Reducing Fraud Waste And Abuse: What You Need To Know About Medicaid Requirements

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http://www.hms.com/our_services/services_program_integrity.asp
Heckler v. Community Health Services of Crawford County

"Men must turn square corners when they deal with the Government." ... This observation has its greatest force when a private party seeks to spend the Government's money. Protection of the public fisc requires that those who seek public funds act with scrupulous regard for the requirements of law...."
Health Care Reform Overview

• Changes designed to improve the integrity of Medicare & Medicaid (MA) programs in order to reduce fraud, waste and abuse

Health Care Fraud and Abuse (HCFAC) Program

• $4.2 billion recovered in 2012
• Return on investment (ROI): $7.90 for every $1
• > $23 billion returned to Medicare Trust Fund since 1997
Understanding Fraud, Waste & Abuse

• Fraud: intentional deception or misrepresentation with knowledge that deception could result in an unauthorized benefit. Knowingly or intentionally submitting a false claim
  ▪ Billing for services not rendered
  ▪ Upcoding
  ▪ Rounding up of time

Understanding Fraud, Waste & Abuse

• Abuse: practices inconsistent with sound fiscal, business or medical practices resulting in unnecessary cost, or reimbursement for services not medically necessary or that fail to meet professionally recognized standards
  ▪ Services billed by mistake
  ▪ Misusing codes
  ▪ Billing for a non-covered service
  ▪ Inappropriately allocating costs on a cost report
Understanding Fraud, Waste & Abuse

- Waste: overutilization of services or other practices that result in unnecessary costs
  - Ordering of excessive testing
  - Recipient use of excessive services

The Auditors
The Audit Landscape: Who Are They?

- Medicaid Recovery Audit Contractor: HMS Holding Corp. (12.5% contingency fee)
- Medicaid Integrity Contractor (MIC): Health Integrity
- Payment Error Rate Measurement (PERM) Program: A+ Government Services
- PA Medicaid Fraud Control Unit (MFCU)
- DPW Bureau of Program Integrity (BPI)
- Other DPW and Medical Assistance Managed Care Organization Program Integrity staff

The Audit Landscape: Who Are They?

- Medicare Administrative Contractor: Novitas Solutions, Inc.
- Medicare Recovery Auditor (f/k/a RAC): DCS
- Zone Program Integrity Contractor ("ZPIC"): SafeGuard Services, LLC
- Other investigators:
  - Federal Office of Inspector General ("OIG")
  - Federal Bureau of Investigation ("FBI")
  - US Department of Justice ("DOJ")

- Action initiated by "relator" on behalf of government
- Incentives/Rewards:
  - 15-25% of recovery if DOJ intervenes
  - 25-30% of recovery if DOJ declines
  - Up to 10% if based in part on publicly disclosed information
  - Attorneys fees, costs and expenses
  - Whistleblower Retaliation Prohibited

Federal False Claims Act: Hypo

XYZ Center submits 2,500 laboratory claims to CMS in the first quarter of 2012. A quarterly financial report indicates that this is a 100% increase in laboratory testing. The compliance officer investigates and it is determined that individual automated multi-channel chemistry panels were inappropriately unbundled in the billing process, resulting in 1,250 faulty claims for $25 each.
Example of FCA Violation False Claims Act

Maximum Penalties:

$25.00 \times 1,250 = $31,250 \text{ (overpayment)}

- Deduct what should have been paid for panels
- ($7,500) for total overpayment of $23,750

$23,750 \times 3 \text{ (treble damages)} = $71,250

Plus

$11,000 \text{ (CMPs)} \times 1,250 = $13,750,000

ACA Payment Suspensions

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ACA Payment Suspensions

- State Medicaid Agency must suspend payments to a provider if:
  - There is a pending investigation of credible allegations of fraud against the individual or entity and
  - No good cause exception applies

ACA Payment Suspensions

- A credible allegation:
  - An allegation from any source
  - That has been verified by the State based upon a preliminary investigation
  - Has an "indicia of reliability"

- If payments are suspended, State must:
  - Refer to MFCU
  - Request MFCU to certify each quarter that investigation is ongoing
"Good Cause" Exceptions to Payment Suspension

- Law Enforcement Request
- More efficient and prompter alternative remedies
- Written evidence from the provider
- Jeopardy to recipient access
- Law enforcement failure to certify ongoing investigation
- Contrary to best interests of the Medicaid Program
- Suspension in part would be effective

ACA Payment Suspensions

- May be imposed without advance notice
- Notice of the suspension must
  - Be provided within 5 days (or 30 days if delay is requested by law enforcement)
  - Include general allegations but no specific information as to ongoing investigation
  - Specify that the suspension is temporary
  - Give provider opportunity to submit written info
  - Inform provider of State appeal procedures
ACA Payment Suspensions

• Payment suspensions are temporary
• Must end when —
  ▪ State Medicaid Agency or law enforcement determine there is insufficient evidence of fraud
  ▪ Legal proceedings relating to the allegations are completed

Monthly Exclusion Checks
DPW MA Bulletin 99-11-05  
(Aug. 15, 2011)

- Recommends that Medicaid providers do monthly screenings for excluded individuals and entities
  - GSA's Excluded Parties List System (EPLS) [https://www.epis.gov](https://www.epis.gov), moved to SAM (SAM.gov)
  - DPW's Medichex List [http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medichexkprecludedproviderslist/S_001152](http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medichexkprecludedproviderslist/S_001152)

Office of Developmental Programs (ODP) – Announcement 031-13

- Reminds providers that they must determine if employees and contractors have been excluded from receiving payments through the Consolidated, Person/Family Directed Services and Adult Autism Waivers.
- Alerts providers that they are responsible to check SAM
New Federal Guidance on Exclusions

- CMS State Medicaid Directors’ Letters:
  - SMDL #09-001 January 16, 2009
  - SMDL #08-003 June 12, 2008
  > http://www.cms.hhs.gov/SMDL/SMD/list.asp#TopOfPage
- OIG Frequently Asked Questions
  > http://oig.hhs.gov/fraud/exclusions.asp

Which Programs Are Affected?

- Federal health care programs
  - Any plan or program providing health care benefits, whether directly through insurance or otherwise, that is funded directly, in whole or part, by the US Gov't (other than the Federal Employees Health Benefits Program), or any State health care program
Which Programs Are Affected?

- State health care program includes
  - Approved Medicaid State Plan (Title XIX)
  - Any program receiving funds under Title V or from an allotment to a State under Title V (Maternal and Child Health Services Block Grant program)
  - Any program receiving funds under Title XX or from any allotment to a State under Title XX (Block Grants to States for Social Services)

OIG Mandatory Grounds for Exclusion

<table>
<thead>
<tr>
<th>Exclusion Period: Minimum 5 Years</th>
<th>Exclusion Period: Minimum 10 Years</th>
<th>Exclusion Period: Permanent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conviction of program-related crimes</td>
<td>Conviction of two mandatory exclusion offenses</td>
<td>Conviction on 3 or more occasions of mandatory exclusion offenses</td>
</tr>
<tr>
<td>Felony conviction: health care fraud</td>
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<tr>
<td>Conviction relating to patient abuse or neglect</td>
<td></td>
<td></td>
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<tr>
<td>Felony conviction: controlled substance</td>
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</tr>
</tbody>
</table>
OIG Permissive Grounds for Exclusion

<table>
<thead>
<tr>
<th>Period of Exclusion: 3 Years Minimum</th>
<th>Period of Exclusion: 1 Year Min.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Misdemeanor conviction relating to health care fraud</td>
<td>Claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of health care, or failure of an HMO to furnish medically necessary services</td>
</tr>
<tr>
<td>Conviction relating to fraud in non-health care programs</td>
<td>Failure to meet statutory obligations to provide medically necessary services meeting professionally recognized standards of health care (Peer Review Organization (PRO) findings)</td>
</tr>
<tr>
<td>Conviction for obstruction of an investigation</td>
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</tr>
<tr>
<td>Misdemeanor conviction: controlled substances</td>
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</tbody>
</table>

OIG Permissive Grounds for Exclusion

<table>
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<tr>
<th>Exclusion Runs with Underlying Determination</th>
<th>No Minimum Period of Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>License revocation or suspension</td>
<td>Fraud, kickbacks, and other prohibited activities</td>
</tr>
<tr>
<td>Exclusion or suspension under federal or state health care program</td>
<td>Failure to take corrective action.</td>
</tr>
<tr>
<td>Entities controlled by a sanctioned individual</td>
<td>Failure to grant immediate access</td>
</tr>
<tr>
<td>Entities controlled by a family or household member of an excluded individual and where there has been a transfer of ownership/control</td>
<td>Failure to disclose required information, supply requested information on subcontractors and suppliers; or supply payment information</td>
</tr>
</tbody>
</table>

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OIG Permissive Grounds for Exclusion

<table>
<thead>
<tr>
<th>No Minimum Period of Exclusion</th>
<th>Other Periods of Exclusion</th>
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</thead>
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<tr>
<td>Making false statement or misrepresentations of material fact</td>
<td>Default on health education loan or scholarship obligations: Exclusion: until default has been cured or obligations have been resolved to Public Health Service's (PHS) satisfaction</td>
</tr>
<tr>
<td></td>
<td>Individuals controlling a sanctioned entity. Exclusion: same period as entity</td>
</tr>
</tbody>
</table>

DPW “For Cause” Terminations & Preclusions

- Failed to comply with DPW regulations.
- Committed a prohibited act.
- Failed to comply with conditions of participation
- Violated the terms of the provider agreement.
- Suspended or terminated from Medicare
DPW “For Cause” Terminations & Preclusions

- Convicted a Medicare or Medicaid related criminal offense
- Convicted a criminal offense relating to the practice of the provider’s profession
- Had a controlled drug license withdrawn or failed to report changes in the Provider’s DEA Number to the Department.

DPW “For Cause” Terminations & Preclusions

- Rendered or ordered services or items which DPW medical professionals have determined to be harmful to the recipient, of inferior quality or medically unnecessary.
- Refused to permit duly authorized State or Federal officials or their agents to examine the provider’s medical, fiscal or other records as necessary to verify services or claims for payment under the program.
ACA – Mandated Provider Terminations

- State Medicaid Agency must terminate participation of individual or entity if that individual or entity has been terminated from Medicare or any other State Medicaid Program
- Termination
  - Must be “for cause”
  - Provider has exhausted appeal rights or appeal period has expired
- CMS developed web-based portal for States to share information

Effect of Exclusion

- No Federal health care program payment may be made for any items or services furnished:
  - By an excluded individual or entity or
  - At the medical direction or on the prescription of an excluded provider
Effect of Exclusion

- Items or services furnished at medical direction or prescription of an excluded individual or entity are:
  - Not reimbursable when Entity furnishing the services knows or should know of the exclusion
  - Even when payment is made to a non-excluded provider, practitioner or supplier

Effect of Exclusion

- Payment prohibition extends to:
  - Payment for administrative and management services not directly related to patient care
  - Coverage of an excluded individual’s salary, expense or fringe benefits, regardless of whether they provide direct patient care
Effect of Exclusion

- Prohibition continues to apply to an excluded individual even if he/she changes professions while excluded
- 900 OIG exclusions in 1990
- 3340 OIG exclusions in 2010
- 48,890 excluded providers on LEIE as of December 1, 2011

Who Should Be Screened?

- All employees, vendors, contractors, service providers, and referral sources
  - Whose functions are a necessary component of providing items and services to Medicaid recipients or
  - Who are involved in generating a claim to bill for services, or are paid by Medicaid (including salaries that are included on a cost report submitted to DPW)
Effect of Exclusion: Examples

- Services performed by excluded nurses, technicians or other excluded individuals where such services are related to administrative duties, preparation of surgical trays or review of treatment plans, even if the individuals do not furnish direct care to Federal program beneficiaries

Effect of Exclusion: Sanctions

- Excluded individual or entity
  - $10,000 CMP for each item or service furnished during exclusion
  - Treble damages for the amount of each item or service
  - Possible non-reinstatement
Effect of Exclusion: Employer Sanctions

- Civil monetary penalties (CMP) exposure if provider submits claim for items or services, furnished directly or indirectly, by excluded individuals or entities
- CMP liability could apply if the excluded person is an employee, contractor, volunteer or "has any other relationship" with the provider
  - E.g., nurses from a staffing agency

Effect of Exclusion: Employer Sanctions

- Up to $10,000 CMP for each item or service
- Assessment of up to three times the amount claimed
- Program exclusion
### Effect of Exclusion: Employer Sanctions

- Penalties of up to $10,000 per day for each day that an excluded person is an officer or managing employee or retains a direct or indirect ownership or control interest of 5% or more in a Medicaid provider.
- OIG recovered >$10 million in settlements for over 60 cases in past 3 years.

### Effect of Exclusion: Employer Sanctions (Medicaid)

- Recoupment of Medicaid payments
  - Actual amount of Medicaid dollars that were expended for those items or services.
  - Amount of expended Medicaid funds expended to pay an excluded individual's salary, expenses, or fringe benefits.
- Termination from all federal health care programs, including Medicaid.
- Exclusion.
Effect of Exclusion –
ODP Regulations

  - Bars payment to vendors and OHCDS if they contract with an entity, or participant who is on LEIE, SAM or Medicheck list or with a provider or individual who employs staff that are listed on the LEIE or SAM.
- 55 Pa Code § 51.152
  - Authorizes termination of MA provider agreement or MA waiver provider agreement if provider is on LEIE, SAM or Medicheck list.

Effect of Exclusion: Sanctions

- Limited employment options
  - Excluded individuals may not service in an executive or leadership role
  - Pay excluded individual exclusively with private funds or from non-federal funding sources AND
  - Services furnished relate SOLELY to non-federal program patients
Proactive Employment Strategies

- Job applications
  - Exclusion inquiries: Have you ever been or are you currently excluded?
  - List all names you have used
  - Falsification is grounds for immediate termination
  - Advise that you are running exclusion checks

Proactive Employment Strategies

- Non-exclusion should be a condition of employment
  - Job descriptions -- Qualification/essential function
  - Advertisement for position
  - On-going obligation to notify of exclusion
- Collective Bargaining Agreements (CBAs)
  - Side agreement or memorandum of understanding
Discovery of an Excluded Individual

- Employee at will: willful misconduct?
- Employment contracts: do you have the right to terminate for exclusion?
- Union employee: review CBA management rights provisions and discipline/terminations
- Civil service: review civil service ordinances

Discovery of an Excluded Individual

- Notice to employee
- Predetermination opportunity to refute the charges
  - Possible defenses:
    - Not me
    - My exclusion was over a while ago
    - Note: reinstatement is not automatic; individual must affirmatively seek reinstatement and be reinstated
60 Day Repayment Rule

ACA Requires Reporting & Refunding Overpayments

- Applies to Medicare and Medicaid
- Overpayments must be reported and refunded w/in 60 days of identification of overpayment
- Treble damages and CMPs up to $50K for knowing failure to return overpayments
- Knowing failure also a false claim under the Federal False Claims Act
CMS Proposed Rule On 60 Day Repayment Obligation

- Proposed regulations issued 2/16/2012
- When does the 60 day repayment obligation start?
- What triggers the repayment?
- How far back in time does the obligation extends?
- How is the repayment made?

CMS Proposed Rules: Knowledge Of The Overpayment

- Overpayment is "identified" if the provider has "actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment"
- Rule creates an incentive to exercise reasonable diligence to determine whether an overpayment exists
- Provider may receive information about a potential overpayment; the provider must make "reasonable inquiry"
CMS Proposed Rules: The Look-Back

- How far back — 10 years of the date the overpayment was received
  - Selected a 10 year period to coincide with the 10 year statute of limitations in the False Claims Act

DPW Provider Self Audits (Medicaid)

- Self-disclosures for non-fraudulent billing made to Bureau of Program Integrity (BPI) result in no interest and no penalty
  - Avoids double damages
- Guideline at http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medicalassistanceproviderselfauditprotocol/S_001151
DPW Self Audit Options

- 100% claims review
- Provider-developed audit work plan approved by BPI
- DPW pre-approved audit work plan with statistically valid random sample (SVRS)
- Use for fee-for-service and managed care services

New Program Integrity Rules
Provider Screening And Enrollment

  - Apply to Medicare, Medicaid & CHIP
- Major components:
  - Screening and enrollment requirements
  - Enrollment re-validation
  - Ordering or referring providers
  - Payment suspensions
  - Terminations

Provider Screening – Risk Levels

<table>
<thead>
<tr>
<th>Screening Required:</th>
<th>Limited</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verification of Provider/Supplier Specific Requirements</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>License Verification</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Database Checks Pre and Post-enrollment</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Site Visits</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Criminal Background Check</td>
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<td>X</td>
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<tr>
<td>Fingerprinting</td>
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<td>X</td>
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</table>
Provider Screening

- Based upon perceived level of risk of fraud, waste & abuse for category of provider or supplier
- Three screening levels:
  - Limited
  - Moderate
  - High
- Each provider type subject to its own screening level, even if part of related entity

Medicare Provider Screening by CMS

- Automated Provider Screening (APS) launched December 2011
  - Verifies truth and accuracy of data submitted on PECOS enrollment applications against independent commercial and health care data
  - Includes checks on status of licensure, sanctions or exclusions, and adverse legal actions
Medicare Provider Screening by CMS

- Revalidation
  - Verifies information on file for enrolled providers to ensure they meet all standards associated with the new screening criteria.
  - 1.5 Million Medicare Providers enrolled as of March 25 2011 must be revalidated by March 25, 2015

Medicare Provider Screening by CMS

- Revalidation
  - By the end of 2012, more than 400,000 providers screened and nearly 150,000 lost the ability to bill the Medicare program
- Ongoing Revalidation required for
  - DME/POS every 3 years
  - All other providers every 5 years
Medicaid Provider Screening by DPW

- Medicaid Database checks apply to:
  - Providers
  - Persons with 5% or greater ownership or control interest
  - Agents and managing employees
- Criminal background checks and fingerprinting apply to:
  - Providers
  - Persons with 5% or greater direct or indirect ownership interest

Medicaid Enrollment Revalidation

- Revalidation period is every five (5) years
- No application fee
- Screening levels consistent with enrollment
SSNs and EINs

- Disclosure of Employer Identification Numbers ("EIN") and SSNs required since 1997 under Medicare
- Applies to providers, suppliers, and each person with an ownership or control interest in the provider or supplier, and
  - Any subcontractor in which the provider or a supplier directly or indirectly has a 5% or more ownership interest, and
  - Any managing employees including directors and officers of corporation and nonprofit organizations and charities

New Medicaid Disclosure Requirements

- Person with 5% ownership or control interest in a "disclosing entities," fiscal agents and managed care entities must disclose:
  - Name and address
    - For Corporation, primary business address, every business location and P.O. Box
  - DOB & SSN for individual
  - Familial relationships
- Managing employees must disclose:
  - Name, address, DOB and SSN
Definitions for Disclosure Rules

- Disclosing entity: a Medicaid provider (other than an individual practitioner or group of practitioners or a fiscal agent)
- Other disclosing entity: any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Social Security Act

Conclusion

- Brave new world has arrived
- Preparation is key
- Examine your systems
- Know the rules and the players
Conclusion

- Audit and monitor
- Assess your risks
- Consult with counsel as necessary
- Train and implement
- Report and refund as necessary

Resources And Useful Information
Web Sites for PA Auditors

- DPW MIC information
  http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/communication/s_002861.pdf
- ZPIC: SafeGuard Services, LLC
  http://www.safeguard-servicesllc.com/zpic.asp
- Medicare RA: DCS
  http://www.dcsrac.com/PROVIDERPORTAL.aspx
- Medicaid RAC: HMS
  http://www.hms.com/
- MIC: Health Integrity

Web Sites for PA Auditors

- PERM: A+ Government Services
  http://www.aplusgov.com/services/
- DPW BPI:
  http://www.dpw.state.pa.us/dpworganization/officeofadministratio
n/bpi/S_001936
- PA MFCU:
- MAC: Novitas Solutions, Inc.
  https://www.novitas-solutions.com/
Other Key Web Sites

- OIG: http://oig.hhs.gov/
  - Quality of care corporate integrity agreements
- DOJ: http://www.justice.gov/
- US Attorney's Office for the Eastern District of Pennsylvania -- quality of care cases:

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