MEDICAID ENFORCEMENT UPDATE

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GENERAL TOPICS

› Medicaid Enforcement Initiatives (MIPs, MFCUs, OIG, RACs)
› Data Mining, Risk Mitigation & Audit Challenges
› Medicaid Enforcement Update
› Compliance Tips
MEDICAID ENFORCEMENT INITIATIVES

- Increased coordination between state and federal authorities resulting in record breaking recoveries
- Increased enforcement Medicaid Integrity Program ("MIP") instituted
- ACA mandates for Medicaid Audit Contractors ("RACs")
- Medicaid Fraud Control Units ("MFCUs") granted authority to engage in data mining

MEDICAID INTEGRITY PROGRAM

- MIP is comprehensive federal strategy designed to prevent fraud, waste & abuse in the $300 billion/year Medicaid program.
- Comprehensive Medicaid Integrity Plan (CMIP) outlines strategy
  - Significant funding for MIP enforcement ($75m)
  - Medicaid Integrity Contractors (MICs) address reviews, education and audit
- MICs identify overpayments (automated review, data mining; and sampling of records)
RECOVERY AUDIT CONTRACTORS

- Under ACA states must establish a RAC
- Paid on a contingency fee basis
- Identify for the State over & under payments
- Coordinates with other contractors/entities performing audits (e.g. DOJ, FBI, OIG, MFCU)

MEDICAID FRAUD CONTROL UNITS

- Certified HHS-OIG to investigate & prosecute health care fraud
- Charged with investigating fraud
- Collects and/or referring collection of identified overpayments to the single state agency
MFCU DATA MINING

- State MFCU could not use Federal funds for “data mining”
- Now rules have reversed that and permit data mining.
- MFCUs must satisfy certain conditions:
  - Identifying methods for coordination with State Medicaid agencies and designating individuals to serve as primary contact;
  - Ensuring MFCU staff are properly trained in data mining technology;
  - Provide OIG annual report (associated costs, # of cases generated, monetary recoveries resulting);
  - Requires OIG approval; good for three years

MFCU DATA MINING

OIG State Policy Transmittal No. 2013

- **Elements** for a complete data mining application:
  - Methods of coordination with State Medicaid Agency (SMA)
  - Staffing and training
  - Reporting
  - Budget Implications
- **Process** for submitting application:
  - Electronic submission: Medicaid Fraud & Policy Oversight Division
  - OIG has 90 days from receipt to review, consult with CMS and approve or deny unless additional info is requested; additional 90 days*
  - Failure to respond by OIG constitutes approval
MFCU DATA MINING

“We believe that allowing MFCUs to receive funding for data mining will enable them to marshal their resources more effectively and take full advantage of their expertise in detecting and investigating Medicaid fraud vulnerabilities”

Federal Register, May 17, 2013

MFCU DATA MINING (Cont’d)

- Florida– July 2010 waiver of 42 CFR § 1007.19
- Waiver terms; Memorandum of Understanding
  - 3 years
  - Limited staff time utilized in data mining
  - Detailed plan how MFCU would coordinate data mining efforts with AHCA’s MIP to avoid duplicating efforts.
- FL MFCU –Has 74 data mining projects for review; 13 cases and 3 complaints opened from these projects
  - Billing for phantom patients, Billing for services and/or equipment not medically necessary, Overcharging, Double billing, Misuse of Medicaid provider and recipient numbers
MFCU DATA MINING
(cont’d)

Results can lead to enforcement action:
◦ Withhold of payments pending investigation outcome
◦ Patients interviewed
◦ Employees subpoenaed
◦ Facilities checked
◦ MFCU agents can enter facility, review records with minimal notice
◦ MFCU agents can investigate any suspected criminal activity, not just Medicaid fraud
◦ Repayments can be extrapolated i.e. without a complete audit, using legislatively authorized and court sanctioned statistical estimating formulas

DATA MINING & EXTRAPOLATION

¬ Automated Review – identify inappropriate and large payment amounts by analyzing large sets of claims to detect “systematic errors”

¬ Complex Review – requires sampling; medical chart and billing records analysis

¬ Extrapolation from a small sample (e.g. 30 claims) to a large universe to find inappropriate payments leading to huge recovery demands
DATA MINING & EXTRAPOLATION

› Risk Mitigation
   ◦ Provider’s own analysis to detect unusual patterns or high risk profiles
   ◦ Billing training and verification protocols
   ◦ Prepare for government audit (e.g. clerical mistakes, sloppy record keeping, attention to detail)

› Extrapolation Challenges
   ◦ Medical, clinical and coverage criteria
   ◦ Statistical calculations

› Statistical sampling basics to challenge

DATA MINING & EXTRAPOLATION

› Preconditions/limitation for extrapolating (e.g. CMS Medicare Program Integrity Manual (PIM))
   ◦ Before extrapolating, must establish sustained or high level of payment error required, or
   ◦ Educational interventional failed to correct payment error

› Technical Grounds
   ◦ Guidance for Medicaid contractors/state agencies conducting audits and using overpayment extrapolations are less detailed and consistent than PIM

› Obtain guidance & Medicaid audit manuals for your state
DATA MINING & EXTRAPOLATION

- State must use a statistically valid random sample (SVRS) that is fair, replicable and allows verification by an independent auditor

- Response to Demand Letter, Recovery Amount Determination, or Damage Assessment
  - **Statistical Expertise** in sampling and statistical formula e.g. OIG RAT-STATS, SAS, R software, etc.
  - **Clinical and Health Information Management expertise** (to assess medical necessity, clinical standards, and coding & billing accuracy)
  - **Regulatory and Legal expertise** (to assess coverage criteria, payer rules, & applicable federal and state law)

DATA MINING & EXTRAPOLATION

- Government Auditing Standards (“GAGAS”)
  - General Guidelines that must be followed by government auditors and may be used when challenging overpayment assessments
  - Objectivity and independence are key; adherence to clear criteria that conform to inter-rater reliability – findings must be prepared to allow for validation and verification of assumptions, methods, and results in a challenge
MEDIWICAD ENFORCEMENT UPDATE

- MFCUs in all states and the District of Columbia
- Most MFCUs are part of Attorney General Office
- Most program integrity functions are part of the state Medicaid agency
- New trend: Offices of Medicaid Inspector General (OMIG) independent of the state Medicaid agency
- OMIGs conduct audits, refer criminal cases to MFCUs

STATES WITH AN OMIG

- Arizona*
- Arkansas*
- Florida
- Georgia*
- Illinois
- Kansas
- Kentucky
- Maryland
- Michigan
- Minnesota
- New Jersey*
- New Mexico
- New York*
- Tennessee
- Texas*
- Utah
- West Virginia
- Wisconsin

*Self Disclosure Policy
NJ OFFICE STATE COMPTROLLER
Medicaid Fraud Division Work Plan

- Primary Care Physicians: Medical necessity reviews of records for non-Medicaid referring providers to identify outliers (excessive ordering) and send letters to alert them to their rank relative to other physicians with possible follow-up audits

- Home Health Agencies: Will audit to ensure that charts contain proper documentation and plans of care

- Hospice: Will use Data Mining Unit to analyze claims to see who has been on hospice for more than 6 months

- Labs: Will review claims from independent clinical labs to see if tests were already included in facility rate, or if services were improperly un-bundled

NY OMIG WORK PLAN

- Primary Care Physicians: Has list of outliers of those ordering controlled substances that exceed that of their peers and review for medical necessity

- Home Health Agencies: Will analyze claims to determine services were actually provided and staff was properly trained; focus on dual-eligible patients to ensure Medicaid is not paying an excessive amount

- Pharmacies: Will audit to verify prescriptions were ordered by a qualified provider and pharmacists are not taking part in drug diversion
HHS–OIG WORK PLAN

- **Home Health Agencies**: Will focus on provider & beneficiary eligibility and review health screening records (i.e., vaccinations for hepatitis/influenza) for workers as required

- **Adult Day Care**: OIG will review Medicaid payments by States to determine whether the providers complied with Federal and State requirements

- **Transportation Services**: OIG will focus on compliance with Federal and State requirements

HARSHIER STATUTORY/REGULATORY MANDATES

- “Federal Financial Participation” to be withheld from states failing to suspend provider payments as required
- Payment suspension required when credible allegation of fraud is under investigation
- No time limit for Medicaid suspensions
- No uniform guidance on verification of fraud
- “Pending investigation” not necessarily by a law enforcement agency
- Allegation can be from a hotline, data mining, audits, etc.
- Each state has “flexibility” to define “credible allegation of fraud” pursuant to individual state law
- Can be an allegation from employee of a physician
HARsher Statutory/Regulatory Mandates Good Cause Exemption

- Recipient access to care would be jeopardized
- Sole community doctor or specialist
- Provider serves recipients in medically underserved area
- Suspension is not in “best interests of Medicaid”
- New Mexico Experience: 15 largest mental health providers suspended, due to “credible allegation of fraud” in audit report with 30,000 beneficiaries affected. Audit report basis for suspension sealed pending completion of investigation and months later some “cleared,” others forced out of business

Exclusion Requirements

- Mandatory 5 year exclusion for health care fraud convictions. 42 U.S.C. § 1320a-7(a); 42 C.F.R. § 1001.101
- Misdemeanor fraud convictions can result in 3 year exclusion or more 42 C.F.R. § 1001.201
- Periods can be adjusted by aggravating or mitigating factors
- Friedman v. Sebelius, 646 F.3d 813, (D.C. Cir. (2012)) – “responsible corporate officer” doctrine can lead to exclusion
- Bee Homes, Inc. case from Maryland – executive’s exclusion can endanger all Medicaid funds
- CVS case from New York – CVS paid $900,000 for employing excluded pharmacist who admitted conviction on job application
TIPS TO MITIGATE SANCTION RISKS

- Many states now impose monthly sanction screening
- OIG recommends monthly checks\(^1\)
- State and Federal sanction lists should be checked
- Screen all Employees/Officers/Vendors/Contractors
- Multiple variation of names should be checked
- Establish sanction screening policies
- New hires and current employees should be checked

\(^1\) OIG, Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, May 8, 2013

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TIPS TO MITIGATE SANCTION RISKS

- Do not hire sanctioned parties, even if services not separately billed for, *e.g.* nurses

- Enrollment in Medicaid can be denied/terminated if a 5% or more owner was convicted in last 10 years for Medicare/Medicaid related crime

- Screen providers in managed care network
add attachment of federal and state websites
jfox, 2/10/2014
HOME HEALTH UNDER INCREASED SCRUTINY

- 40% of MFCU criminal cases are home health
- Leading number of cases by DOJ Medicare Strike Force
- Services billed, but not performed
- Billing for services to deceased/hospitalized clients
- Improperly trained staff
- Provision of services to family members
- Falsification of information used for submitting claims
- Services provided by excluded individuals
- Phony personal care assistant: a relative or family friend
- Kickbacks to physicians to qualify beneficiaries
- Kickback to individuals to pose as beneficiaries
- Personal assistants/beneficiaries in collusion splitting benefits
- Patient recruiter kickbacks recruit beneficiaries

TIPS TO MITIGATE HOME HEALTH COMPLIANCE RISKS

- Audit client and CHHA information for “red flags”
  - Multiple clients at same address
  - Multiple clients with same treating physicians
  - CHHAs working at same address
  - CHHAs residing in same apartment building/address as clients
  - Excessive number of client transfers
- Conduct monthly sanction screening checks
- Determine if CHHAs working for multiple agencies
- Check handwriting/information on CMS form 485 against client/CHHA records
- Check driver license/auto ownership info for CHHAs
TIPS TO MITIGATE HOME HEALTH COMPLIANCE RISKS (Cont’d)

- Check for supervisory visit forms signed in blank
- Audit supervisory visit forms for “red flags”
  - Multiple forms for nurse on same date
  - Misspelled names of patient/CHHA
  - Excessive number of daily/weekly visits by nurse
  - Majority of forms dated at 60 day deadline
- Audit CHHA training materials
  - CHHA names missing from attendance lists
  - CHHAs signing in different inks
  - CHHA names misspelled on attendance lists
  - Instructor’s name missing/misspelled
  - Undated attendance lists

ADULT DAY CARE ISSUES UNDER SCRUTINY

- Verify client attendance, check sign-in sheets with transportation logs
- Proper staffing at centers
  - Number of RNs, LPNs on duty
  - Administrator on duty, qualifications of same
  - Staff present for activities being provided
- Verifying centers are open & providing services for all days claimed
- Verify capacity of center has not been exceeded
- Look at any instances of abuse/crimes, proper reporting of same
Adult Day Care: Compliance Tips to Mitigate Risk

- Audit transportation logs and client sign-in sheets
- Maintain detailed attendance records for all staff, including administrators
- Train all staff regarding capacity restrictions
- Report all instances of suspected abuse/crimes

COMPLIANCE TIPS

  - Extended protection of CEPA to “watchdog employees”
  - Implies compliance officers can be protected “whistleblowers”
- Medicaid providers should have compliance officers
- Document proper action to any and all issues raised by compliance officers
- Document evidence of proper compliance oversight
RECENT MEDICAID ENFORCEMENT ACTIONS

- **DME** – Owner of Kim’s Medical Supplies (“KMS”) in Los Angeles, pled guilty to fraud against Medicare/Medi-Cal of more than $650,000 for un-needed power wheelchairs (PWCs) and using fraudulent prescriptions forged by her co-conspirators.

- **Home Health Care** – Owner of Home Care Solutions in NJ was arrested for billing Medicaid for services not rendered and some beneficiaries at time of service were hospitalized or on vacation. Owner of Ultimate Care Home Health Services in Texas was sentenced to 10 years in prison and ordered to pay $25.5 million for a scheme where he recruited beneficiaries to sign up for home health care services for which they did not qualify.

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RECENT MEDICAID ENFORCEMENT ACTIONS

*(cont’d)*

- **Adult Day Care** – Owners of Garden Adult Medical Day Care in NJ fined $1.6 million for billing for services never provided. Adult Daycare Villas in Missouri fined $70,000 for billing for services never provided; Owner excluded from Medicaid.

- **Mental Health Center** – Supervisor at Health Care Solutions Network in Florida sentenced to 10 years in prison and fined $15 million for alteration, fabrication, and forgery of thousands of documents that purported to support the fraudulent claims.

- **Behavioral Health** – Owner of three behavioral health facilities in NJ fined $2.7 million for billing for patients for which no documentation could be found; and billing for patients treated elsewhere. Even submitted claims on days they were closed.
Ambulance Fraud—A Tennessee couple was convicted for submitting fraudulent claims totaling more than $1.6. They misrepresented patient transfers on stretchers, when in reality; patients were riding in the front seat or jump seat of the ambulance.

Pharmacy Fraud—A Maryland pharmacy owner and two employees in Maryland convicted for health care fraud and identity theft in connection in a $3.6 million fraud by submitting false claims for prescription refills. A pharmacist in Florida pleaded guilty to fraud of $351,358.14. Their pharmacy submitted claims for prescriptions, not filled or provided to beneficiaries and recipients.

Medical Practice—A medical practice in Tennessee pleaded guilty to health care fraud for billing for more infant hearing exams than medically necessary and for urinalysis not performed. He was excluded for 20 years and ordered to pay $1.6 million.

Questions?

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