FROM THE DESK OF:
ILLINOIS STATE REPRESENTATIVE DWIGHT KAY
112TH DISTRICT

PRESS RELEASE - 25 JUNE 2014

Your Tax Dollars Are Buried in the Backyard

The Illinois media recently reported that Illinois' Department of Healthcare and Family Services paid $12 million in Medicaid benefits for deceased Illinois Medicaid recipients. These improper payments of taxpayer dollars are an example of why Illinois is cash strapped. More disturbing is my investigation of the past year that has discovered that HFS has routinely failed to protect Illinois taxpayers from fraud.

In 1999, the Healthcare and Family Services Office of the Inspector General knew they had a problem. The OIG staff reviewed a limited set of data containing three months of claims. They discovered that 963 deaths were reported during the fourth quarter of fiscal year 1997 and $1,119,269 in inappropriate payments were made to 94 providers on behalf of 145 deceased clients. What did HFS do? NOTHING. Not one corrective, preventive measure was taken by HFS.

My investigators learned that this issue would resurface year after year in HFS meetings. The problem is not unique to Illinois, but it is obvious that Illinois' Department of Healthcare and Family Services is not tough on waste or fraud. In the past two years alone, most of the fraud cases have been settled via loose corporate integrity agreements that have not permitted the state to recover funds rightfully due the state.

In the years prior to the Quinn administration hundreds of cases were sent to the Medicaid Fraud Control Unit. Then, that trend came to an end. The problem was so alarming that the Illinois State Police sent a letter on November 29, 2010, to John Allen (the OIG at HFS) detailing that they had not received cases from the OIG. It was common for 1,600 plus Illinois cases to be referred to the OIG each year for investigation of potential fraud. It is required by Federal Law (ACA, Section 6402(h)(2)) that once a credible allegation of fraud is made that all payments to the provider are suspended. My investigation team has interviewed state employees that have said that the providers are checked against campaign donors prior to any referral to the Illinois State Police. I wonder if the lack of referrals to the ISP relates to mismanagement or campaign donations by certain medical providers?

In 2011, the federal government enacted the Electronic Health Record Incentive Program to incentivize doctors to adopt, implement and upgrade medical record systems. The program has a requirement to check the death files against the recipient and provider roles during the EHR start-up. The program was administered by Renee Perry.

Through my investigation, I have obtained records reflecting that Wyona Johnson and Eppie Dietz, both working for HFS's Office of the Inspector General, were scheduled to meet with an EHR staff responsible for discussing death match files, since the law requires that providers are checked prior to issuing payments. Fifteen meetings were scheduled with OIG supervisors Johnson and Dietz. The EHR staff sat in a conference room with no one from the OIG's office to meet and deliberate. The EHR staff were deemed irrelevant since Johnson and Dietz both chose not to attend these meetings and did not bother to call or reschedule these meetings.

My investigation also discovered that eventually the EHR staff conducted its own research and learned that the versions of the data files were seven years old, thus the potential to pay a Medicaid provider for a deceased recipient was very high. This matter was researched by EHR staff with the assistance of Mark Langenfeld whom managed the Medical Data Warehouse which holds all of the Medicaid claims. Subsequently, Renee Perry moved to another position in state government and with their history within HFS, both Johnson (formerly Rod Blagojevich's Inspector General and Ethics Officer) and Dietz took employment with the HFS Office of Information Systems. This office has been under attack for its decisions to outsource government jobs to H1B visa workers. Johnson took control of the very program that mandates the double-check of death match files. To date neither Johnson nor Dietz have stepped up to fix the problem that has led in the past to the Medicaid payments to providers of deceased clients amounting to millions.

Unfortunately, Director Hamos seems to have been left in the dark by her own staff and has brought in Avery Dale, Manager of Special Projects with the Division of Medical Programs, to investigate the reason(s) the state is years behind in checking the deceased files. The death matching is really tangential to the systemic failures of HFS in regards to fraud detection.

Under the direction of OIG Brad Hart, and at the time Wyona Johnson, the OIG have held, and continue to hold in “technical review” hundreds of fraud cases with credible allegations of fraud. Why are cases being held? The Affordable Care Act provisions require HFS to suspend payments to any provider whom HFS refers to the Illinois State Police Medicaid Fraud Control Unit. As one whistleblower described it, “Wyona Johnson was responsible for deciding what cases are assigned and what cases are sent to the Illinois State Police Medicaid Fraud Unit to be further investigated and she along with Brad Hart held cases in fear of retaliation by the political powers during election time. The providers committing fraud are connected at the highest levels.”

The problem was so alarming that in November 2010, Illinois State Police Captain Mike Zerbonia stated in answers to a Senate Committee inquiry, “suggestions have been made...but no actual changes have occurred” in five years and “we could provide recommendations that could reduce fraud, but the bureaucracy has to be willing participate....and not actively stifle our recommendations.”

There are solutions to the problems that confront HFS. The insurance industry has used various methods of data collection to determine if a person is deceased. Mandated billing transactions can be implemented similar to the ones required to be sent when a baby is born to a Medicaid recipient. In the final analysis it comes down to some fundamental issues. In the last year alone it is estimated that the same management personnel referenced above have been responsible for hiding over $80 million in fraud from the Illinois Auditor General and the general public.

HFS under Rod Blagojevich referred 80% less potential fraud cases than the administration before him. Under the Quinn Administration almost no cases of potential fraud have been referred to the Medicaid Fraud Control Unit at the Illinois State Police for investigation and prosecution. Anytime HFS refers a case to ISP they are required to suspend payments. Has all the fraud stopped or have we merely created a system that allows some providers to avert Medicaid fraud investigations as long as they are a campaign donor?

Why all my interest? I am a sitting member on the Human Services Appropriations Committee of the Illinois House of Representatives which has constitutionally mandated oversight authority over the Department of Healthcare and Family Services. It is my job to see that taxpayers are protected. It is also my job to assure that taxpayer's money is properly spent and those that are committing fraud are prosecuted.

END
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----- Forwarded by Timothy Becker/IlStPolice on 11/24/2010 11:33 AM -----

Michael Zerbonia/IlStPolice

11/24/2010 11:01 AM

To Timothy Becker/IlStPolice@IlStPolice

cc

Subject Questions

Here are the answers....let me know if you need anything else.

(See attached file: Medicaid Questions.docx)

Captain Mike Zerbonia
Medicaid Fraud Control Bureau
[redacted]

Illinois State Police
Captain Michael Zerbonia
Lieutenant William Colbrook

1. What is your Agency's role in the Medicaid system?

The Illinois State Police Medicaid Fraud Control Unit (ISP-MFCU) is funded by the federal Department of Health and Human Services (DHHS) specifically to combat fraud within the Medicaid system and assist the DHHS-Office of Inspector General (DHHS-OIG) in similar Medicare investigations. Through multiple task forces established through the Department of Justice, the ISP-MFCU coordinates the fight against health care fraud with the three United States Attorney's Offices, DHHS-OIG, the FBI, the Illinois Attorney General, and numerous other federal, state and local law enforcement agencies. Additionally, the MFCU works with the Illinois Department of Public Health (IDPH) to combat the exploitation, abuse, and neglect of Medicaid recipients

2. How much of your budget is tied to the Medicaid system? How many Medicaid recipients do you serve? Through which programs?

The ISP-MFCU expends 25% of its budget from state GRF funds. The remaining 75% of the budget is funded through DHHS via federal funds. These funds are NOT attributable to health care expenditures for recipients and are separate and apart from those types of expenditures. Therefore, there is no "service" to Medicaid recipients. Federal rules prevent the ISP-MFCU from pursuing fraud committed by "recipients" of the Medicaid system; however, there are some instances when recipient abuse may be investigated to further the investigation of fraud by a provider.

3. From your Agency's viewpoint, what is the best way to reduce Medicaid costs without severely impacting services?

Without going into voluminous arguments about what services should be provided... The best way to reduce costs of the Medicaid system and its numerous "waiver" programs is to alter the culture of the departments that service those programs. The local bureaucrats operating the programs do not "see" fraud, only their assistance to people with needs. Never comprehending that those people might be "gaming" the system. The courts question why the state "pays and chases." (i.e., pays for services then chases down those that abuse the system and tries to get the funds back when those funds are no longer available.) The application and initial background check process must be tightened up. Stop increasing the appropriations for those programs that are havens for abuse and fraud, or lack the ability to assist law enforcement with prosecution (*DHS-ORS has gone from $250m to $450m+ in the few years that we've been dealing with them*). Tighten up documentation requirements for waiver agency programs so that individuals

cannot obtain funds without being able to verify the provision of services (DHS-ORS, Aging's Homemaker program, etc). Suggestions have been made, forms provided since 2005, but no actual changes have occurred. Put in OIG's that have the authority, experience and desire to combat fraud…DHS-OIG has no fraud authority. Other areas that could be enhanced are as follows:

- providing direct access to Medicaid fraud units,
- increasing the size and budget amounts of Medicaid Fraud units,
- removing "pro-active" limitations imposed on the Medicaid Fraud units,
- mandating revisions to programs currently ramped with fraud
- review and limit the ability of Medicaid/Medicare provides to donate large campaign contributions to political figures,
- limit the lobbyist influence which hinders the successful implementation of anti-fraud initiatives

4. What is your Agency doing to maximize federal funding? What else can the State do to capture these funds?

Other than maximizing the expenditures we incur to obtain the full amount of federal funding, this question does not apply to us.

5. What is your Agency doing to combat Medicaid fraud and waste? What else can the State do?

The ISP-MFCU's obligations under the federal rules are to investigate, prosecute and review the operations of the Medicaid system and provide feedback to the Single State Agency (HFS) related to operational changes, rules changes and the like which will combat fraud. Unfortunately, our concerns often are left by the wayside by the bureaucracy. i.e., we suggested that the Nicoderm rules needed changed (in 2005) to prevent the black market of recipients obtaining prescriptions for Nicoderm, and selling the goods back for cash…no action taken although the Department's OIG stated that they were in the process of taking action when questioned by the feds; we questioned the OIG's office regarding duplicate payments/claims from non-emergency transportation providers…little action has ensued; we altered the claims forms for DHS-ORS personnel to simply include the times worked by the providers, which has resulted in numerous convictions in the only area where this is required by the local office, but that form and those suggested changes have NEVER been implemented. We could provide recommendations that could reduce fraud, but the bureaucracy has to willingly participate…and not actively stifle our recommendations. The revocation of "collective bargaining rights" could be revoked and the hourly wages for PA's could be reduced back to minimum wage. They are unskilled, generally non-service providing people anyway. As for the state, the government can start restricting the programs (require those with eligible insurance through their employer to obtain that insurance coverage before All-Kids participation is allowed. Many people getting on All-Kids have insurance available to them through employers, but don't want the funds taken out of their check when the taxpayers can pay for children's care). A complete review of all

programs should be conducted. For instance, the Personal Assistant Program through the Department of Rehabilitation Services and babysitting services are wrought with fraud.

6. What steps has your Agency taken to comply with the new Federal Affordable Care Act? How will this Act's implementation impact your Agency?

To my knowledge, we have not had any particular actions toward implementation. We are more on the enforcement side, which should provide us additional federal funds (through HHS-OIG or CMS) to perform investigations and prosecutions. The act itself does not directly affect our operations other than the fact that the system will expand by 700,000 recipients; which will increase the potential for provider fraud.

7. Can you identify any inefficiencies within our State's Medicaid system? How can these inefficiencies be corrected?

The single biggest inefficiency within the Medicaid system is the detection of fraud. The Single State Agency (HFS-OIG) has minimal staff working in their fraud detection unit. Additional staffing in the HFS-OIG fraud detection office would more than pay for itself in stopping fraud and the recoupment of funds. These inefficiencies and loopholes in the systems could be remedied through implementation of rules, policy changes, provider/recipient education, etc

8. Can you identify any loopholes within state statute or administrative code that have allowed for Medicaid fraud?

An example of this would be the 90853 rule which allowed significant fraud for years before it was changed by the J-car committee after significant efforts of the ISP, MFCB. An overall review of the rules governing the Medicaid disbursement would be recommended; with input from the law enforcement and prosecutorial offices which handle Medicaid fraud (other examples would be allowing a spouse to care for their spouse through the ORS programs and stopping rule changes that would limit the abuse of the group psychiatry codes).

Death Notification Project

Identifying the Cause of Delay in Notifications

OIG 00-0046

February 2000

Death Notification Project Report
February 15, 2000
Page 1

Introduction

Historically, the Department of Public Aid (DPA) has been challenged by a lack of timely notification when clients die in long term care facilities. DHS local offices contend that providers fail to give timely notice. Providers respond that they have provided the notice and that the DHS local office has not processed the death notification. In either event, the taxpayer loses because overpayments occur. In effect, these overpayments are an interest-free loan to long term care providers. However, they are eventually recovered through an automated reconciliation process.

In 1997-1998, the Office of Inspector General (OIG) examined this problem in its study of postmortem payments to long term care providers. The OIG reviewed 963 deaths reported in the fourth quarter of FY 1997. On average, the client's case record was not corrected for 171 days after date of death. We found $1,119,269 in payments the department continued to erroneously make because it was unaware the client had died. The vast majority of those overpayments were made to the nursing homes themselves.

However, in 49 cases there were also non-institutional provider overpayments. In those 49 cases, a more in-depth study found 116 services supposedly provided to the client after death. Although the dollar impact is small ($7,301) by comparison, one-fifth of those services are potentially fraudulent on the part of the provider, rather than inadvertent error.[1]

Beginning in the spring of 1998, the DPA and the Department of Human Services (DHS) initiated steps to help correct this problem. First, nursing homes were instructed to simultaneously notify DHS' Exception Processing Unit (EPU) when they notified the DHS local office of a patient's death. Second, in October of that year, DHS implemented a process to serve as a safety net for the DHS local offices and DHS' EPU. If neither of those entities canceled the case, a match against the Social Security Administration's automated BENDEX report would catch the error after 60 days. [2]

In the fall of 1998, attention to this issue was also heightened when the Office of Auditor General (OAG) cited the department on the subject of timely notifications. Its report stated: "The Illinois Department of Public Aid could be quicker in stopping payments to nursing homes for long-term care (LTC) after residents die or leave." It further recommended that DPA "continue its efforts to implement a system to detect an overpayment situation prior to payment." The agency accepted this finding.

In the late summer of 1999, DPA Director Ann Patla requested that the OIG coordinate a study to determine who is responsible for untimely notice upon the death of long term care patients with the purpose of factually identifying systemic weaknesses and determining if specific problems had been mitigated. If not, Director Patla wanted recommendations to ensure these

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[1] No automatic reconciliation and recovery occurs for overpayments to non-institutional providers.

[2] On April 9, 1999 DHS requested that BENDEX match death records not only against active cases, but inactive cases as well (PIR #38893). This process would ensure automatic reconciliation for inactive cases that had been canceled for reasons other than death. As of January 28, 2000, this request has not been completed.

problems did not continue. In August of 1999, OIG, DHS Community Operations and DPA Medical Programs staff formed a workgroup to accomplish that task.

Review Process

The workgroup first decided to focus on the long term care facilities with the highest incidences of overpayments due to late notice of death. The top 26 such providers represented 627 long term care clients whose deaths occurred between January 1, 1999 and June 30, 1999. Each of these cases had already been canceled. They were split nearly equally between those with payments after death and those for which no overpayment occurred. A random sample of 239 cases with the same proportions was drawn. The review involved 16 DHS local offices covering these 26 nursing homes. Presumably because they are the most populous counties, the bulk of the cases were located in Cook (Nursing Home Services) and DuPage counties.

The study's primary goal was to identify whether nursing homes or DHS local offices are responsible for late case cancellations due to death. To do that, reviewers tried to determine: 1) the correct date of death; 2) if the long term care facility made the death notification; 3) if and when the DHS local office and DHS' EPU received the death notification; 4) which entity actually canceled the case and 5) when the case was canceled. In some cases, we were unable to confirm the second and third points.

To accomplish those tasks, reviewers first checked with DHS' Exception Processing Unit. If the case had been canceled there and all other necessary information was available, no further examination was required. If not, the reviewers visited both the nursing home and the DHS local office to examine their respective records. The final step was to contact the Illinois Department of Public Health for death verifications not captured through the review process by that point.

During the review process, we discovered that in the majority of cases the data in the MMIS eligibility file did not match the MMIS LTC Segment. Data systems changes (PIR # 40009) were completed in January 2000 to ensure that these two files are kept in synch. In addition, all cases in this review requiring MMIS corrections were completed by either DHS' EPU or DPA's BLTC in December 1999.

Appendix 1 of this report documents the findings on each of the 239 cases examined in this study. Appendix 2 lists the 26 facilities with aggregate information on their performance in this area. Finally, Appendix 3 depicts our findings by DHS local office.

Findings

- A significant number (21%) of all death notification forms (Long Term Care Facility Notification - more commonly known as the DPA 1156) were unable to be located.[3] Of the 79% we did find, only 27% were signed by the provider within the required five days after the client's death. Of the located forms, 18% were completed more than 51 days

[3] We accept two premises related to this issue. 1) If located and completely filled out, the DPA 1156 was completed by the nursing home on the date reflected next to the signature space on the form. 2) The nursing home actually submitted the DPA 1156 on that same day.

after death. The most extreme example was one that was signed 305 days later. On average, 32 calendar days elapsed between the death and the signature date on the form.[4]

- The DHS local office canceled 54% of the cases. Social Security Administration's automated BENDEX system canceled 32% of the cases.[5] DHS' EPU canceled the balance (14%) of the cases. EPU's cancellations averaged 26 days after death while the DHS local office took an average of 46 days and BENDEX's average was 75 days.

- It is impossible to empirically determine if providers are generally complying with the requirement to also submit the DPA 1156 to the EPU. DHS' EPU only keeps the forms for the cases it actually cancels and does not date stamp these forms. However, it appears compliance is low for two reasons. First, we found DPA 1156s at DHS' EPU from only eight of the 26 providers in this review. Second, of the 64 DPA 1156s located at DHS local offices, 13 of them represented cases that were ultimately canceled by BENDEX. Of these 13 cases, only 1 was received within 5 days of death. If there were widespread submissions to EPU, those cases should have been canceled there instead.

- Untimely case cancellations caused significant overpayments. DHS' EPU accounted for the least loss with only seven of its cases causing overpayments totaling $14,101. Cancellations by the DHS local office (58 cases with $199,846 in overpayments) and BENDEX (54 cases with $211,372 in overpayments) were roughly equal.

- Of all overpayment cases, 75% remained active at least 60 days after death before cancellation. DHS' policy to not centrally cancel cases (BENDEX) until at least 60 days after death contributes to this.[6]

- Even as a safety net, however, BENDEX is problematic in that it automatically uses the last day of the month as the date of death. Further, it is only available for data matching on a monthly basis. The vast majority of BENDEX-canceled cases require additional intervention to correct the date of death.[7]

- There is no one "best" source of accurate, timely and automated information on client deaths. BENDEX only includes the month and year of death. Social Security Administration's State Online Query (SOLQ) system includes the actual date of death and

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[4] All days in this report are calendar days.

[5] SSA's BENDEX files that have received a death code (T1 or X1) for two consecutive months are matched monthly against active single person cases within DHS' Client Information Database (CIS) for central cancellation.

[6] DHS' premise is that canceling the case the first time the client is reported by SSA to be dead would mean that some of those cases would have to be later reinstated if the list was inaccurate.

[7] Until the date of death is corrected, no automatic reconciliation and recovery can occur for the period from the date of death through the end of the month in which BENDEX canceled the case.

would likely be a better source of information.[8] However, in 18 of the 239 cases in the sample, SOLQ appeared to have an inaccurate date of death.

- We were able to accurately determine the timeliness of DHS local office cancellations in 25% of the cases canceled by them. Of those, cancellation took an average of 18 days from receipt of the DPA 1156.

- The requirement for providers to notify DHS' EPU was not effectively implemented. In April 1998, DPA notified providers through an Information Notice to submit the DPA 1156 to DHS' EPU within five days of a patient's death. The notice provided a mailing address, advised that a fax machine would be installed, and stated that the Department would notify facilities of the number once it is available. The fax machine was not installed for approximately one year. It then took DPA until August 1999 to issue a Provider Bulletin notifying providers of the fax number.

- Poor record keeping at both long term care facilities and DHS local offices was a major impediment to conducting this study. Nursing home files were missing 20% of the DPA 1156s. DHS local offices could not find 24% of client case files (the entire file was missing). Of the DPA 1156s located at nursing homes, only 38% were located at the DHS local offices. Even for those cases canceled by the DHS local office, only 40% of the DPA 1156s could be located.

It is important to note these findings do not represent the universe of all LTC facilities, but only those 26 with the highest incidences of overpayments due to late notice of death.

Recommendations

- Enforce the requirement that all providers submit by fax the DPA 1156 to the Exception Processing Unit within five days of the client's death. Require all providers to maintain evidence of submission such as the fax confirmation sheet.

- Increase monitoring of the 26 nursing homes in this study that have the most egregious conduct to include, but not necessarily be limited to:
  - Place them on written notice of these findings.
  - Re-examine their conduct within one year. If they fail to follow procedures, refer them to the Medicaid Fraud Control Unit for criminal investigation and prosecution under the False Claims Act.
  - Review the viability of placing these providers on a payment system with additional and increased integrity measures.
  - Mandate participation in the Long Term Care EDI program that is currently being tested.[9]

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[8] SOLQ contains data on SSA, SSI and Medicare recipients.

[9] The Electronic Data Interchange (EDI) project is voluntary and allows nursing homes to electronically notify Public Aid of changes relative to a patient's status. It is expected to be fully operational statewide by

- Put into rule the language from the federal Office of Inspector General Draft Compliance Program Guidelines for Nursing Homes (October 19, 1999 Federal Register) regarding expectations that nursing homes will adopt aggressive internal programs to prevent billing errors, inappropriate billing and the keeping of overpayments. Evaluate placing such language in all or some of the following documents: Provider Agreements, Provider Manuals, Prepayment Notices, Remittance forms, and the Billing Certification that is produced with every electronic transaction. Adopting this language will allow us to:
  - Withhold payments for late submittals of deaths as we do for provider cost reports that are not submitted timely.
  - Develop a new audit program to define which facilities are not timely in reporting deaths.

- Assess the feasibility of replacing BENDEX with SOLQ to capture the actual date of death.

- Continue to monitor the Consolidated Death Match Report for appropriate cancellations or corrections on cases with deceased recipients. Begin recommending that DHS take the required corrective action on individual Medicaid cases that remain active or have incorrect data.
  - Identify any NIPS claims paid after the date of death and take recoupment measures when appropriate.

- Systematically transfer MDS nursing home reported deaths to the client data base (and MMIS) so that a recipient discharge would be done.[10]

Conclusion

The intent of this project was to identify responsibility for late case cancellations. It is common to find that there is no one party that is completely at fault.

- The Department of Public Aid was not effective in encouraging compliance as DHS' EPU fax number was not published until August 1999.
- A standard for timely handling of DPA 1156s received from providers should also be established.
- DHS local offices, particularly Nursing Home Services and DuPage County, need to do a better job in terms of record keeping and timely action. Their inability to locate a significant portion of the case files or even a majority of the DPA 1156s in the sample makes empirical examination of this problem more difficult.
- If DHS' EPU had kept all DPA 1156s received on file, there would have been a better audit trail for this review.
- The current BENDEX policy guarantees at least 60 days pass before cancellation for those cases missed by both the DHS local office and DHS' EPU.

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summer 2000. Currently, DPA is already receiving more than 1,500 such electronic notices every month.

[10] This recommendation was initiated on June 16, 1999 (PIR #39271) by DPA's Division of Medical Programs. As of January 28, 2000 it has yet to be completed.

The actions of both DPA and DHS have the net effect of "providing cover" to the nursing homes' contention that they act timely. Nonetheless, we believe it is clear that such a contention would be unfounded, at least for the nursing homes studied in this project.

The lion's share of responsibility for late cancellation of cases due to death lies with the provider. First, there is no evidence that the facility completed a DPA 1156 in 21% of the cases. In the remaining cases, 73% were completed later than the policy time requirement. It appears that most nursing homes are not submitting the DPA 1156 to DHS' Exception Processing Unit. Finally, the provider stands to gain financially and has nothing to lose if it fails to comply to make timely notifications of client deaths.