ADDRESSING MEDICAID FRAUD AND ABUSE-2011

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GOALS OF THIS PRESENTATION

- THE NEW CONTEXT IN FRAUD AND COMPLIANCE
- RISKS IN THE NEW CONTEXT FOR ORGANIZATIONS
- LESSONS FROM THE DECEASED PATIENTS PROJECT
- COMPLIANCE AND SECTION 6402 of PPACA-DUTY TO REPAY IDENTIFIED OVERPAYMENTS

TRENDS IN THE LAW OF FRAUD ABUSE AND COMPLIANCE

- OLD MODEL-FRAUD-INTENTIONAL CONDUCT
- OLD MODEL-ABUSE-SUSPECTED BUT UNPROVEABLE INTENTIONAL CONDUCT;PATIENT NEGLECT OR MISTREATMENT
- NEW MODEL-FAILURE OF COMPLIANCE SYSTEMS AND CONTROLS
- NEW MODEL-"IMPROPER PAYMENT" OR "OVERPAYMENT"
- "RETENTION OF OVERPAYMENT"

DEALING WITH THE BIGGEST CUSTOMER

- PREDICTIONS
  - government payors for more of market (combination of public availability, mandates for private insurance)
  - Medicaid-increasing federal oversight of state program integrity efforts, takebacks from states for improper payments
  - Data hunters, gatherers, miners –RACs, MICs, specialized aggregators, portals, math anomaly experts

DEALING WITH THE BIGGEST CUSTOMER

- MEDICAID OVERSIGHT
  - Deficit Reduction Act (2006)
    - Medicaid Integrity Group
    - Medicaid Integrity Contractors
    - Medicaid program integrity reviews
    - Payment Error Rate Measurement (PERM)
    - Inspector General work plan and takebacks
    - State False Claims Act incentives
    - Mandatory Certification-inform employees of whistleblower rights

DEALING WITH THE BIGGEST CUSTOMER

- 2009 Fraud Enforcement and Recovery Act Amendments (FERA)
  - Liability for improper retention of overpayments
  - Enhanced whistleblower protections (including protection of “contractors” as well as employees)

DEALING WITH THE BIGGEST CUSTOMER

- AFFORDABLE CARE ACT(ACA)-2200 pages to change health care-AND FRAUD AND COMPLIANCE (SECTIONS 6400-6500)
  - MANDATORY DISCLOSURE OF OVERPAYMENTS TO MEDICARE AND MEDICAID-PPACA Section 6402 (a)
  - MANDATORY COMPLIANCE PROGRAMS
  - MANDATORY SUSPENSION OF PAYMENT UPON INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD BY MEDICAID Section 6402 (h)
- 2010 SENTENCING GUIDELINES ON "EFFECTIVE" COMPLIANCE PROGRAMS

DEALING WITH THE BIGGEST CUSTOMER

- “Improper payments” rather than intentional conduct is new federal standard- Improper Payments Elimination and Recovery Act (“IPERA” 2010)
- IPERA - $50 billion reduction in improper payments between 2009 and 2012
- IPERA - federal commitment to incentivized audit contractors
- Data mining and analysis-no longer just claims data, but quality data, performance data, denials, overrides, claim resubmissions

WHAT NEEDS TO BE DONE TO PREVENT HEALTH FRAUD, WASTE, AND ABUSE-POPULAR VIEW

- CBS Sixty Minutes October 2009
- Didn't anybody in Medicare check to see if any of these charges were valid?" Kroft asked Tony.

  "Sometimes they'll do it. But by the time they did it, it was too late," Tony said. "We've already made $300,000, $400,000, $500,000 on it. And then we will never send 'em nothing back. And then at 30 days they'll send an inspector to your office. And by that time...it's all closed down."

LAW ENFORCEMENT CURRENT RESPONSE

- “We will punish these criminals to the **fullest extent** of the law …”
- “We're bringing to bear the full resources of the federal government against individuals and corporations who illegally divert taxpayer resources for their own gain.
- “ . . .our approach is working. HEAT has enabled the recovery of stolen funds and the return of millions of dollars to the U.S. Treasury and the Medicare Trust Fund.”

CONTROLLING HEALTH CARE FRAUD AND ABUSE REQUIRES A PREVENTION STRATEGY AS MUCH AS A PROSECUTION STRATEGY

- Who gets into the program? (enrollment, exclusion)
- How do we oversee providers once in the program?
- What controls do providers themselves have to assure compliance and prevent fraud and abuse?
- How do agencies respond to information suggesting fraud or abuse?

CONTROLLING HEALTH CARE FRAUD AND ABUSE REQUIRES A PREVENTION STRATEGY AS MUCH AS A PROSECUTION STRATEGY

- Inspection before admission into program
- Undercover investigations-random and predicated
- Mandatory compliance programs
- Exclusion of individuals who violate their duties
- Focus on compliance/ disclosure obligations of health care providers

THE NEW STANDARD-EFFECTIVE COMPLIANCE PROGRAM

- MANDATORY COMPLIANCE PROGRAMS FOR ALL MEDICAID PROVIDERS OVER $500,000/ YEAR (NEW YORK)
- ALL PART C and D PROGRAM PLANS
- MEASURING COMPLIANCE OUTCOMES, NOT JUST STRUCTURE OR PROCESS
- MANDATORY REPORTING OF OVERPAYMENTS WITHIN 60 DAYS OF IDENTIFICATION

MEDICAID MANAGED CARE

42 CFR § 438.608 Program integrity requirements

- (a) *General requirement.* The MCO or PIHP must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.
- (b) *Specific requirements.* The arrangements or procedures must include the following:
- (1) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards.
- (2) The designation of a compliance officer and a compliance committee that are accountable to senior management.
- (3) Effective training and education for the compliance officer and the organization's employees.

MEDICAID MANAGED CARE **42 CFR § 438.608 Program integrity more specific requirements**

- (4) Effective lines of communication between the compliance officer and the organization's employees.
- (5) Enforcement of standards through well-publicized disciplinary guidelines.
- (6) Provision for internal monitoring and auditing.
- (7) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's or PIHP's contract.

ACA COMPLIANCE REQUIREMENTS-NURSING FACILITIES

- **Section 6102 of the Affordable Care Act requires a nursing facility or skilled nursing facility to have in operation a compliance and ethics program** by March 24, 2013; final CMS regulations required by March 24, 2012
- Draft CMS regulations expected fall 2011

ACA COMPLIANCE REQUIREMENTS-ENROLLMENT

- **Section 6401(a) of the Affordable Care Act requires that providers and suppliers, as a condition of enrollment in Medicare, Medicaid or CHIP establish a compliance program that contains certain "core elements"**
- – The Secretary, in consultation with the HHS OIG, must establish core elements
- – The Secretary may determine the date that providers and suppliers must establish the required core elements
- – The Secretary **must** consider the extent to which adoption of compliance programs by providers or suppliers is widespread

TESTING FOR EFFECTIVE COMPLIANCE PROGRAMS-BILLING FOR DEAD PATIENTS

- EVERY MONTH, THREE HUNDRED CLAIMS ARE SUBMITTED TO NY MEDICAID FOR DECEASED PATIENTS.
- NOT ALL ARE PAID (IF MORE THAN 30 DAYS LATE, EDIT SHOULD STOP PAYMENT) BUT-
- WHY DO HOSPITALS, NURSING HOMES,PHARMACIES, AMBULETTES BILL FOR DEAD PATIENTS?
- WHAT DO DEAD PATIENT CLAIMS TELL US ABOUT SYSTEM WEAKNESSES?
- KEY-INFORMATION ABOUT CAUSATION, NOT JUST COLLECTION OR PROSECUTION
- WHEN AN IMPROPER PAYMENT IS IDENTIFIED, ROOT CAUSE AND RESPONSIBLE INDIVIDUAL ARE IDENTIFIED

NEW YORK DECEASED PATIENT PROJECT

- DECEMBER 2009-300+/- certified letters, return receipt requested
- Tell us: person who performed service, person who prepared bill for service, documents supporting claim, and-
- Tell us if the person is not actually dead (based on prior rates, about 3%)
- Please get back to us in two weeks.
- Send us a check if you got paid for an improper claim.

NEW YORK DECEASED PATIENT PROJECT

- By December 23, less than 2/3 of providers responded
- About 65 send checks-most with no other documentation
- Some providers explain that they are allowed to bill for a month, as long as the patient is alive for one day (in some cases, they are correct)
- I join my staff in calling non-responders

NEW YORK DECEASED PATIENT PROJECT

- SOME NON-RESPONDERS INCLUDE MAJOR HOSPITALS AND OTHER HEALTHCARE INSTITUTIONS
- SYSTEMS ISSUES-BILLERS WHO GET LETTER AFRAID TO TELL PHYSICIAN
- COMPLIANCE OFFICERS WHO GET LETTER DO NOT KNOW WHAT TO DO
- WHO OWNS THE PROBLEM? WRONG QUESTION

LESSONS FROM DECEASED PATIENTS PROJECT

- Provider states that, " ABC Homecare was unaware that the patient was deceased at the time the service was billed to Medicaid and would have no reason to believe that the patient was deceased since the primary insurance had paid the claim". “ We will advise the provider to void the claim.”
- LESSON: Provider relies on payment system rather than compliance system to assure claim is accurate.

LESSONS FROM DECEASED PATIENTS PROJECT

Provider states that, " The cause of this error in billing was due to a lack of communication on the part of the early morning driver who was responsible for transporting these patients. The drivers lack of both performance and professionalism led to his termination".

LESSON: Provider blames employee for system failure. Did compliance assess risk of other improper claims related to this driver?

LESSONS FROM DECEASED PATIENTS PROJECT

- Provider states that, " Please be advised that due to a clerical error with our billing system, billing incorrectly occurred on 6/20/09 and 6/23/09. We are voiding both claims and returning the money received. We discovered, upon further investigation, that the above recipient had been a "standing order" whom we transported to and from renal dialysis treatment three times a week for several years. We placed a "Hold" on this recipient which was inadvertently missed by the billing clerk and two claims were billed in error".
- LESSON: Provider blames employee for system failure- How often did the “hold” system not work?

LESSONS FROM DECEASED PATIENTS PROJECT

- Provider states that, " Patient's son called to request refill for the above date of service and the signature was also the patient's.
- LESSON: Provider will insist on “fact” which cannot be true, if death data is accurate.

LESSONS FROM DECEASED PATIENTS PROJECT

- Called 717-761-xxxx was transferred to customer service by the operator. Called Bradlee at 717-214-xxxx a contact from the Dec 09 mailout for one of the drug store chain responses. She asked me what store numbers they were and where they were mailed. She asked me to fax the letters to her since she never received them from the stores. I faxed them to 717-214-xxxx. She said she will be the one to respond to them.
- Compliance lesson: In some organizations, no effective process exists to bring compliance issues to compliance officer

THE TWO MOST IMPORTANT MEDICAID INTEGRITY PROVISIONS OF ACA

- MANDATORY REPORTING AND REPAYMENT OF OVERPAYMENTS BY PROVIDERS
- IMPROPER RETENTION OF OVERPAYMENT 60 DAYS AFTER IDENTIFICATION IS A FALSE CLAIM (invokes treble damages, penalties, and whistleblower provisions)

ACA SECTION 6402 MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

- *"(d) REPORTING AND RETURNING OF OVERPAYMENTS.—*
- *"(1) IN GENERAL.—If a person has received an overpayment, the person shall—*
- *"(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and*
- *"(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.*

PPACA SECTION 6402 (d) MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

- *"(3) ENFORCEMENT.—Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title. (False Claims Act)*

WHEN MUST AN OVERPAYMENT BE RETURNED?

- PPACA 6402(d)(2)
- An overpayment must be reported and returned . . .by the later of-
- (A) the date which is 60 days after the date on which the overpayment was **identified**; or
- (B) the date on which any corresponding cost report is due, if applicable

THE OBLIGATION TO RETURN AN IDENTIFIED OVERPAYMENT IS CONTINUING

- CRITICAL DATE: WHEN WAS THE OVERPAYMENT IDENTIFIED
- NOT: WHEN WAS THE OVERPAYMENT RECEIVED
- CONTINUING DUTY TO REPAY IDENTIFIED OVERPAYMENTS FROM PRIOR TIME PERIODS

PROVIDER MUST STATE THE REASON FOR OVERPAYMENT

- **notify the State to whom the overpayment was returned in writing of the reason for the overpayment**
- **Maine Standard-30 days**
- **OMIG's Disclosure Protocol, available on the OMIG website, www.OMIG.state.ny.us**
- COMPARE WITH PA 2010 self-audit protocol: http://www.dpw.state.pa.us/omap/omapfab.asp
- COMPARE WITH NJ Self-Disclosure Process www.nj.state.us/njomig
- Mass., Ct. Do not yet have disclosure protocols
- COMPARE WITH federal OIG self-disclosure protocol http://oig.hhs.gov/authorities/docs/selfdisclosure.pdf.
- COMPARE WITH CMS "unsolicited/voluntary refunds" to Medicare contractors (checked July 2, 2010)
- See, e.g., http://www.wpsmedicare.com

CONSEQUENCES OF FAILURE TO REPORT

- False Claims Act imposes liability for a person who“knowingly conceals or knowingly and improperly avoids or decreases an **obligation** to pay or transmit money or property to the Government” **new** 31 U.S.C. 3729(a)(1) (G) added by FERA
- “knowingly” includes reckless disregard, deliberate ignorance
- An overpayment which is timely reported and explained will not give rise to FCA liability even if the provider is unable to repay it within 60 days, unless there is evidence of improper “avoidance.”

“OVERPAYMENT” INCLUDES:

- PAYMENT RECEIVED OR RETAINED FOR SERVICES ORDERED OR PROVIDED BY EXCLUDED PERSON “no payment will be made by Medicare, Medicaid or any of the other Federal health care programs for any item or service furnished by an excluded individual or entity or at the medical direction or on the prescription of a physician or other authorized individual who is excluded . . .” 42 CFR 1001.1901

GOALS OF THIS PRESENTATION-WERE THEY MET?

- THE NEW CONTEXT IN FRAUD AND COMPLIANCE – “improper payments”
- RISKS IN THE NEW CONTEXT FOR ORGANIZATIONS – mandatory compliance, whistleblower risk, payment suspension
- LESSONS FROM THE DECEASED PATIENTS PROJECT-responding to identified issues
- COMPLIANCE AND SECTION 6402 of PPACA-DUTY TO REPAY IDENTIFIED OVERPAYMENTS-the most imortant integrity section of ACA