to pay her home mortgage.

Tia Smiley, 40 of New Orleans, pled guilty to one count of Medicaid fraud and was ordered to pay court costs and other fees, complete 100 hours of community service, and serve three years supervised probation. She and Stamps are now prohibited from maintaining employment, seeking employment, contracting with and/or maintaining an interest in any provider of Medicaid or Medicare.

“I commend my team for achieving these convictions which result in nearly $1.4 million back to Louisiana in restitution and civil penalties,” said Louisiana Attorney General Jeff Landry. “My MFCU investigators and prosecutors work tirelessly to protect services for those in need and the taxpayers who pay for this welfare; today is a great example of their fine efforts on behalf of our State.”

Stamps was the owner of a behavioral health company (A New Directions Support Services) while Smiley worked as her biller. On top of the scheme for which they were arrested and prosecuted as Medicaid providers, Stamps and Smiley were also both Medicaid recipients.

Auditor: DSHS failed to catch, report employee welfare fraud

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Medicaid Fraud, Waste and Abuse Curator: Volume 1

SourceURL: https://www.kitsapsun.com/story/news/2018/10/31/state-auditor-dshs-failed-catch-report-employee-welfare-fraud/1838065002/

Andrew Binion, Kitsap Sun Published 2:55 p.m. PT Oct. 31, 2018 | Updated 5:26 p.m. PT Oct. 31, 2018

Kitsap County courthouse(Photo: Kitsap Sun file)

OLYMPIA -- A Department of Social and Health Services supervisor who was one of Kitsap County's top welfare cheats over the past 10 years was able to rip off the system because the process the department used to determine her eligibility was not "effectively performed."

That finding, issued in October by the state Auditor's Office, also found the department did not "quickly" notify the auditor of the supervisor's illegal activity, as required by law.

The supervisor, fired in October 2017, was accused of taking $30,877 in child care benefits and $1,086 in food benefits through 2015 and half of 2016. When applying for the benefits, she

claimed she was a single parent living with her mother and she was her family's sole source of income.

"However, it was determined that she actually lived with her husband and their combined income made them ineligible for benefits," according to the Fraud Investigation Report published Oct. 4. The employee's husband was not charged.

MORE: Neighbors rally against Gorst quarry expansion

The woman had also received medical benefits from the state Health Care Authority. "However, the Department did not refer the complaint to the (Health Care Authority) to pursue the allegation of medical benefit misappropriation," according to the auditor's report.

The auditor also recommended the department report suspected losses and illegal activity promptly -- the department received an anonymous report of the employee's fraud in October 2015 but didn't tell the Auditor's Office until April 2017 -- and refer all reports of potential Medicaid fraud to the Health Care Authority.

The Kitsap Sun wrote about the woman's case in April after reviewing 20 cases of welfare theft charged in Kitsap County Superior Court dating back to 2008, the beginning of the "Great Recession."

Additional reporting into the cases -- which saw a significant uptick starting in 2016 -- found the employee had the ability to pay back the state in one lump sum, avoiding a felony conviction on her record. Paying back the money was part of her diversion agreement.

A woman of more modest means found to have scammed the department of $30,000 when she did not report her husband had moved back into her house -- after he was jailed on a domestic violence charge for assaulting her -- was unable to pay back the state all at once and did not receive diversion. She pleaded guilty and was sentenced to two months of house arrest.

She told the newspaper that she was a house cleaner and after serving her sentence feared she would be hindered in finding a job because of her felony record.

The auditor's report recommended the department ensure adequate oversight and monitoring "especially when it involves department employees."

In response to the recommendation the department strengthen oversight, the department wrote that earlier this year it made changes to its processes to reduce errors when counting members of households and ensure reviews for "high-risk" cases.

In response to the recommendation that it promptly report fraud to the auditor and the Health Care Authority, the department wrote that it was convening workgroups to develop procedures to do so.

NJ Comptroller: Illegal Medicaid Amnesty Deals Cut in Lakewood Case

NJ Comptroller: Illegal Medicaid Amnesty Deals Cut in Lakewood Case

SourceURL: http://thejewishvoice.com/2018/10/31/nj-comptroller-illegal-medicaid-amnesty-deals-cut-in-lakewood-case/

10/31/2018

After 26 Lakewood residents, all observant Jews and a prominent rabbi, were arrested on charges alleging they under-reported their incomes to qualify for benefits like food stamps, housing assistance and Medicaid, the amnesty program was formed.

A discrepancy has emerged in the office of the New Jersey state comptroller between the controller, Phillip J. Degnan and three levels of managers who work for him. The issue is in regards to the repayment of Medicaid fraud to taxpayers.

Degnan said that one of his employees went rogue by discounting $2.7 million on the repayment while the managers said the office knew about the already knew about the arrangements.

A memo from 2017 presents a conflicting account about the amnesty program offered by the office and adds to the controversy surrounding the program. In 2017, 159 Ocean County Residents came forward and admitted that they received Medicaid benefits that they were not eligible for. Ocean Country is situated along the Jersey Shore and it is where the Lakewood Township is located, where a large community of Orthodox Jews live, worship and learn.

While Degnan has refused to name the person has said was negotiating the deal for restitution payments, sources with knowledge of the amnesty program say it was Andrew Poulos Jr., an employee of the office since 2011. Poulos stopped working for the comptroller's office in December 12, 2017, the last day a person could submit an application for the amnesty program.

After 26 Lakewood residents, all observant Jews and a prominent rabbi, were arrested on charges alleging they under-reported their incomes to qualify for benefits like food stamps, housing assistance and Medicaid, the amnesty program was formed. Another factor according to officials in offering the amnesty program had to do with inadequate investigative means.

The program was financially a success. The office able to raise over $2.2 million – more than four times the amount the office had collected due to criminal prosecutions. However, it never amounted to the $2.6 million because of the lower repayment totals.

Moshe Newhouse, a Lakewood school board member applied for the program and only repaid half of the $48,000 in benefits he received between 2013 and 2015. Newhouse was faced with calls to resign from his position that he still serves under.

While acknowledging flaws in its execution, Degnan has defended the program while conceding flaws in its execution. The program was only open to Ocean County residents and applications were accepted from September 12 to December 12, 2017. Degnan's office does not use the wordage, "amnesty program." Degnan said that an internal investigation started when he discovered a staffer had been bargaining for lower repayments and ran contrary to Degnan's official statements that all benefits received unlawfully must be paid back in full.

However, a memo written by Poulos in late November reports that he had a meeting with three of his superiors after receiving a request to change the terms of the program. That request came from a Lakewood lawyer named Yosef Jacobovitch who represented many of the people who sought amnesty. His proposal was twofold: Either extending the repayment period or allowing the individuals to repay less money sooner.

By: Andrew Schiff

Mississippi man pleads guilty to misusing mother's money

Mississippi man pleads guilty to misusing mother's money

SourceURL: https://www.mrt.com/news/crime/article/Mississippi-man-pleads-guilty-to-misusing-13350736.php

Published 6:09 am CDT, Wednesday, October 31, 2018

JACKSON, Miss. (AP) — A Mississippi man has pleaded guilty to spending his mother's money on himself, rather than paying her medical bills.

WLBT-TV reported that 62-year-old Steven Adkins of Madison pleaded guilty Monday to one felony count of exploitation of a vulnerable person.

Adkins was sentenced to 10 years in prison.

An investigation by the Attorney General's Medicaid Fraud Control Unit found that Adkins spent more than $30,000 of his mother's money between March and December of last year.

The attorney general's office said Adkins withdrew money from her account and spent it on himself rather than paying her medical bills.

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Information from: WLBT-TV, http://www.wlbt.com

Abuse

Nurse pleads guilty to stealing opioid drugs while at Johnson County care facility

SourceURL: https://www.kansascity.com/news/local/crime/article220666170.html

Nurse pleads guilty to stealing opioid drugs while at Johnson County care facility

By Tony Rizzo

trizzo@kcstar.com

October 26, 2018 10:35 AM

Updated October 26, 2018 11:13 AM

A Johnson County nurse has pleaded guilty to stealing opioid drugs while working at a residential care facility in Gardner, Kan.

Jeremy Keith Bailey pleaded guilty Thursday in Johnson County District Court to possession of a controlled substance, theft and Medicaid fraud.

The Kansas Attorney General's Office said that Bailey, 41, surrendered his nursing license as part of the plea agreement.

Bailey was charged earlier this year with stealing the Percocet while working as a registered nurse at the Meadowbrook Rehabilitation Hospital.

Sentencing for Bailey is scheduled for Dec. 18.

Meadowbrook Rehabilitation Hospital Google Maps

Warrant: Albuquerque psychiatrist over-medicated hundreds of children in his care

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SourceURL: https://www.currentargus.com/story/news/local/2018/10/30/psychiatrist-drug-overdose-deaths-albuquerque-new-mexico/1812010002/

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New Mexico’s lax prescription oversight puts kids in danger

Barnes with her youngest grandson at home.

Amy Linn, Searchlight New Mexico Published 7:00 a.m. MT Oct. 30, 2018 | Updated 11:36 a.m. MT Oct. 30, 2018

Three of Barnes' grandsons at home.(Photo: Don Unser, Searchlight New Mexico)

Unlike many doctors, Albuquerque psychiatrist Edwin Bacon Hall, 74, accepted patients on Medicaid and saw them in a timely manner. He often treated foster children, who were sent his way with the approval of their legal guardian, the Children Youth and Families Department (CYFD).

On at least one occasion in his office, he prescribed drugs while dressed as a clown. But what really drew attention was the number of pills he handed out.

"Hall has been a scourge of child psychiatry, and people have known about his bad practices for years," said George Davis, CYFD's former director of psychiatry. "He was widely known as one of the worst prescribers in New Mexico."

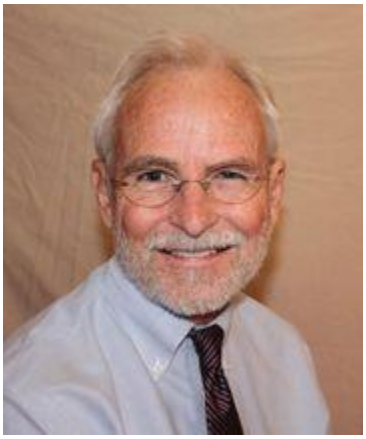
PRESCRIPTION FOR DISASTER: New Mexico's lax oversight puts kids in danger

Today, the longtime Albuquerque practitioner is under investigation by the New Mexico Attorney General's Office in connection with the drug overdose deaths of 36 patients, according to a search warrant filed in Second Judicial District Court on Sept. 5.

Attorney General Hector Balderas declined to comment on whether any of the deaths involved a minor. But the ongoing investigation includes an examination of Hall's prescriptions to both children and adults, he said.

MORE: A third of foster children on psychotropic drugs in some states received no oversight, study finds

The warrant accuses Hall of over-medicating 754 children in his care, prescribing an "elevated" number of psychiatric medications that were "outside normal prescribing habits."



George Davis (Photo: Don Unser, Searchlight New Mexico)

Law enforcement sources say Hall is also under investigation for alleged child abuse and Medicaid fraud. His attorney, Molly Schmidt-Nowara, declined to comment.

Agents with the state's Medicaid Fraud Control Division are now scouring records and correspondence from the doctor's Girard Avenue office. According to legal documents, the foster children he saw there -- many of them under age 10 -- received "egregious," "unprofessional" and "illogical" quantities of psychiatric drugs.

Alyssa Otero, 21, recognizes this firsthand. At 14, after being in and out of foster care all her life, she was deeply depressed and taken to Hall for treatment.

"The first time I met him, he was in a clown outfit," she says. "The orange hair, the makeup, the nose, everything."

Otero, a youth leader for NMCAN, an Albuquerque foster care advocacy group, remembers it all too clearly.

MORE: Generation Rx talks drug misuse

"He didn't say a word to me. He just handed me four months of prescriptions for Adderall. It was, 'Here's the prescription, here's the prescription, here's the prescription -- goodbye.'"

Hall may be an extreme example, but his case highlights the state's failure to protect children, a Searchlight New Mexico investigation has found.

"There are others like him out there," Davis affirms. "If there was the slightest oversight, he would have been out of business 20 years ago."

Barnes with two of her grandsons at home. (Photo: Don Unser, Searchlight New Mexico)

In 44 other states, psychiatric drug use is monitored or guided by child welfare agencies, Medicaid or health offices, pharmacy boards or managed-care organizations — each of which can put the brakes on a runaway prescriber.

New Mexico agencies also have the power of oversight. But even though CYFD workers approved Hall's prescribing actions — signing off on each medication change — they neglected to stop him, according to foster treatment records reviewed by Searchlight New Mexico.

MORE: Pecos Valley Drug Task Force gets $365K in federal grant funds

Davis tried. As head of psychiatry at CYFD, he says he repeatedly introduced measures that would "red flag" medical providers who misused their prescriptive powers.

A red flag works by triggering a peer review or demanding prior authorization when physicians deviate from "best practice" guidelines. For example, a doctor in Washington who prescribes two anti-psychotics to a 6-year-old can expect a specialist to intervene and review the case.

Davis says he first organized a task force in 2006 to study New Mexico's over-medication problem and find solutions. In 2013, the group proposed guidelines about medicating and properly monitoring children. They went nowhere, he says. In 2017, the task force issued a comprehensive report, formal guidelines and a cheat sheet to make the rules easy to follow. Neither CYFD nor the Human Services Department (HSD) published them or made them enforceable, according to Davis.

In response to a request by Searchlight for the 2017 report, CYFD on Sept. 11 said there was “no written material on the topic.” Two weeks later, the agency reversed itself.

Bryce Pittenger, director of Behavioral Health Services, said the report did exist and “was not buried or put on a shelf.” She said it was emailed to HSD, the secretary of CYFD, the state’s managed care organizations, behavioral health providers and dozens of “stakeholders.”

But she also acknowledged that publishing the report might be a good idea.

“I’ll have to ask the secretary about that,” Pittenger said.

Path to investigation

It finally took a grandmother to spark an investigation into Hall’s practices. It happened in 2016, after she discovered her three grandsons were ingesting seven powerful psychiatric drugs a day. The drugs were prescribed by Hall, the children’s psychiatrist during a two-year period when they were in foster care.

Outraged, she sought the advice of a Santa Fe psychiatrist, who alerted Davis at CYFD. Davis, in turn, filed a complaint with the New Mexico Medical Board; it included his review of the medical files for 15 children, nearly half of whom had received drugs that might interact in dangerous ways.

According to the search warrant, all 15 children were referred to Hall by Red Mountain Family Services in Rio Rancho, the same treatment foster care agency responsible for the three grandsons. Requests to Red Mountain for comment went unanswered.

The Medical Board launched an investigation in May 2016 and suspended Hall’s license 17 months later, in October 2017. Among the reasons it gave were the numerous patients who had died while under his care.

Those revelations have so far led to three civil suits. Two charge Hall with medical negligence. One is a wrongful death suit filed in Second Judicial District Court on behalf of a 25-year-old mother of two. For four years, Hall gave her prescriptions for amphetamines and

benzodiazepines, addictive sedatives, the lawsuit says. She died of an accidental overdose Feb. 6, 2017.

Searchlight New Mexico is a nonprofit, nonpartisan media organization that seeks to empower New Mexicans to demand honest and effective public policy.