

INTRODUCTION TO HEALTH FRAUD AHLA/HCCA FRAUD AND COMPLIANCE CONFERENCE 2012

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NEW YORK CITY HRA

- 3 million Medicaid recipients
- \$30 billion in Medicaid benefits each year
- 12,000 employees (more than twice as large as CMS)
- Rich data sources and analytics
- Mayor Bloomberg/Commissioner Robert Doar-commitment to program integrity
- How social programs work in practice

MY EXPERIENCE

- Assistant US Attorney in health care fraud
- 4 years as New York State's first Medicaid Inspector General
- 1 year as New York City Chief Integrity Officer/Executive Deputy Commissioner
 - Enforcement function
 - Compliance function

GOALS OF THIS PRESENTATION

- DEFINING FRAUD AND FRAUD PREVENTION
- IMPOSING DUTIES-GOVERNMENT APPROACH TO FRAUD CONTROL
- HOW DO FRAUD VIOLATIONS OCCUR? HOW DO ORGANIZATIONS AND INDIVIDUALS RESPOND?
- FRAUD AND SECTION 6402 of PPACA-CONFESS,CALCULATE, AND COLLECT
- THINKING ABOUT FRAUD RISKS

HEALTH FRAUD AND ABUSE-A GROWTH BUSINESS

- AFFORDABLE CARE ACT(PPACA)-2200 pages to change health care-AND FRAUD AND COMPLIANCE (SECTIONS 6400-6500)
- MANDATORY DISCLOSURE OF OVERPAYMENTS TO MEDICARE AND MEDICAID-ACA Section 6402(a)
- MANDATORY COMPLIANCE PROGRAMS
- DATA ANALYSIS AND TARGETING
- BOUNTY HUNTERS-Medicare RACs, Medicaid RACS,
- WHISTLEBLOWERS
- IMPROPER PAYMENTS MEASUREMENT AND RECOVERY

HEALTH CARE FRAUD AND ABUSE

- 3 Models- 3 Ways of thinking
- Fraud-intentional breach of standard of good faith and fair dealing as understood in community, involving deception or breach of trust, for money-lies, kickbacks
- “Fraud and abuse”- highly technical analysis of statutes and regulations-Stark prohibition on “self-referral”-no intent
- Fraud control-compliance business process-prevention and remediation

CORE LEGAL CONCEPTS

- Fraud-18 U.S.C. 1341, 1343, 1347 (mail, wire, health care)
- Kickbacks **42 U.S.C. 1320a-7b**
- Obstruction-18 U.S.C. 1512
- False Claims (civil and criminal) 31 U.S.C. 3729 (includes “improper retention” of funds received),18 U.S.C. 287
- 18 U.S.C. 666-bribery and embezzlement
- 18 U.S.C. 1001-false statement or record in matter within jurisdiction of United States; knowing concealment

CORE PRACTICE CONCEPTS

- Corporate knowledge and intent
- What to do with/for senior officers
- Collateral consequences of any resolution of case
 - Mandatory and permissive exclusion
 - Tax and IRS reporting (e.g., IRS-990)
 - Licensing
 - Credentialing/Provider Enrollment
 - Contracting/Procurement/Financing
 - Reporting and disclosure (SEC)
 - Civil litigation with third parties

FRAUD PRACTICE ISSUES

- HOW EXTENSIVE AN INQUIRY
- WHEN AND HOW TO DISCLOSE
- PRIVILEGE AND WORK PRODUCT
- REMEDIATION/REFUND
- CIA (Corporate Integrity Agreement)
- DPA (Deferred Prosecution Agreement)
- MEDIA/CONSTITUENCIES
- DUE DILIGENCE IN ACQUISITION AND IN REPRESENTATIONS

IMPOSING DUTIES-GOVERNMENT APPROACH TO FRAUD CONTROL

- CMS CERTIFICATIONS

- Cost Reports
- Claims
- Enrollment
- Audit Responses

CMS-855A Certification (Medicare provider enrollment agreement) (two authorizing officials must sign for provider)

- I agree to abide by the Medicare laws, regulations and program instructions that apply to this provider. . . . I **understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions** (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on **the provider's compliance with all applicable conditions of participation** in Medicare. (Emphasis added.)

CMS 855A ENROLLMENT AGREEMENT (60 pages)

- 2 authorizing officials must sign:
- "I agree to notify the Medicare contractor of any future changes to the information contained in this application in accordance with the time frames established in 42 C.F.R. § 424.520(b). I understand that any change in the business structure of this provider may require the submission of a new application."

CMS Cost Reports – Worksheet S

- MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. (Emphasis added.)

Cost Report Certification by Provider

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying . . . cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by [Provider] for the cost reporting period beginning [] and ending [] and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the health care services identified in this cost report were provided in compliance with such laws and regulations.

CMS Claim-Form Certifications

- CMS-1500 (and electronic X12N Health Care Claim: Professional (837))
 - I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.
- *See also* CMS-1450 (*i.e.*, UB-04)

U.S. ex rel. Hutcheson v. Blackstone (1ST CIR.2011)

- Blackstone “caused” hospitals (“unwittingly”) to submit materially “false or fraudulent” claims because the claims did not meet a “a material precondition” for payment.
- Alleged kickbacks “would have been capable of influencing Medicare’s decision whether to pay the claims had it been aware of them.”
- A submitting entity’s representation about its own legal compliance can incorporate an implied representation concerning the behavior of non-submitting entities.

CONFESS, CALCULATE, AND PAY-REQUEST

- In August, DOJ sent an email to hospitals nationwide asking them to conduct self-audits to identify Medicare fraud involving implantable defibrillators and calculate potential penalties under the False Claims.

CONFESS, CALCULATE, AND PAY-STANDARDS

- Whether there was a medical need for the hospital to violate CMS rules;
- Whether the patient was harmed;
- If the hospital was aware or had a statistical pattern of implanting the devices against CMS guidelines; and
- If the hospital has an established compliance program

ATTORNEY AND COMPLIANCE OFFICER ROLE IN FRAUD AND ABUSE ISSUES

- How do people respond to perceived threat?
- 18 U.S.C. 1512-obstruction by destruction of evidence, misleading or corrupt persuasion of witnesses, preventing documents from being made available
- You can usually address the underlying issue-much harder to address obstruction (as perceived by investigators/prosecutors)
- Fix your problems before the investigation is complete

THE MOST IMPORTANT INTEGRITY PROVISIONS OF ACA

- MANDATORY REPORTING, REPAYMENT, AND EXPLANATION OF OVERPAYMENTS BY “PERSONS”
- “KNOWING” RETENTION OF OVERPAYMENT BEYOND 60 DAYS IS A FALSE CLAIM (invokes penalties and whistleblower provisions)
- MANDATORY COMPLIANCE PLANS (first in nursing homes, later in other providers) which will include mandatory reporting of overpayments, mandatory review and follow up-
- Will CMS impose ACA's compliance requirements?

A TALE OF TWO CASES AND COMING ATTRACTIONS

- DAVID TREMOGLIE AND BUSTLETON GUIDANCE CENTER 1999 (investigation begun in 1997 after class action suit)
- MAXIM HEALTH CARE 2011(investigation begun in 2004 after filed whistleblower case)
- HEALTH CARE INVESTIGATIONS AFTER 2010- COMPLIANCE, REPORTING, PAYMENT SUSPENSION

DOCTOR TREMOGLIE

- Fraud
- Abuse
- Improper Payments
- Risk of patient harm
- Role of private regulators
- Time for our video demonstration-USA v. Tremoglie
- What should attorneys/compliance officers have done?

RICHARD WEST-PATIENT -MAXIM WHISTLEBLOWER

- "I'm on oxygen, I wasn't getting the nursing care I needed and services were being cut back because of me being over the so-called spending limit. There were times I thought I would die."
- After checking his own medical records, he discovered the company providing him with nursing care appeared to have overbilled Medicaid for hundreds of hours for people who were never there.

MAXIM HOME HEALTH-2011-THE NEW MODEL HEALTH CASE

- Maxim Healthcare Services, company with 360 offices nationwide offering home health care services, agrees to pay about \$150 million to settle civil and criminal charges - false billings to Medicaid and the Department of Veterans Affairs (no Medicare)
- nine current and former Maxim employees have pleaded guilty since 2009 to felony charges

MAXIM CONSPIRACY TO DEFRAUD- criminal information

- “Maxim emphasized sales goals at the expense of clinical and compliance responsibilities”
- During the relevant time period, Maxim did not have in place “appropriate training and compliance programs to prevent and identify fraudulent conduct.”
- “Relevant time period” before ACA.

MAXIM PROSECUTION

- Criminal Information
 - False documents re training
 - False documents re evaluations by supervisors
 - Billing through licensed offices other than the unlicensed office where care was actually supervised
 - Documents certified that mandated training had been received when it had not been
 - Conditions of participation violations are basis for criminal prosecution

MAXIM CIVIL FALSE CLAIMS RELEASE

- “submitting or causing to be submitted false claims to state Medicaid programs and the VA, for services not reimbursable by state Medicaid programs or the VA because Maxim lacked adequate documentation to support the services purported to have been performed”

MAXIM CIVIL FALSE CLAIMS RELEASE

- “for the following offices, during the following periods, submitting or causing to be submitted false or fraudulent claims to state Medicaid programs for services not reimbursable by state Medicaid programs because the offices were unlicensed:”

MAXIM DEFERRED PROSECUTION AGREEMENT

- “The company has identified and disclosed to law enforcement the misconduct of former Maxim employees, including providing information which has been critical in obtaining the convictions of some of the individuals who have pleaded guilty to date. The company has also significantly increased the resources allocated to its compliance program.” DOJ press release 9/12/2011

MAXIM DEFERRED PROSECUTION AGREEMENT

- “This Office (i.e., the NJ US Attorney’s Office) acknowledges that neither this DPA nor the Criminal Complaint alleges that the Company’s conduct adversely affected patient health or patient care.”
 - Paragraph 2, DPA
- “ Government acknowledges that Maxim's conduct did not adversely affect patient health or patient care”
 - Maxim Press Release

MAXIM DEFERRED PROSECUTION AGREEMENT

- reforms and remedial actions the company has taken – beginning in May 2009 –
- significant personnel changes: terminating senior executives and other employees the company identified as responsible for the misconduct

MAXIM DEFERRED PROSECUTION AGREEMENT

- “reforms and remedial actions the company has taken – beginning in May 2009- establishing and filling of positions of chief executive officer, chief compliance officer, chief operations officer/chief clinical officer, chief quality officer/chief medical officer, chief culture officer, chief financial and strategy officer, and vice president of human resources; hiring a new general counsel”

MAXIM PRESS RELEASE

4/13/2011

- "Maxim Healthcare Services Expands Compliance Program"
- Maxim's Chief Compliance Officer Jackie Baratian (former OIG/OGC) says "In today's healthcare climate it is more important than ever that Maxim follows federal and state laws and regulations to protect our patients, clients, and employees."

CONTROLLING HEALTH CARE FRAUD AND ABUSE REQUIRES A PREVENTION STRATEGY(CMS and states) AS MUCH AS A PROSECUTION STRATEGY(DOJ)

- Who gets into the program?
- 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 potential 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
- Exclusion of individuals who violate their duties
- Focus on compliance obligations of health care providers
- In investigations, what is compliance culture?

TRENDS IN THE LAW OF FRAUD ABUSE AND COMPLIANCE

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

A CULTURE OF NON-COMPLIANCE

- How do behaviors inconsistent with established rules become acceptable or tolerated?
- What mixture of compliance, communication, and enforcement are most efficient and effective in changing the extent of non-compliance?
- Business process review

DR. DAN ARIELY ON CHEATING

- 1. Will people cheat when given a chance to do so?
- 2. How much will people cheat ?
- 3. How will the magnitude of dishonesty be affected by the magnitude of external rewards?
- 4. Will cheating by “just a bit” cause people to think of themselves as dishonest.
- Dan Ariely, Ph.D. Sloan School, MIT(now at Duke) author of *Predictably Irrational* (2009) and *The Upside of Irrationality* (2010)

LESSONS FROM PROF. ARIELY

- CHANGING THE PROBABILITY OF “GETTING CAUGHT”
- CHANGING BELIEFS ABOUT AVERAGE PERFORMANCE
- INCREASING AWARENESS OF MORAL STANDARDS

AN EFFECTIVE PROGRAM- 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

LESSONS FROM DECEASED PATIENTS PROJECT

- Provider states that, " C & C 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

- Called 717-761-xxxx was transferred to customer service by the operator. Called Bradlee at 717-214-xxxx a contact from the Dec 09 mail out for one of the Rite Aid 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 address identified issues

THE MOST IMPORTANT PROGRAM INTEGRITY PROVISIONS OF ACA

- MANDATORY REPORTING AND REPAYMENT OF OVERPAYMENTS BY PROVIDERS
- IMPROPER RETENTION OF OVERPAYMENT IS A FALSE CLAIM.
- MANDATORY COMPLIANCE

THE STEALTH PROVISION OF ACA

- STATES MUST SUSPEND PAYMENT TO PROVIDER WHICH IS SUBJECT OF AN INVESTIGATION INTO CREDIBLE ALLEGATION OF FRAUD (6402(h))
- new regulation 42 CFR 455.23
<http://edocket.access.gpo.gov/2011/pdf/2011-686.pdf>
- FAQs on CMS website

PPACA 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
- Use New York 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
- COMPARE WITH federal OIG self-disclosure protocol
<http://oig.hhs.gov/authorities/docs/selfdisclosure.pdf>.
- COMPARE WITH CMS "unsolicited/voluntary refunds" to Medicare contractors
- See, e.g.,
<http://www.trailblazerhealth.com/Publications/Job%20Aid/UnsolicitedVoluntaryRefunds.pdf>
- Compare with CMS draft guidance on return of overpayments 77 FR 9179-9187 (2/16/2012)

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

ACA 6402(a) and whistleblowers

- “Identify”
- Obligation to disclose”
- Discussion of improper billing
- Failure to disclose
- ANY PERSON IN THE ROOM CAN BE A WHISTLEBLOWER

USEFUL INFORMATION

- **Fraud Detection Systems:** Additional Actions Needed to Support Program Integrity Efforts at Centers for Medicare and Medicaid Services
 - [GAO-11-822T](#), Jul 12, 2011
- **Fraud Detection Systems:** Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use
 - [GAO-11-475](#), Jun 30, 2011

USEFUL INFORMATION-CMS

- CMS MEDICARE PROGRAM INTEGRITY MANUAL <http://www.cms.gov/Manuals/IO/M/itemdetail.asp?itemID=CMS019033>
“MAC, CERT and Recovery Auditor staff shall not expend Medicare Integrity Program (MIP)/ MR resources analyzing provider compliance with Medicare rules that do not affect Medicare payment. Examples of such rules include violations of conditions of participation (COPs). . . that do not change the Medicare payment amount ”

USEFUL INFORMATION CMS

- Medicare Program Integrity
<http://www.stopmedicarefraud.gov/heatsuccess/index.htmlh>
- <http://aging.senate.gov/crs/medicare18.pdf>
(2010 (Congressional Research Service summary))
- Medicaid Program Integrity website
 - <https://www.cms.gov/medicaidintegrityprogram/>
 - Medicaid Program Integrity Annual Report FY 2011

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