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HCCA San Juan Regional Conference

Compliance Programs in Puerto Rico

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OIG conducts onsite reviews to determine whether Units meet the performance standards and comply with laws, regulations, and policy transmittals. The resulting OIG reports present background on the Units, findings, and recommendations for improvement.

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False Claims to Government of Puerto Rico Programs, Contracts, and Services Act
 Act. No. 154-2018

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Rosselló presenta su medida para el fraude al Medicaid que incluye creación de nueva oficina

Firman ley para combatir el fraude al Medicaid y otros programas

Envío un proyecto de ley a la Legislatura federal.

El gobernador dijo que esperaba que los casos de fraude disminuyeran una vez entraran en vigor estas medidas de control y vigilancia. (Enfoque)

La nueva ley establece como delito grave el fraude al Medicaid y otros programas y agencias del gobierno.

Gobernador Rosselló Nevares firma medida para evitar fraude al Medicaid y asegurar fondos federales de Salud

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False Claims to Government of Puerto Rico Programs, Contracts, and Services Act

- + Act. No. 154-2018 (Approved July 23, 2018)
- + The purpose of the law was to create the "False Claims to Government of Puerto Rico Programs, Contracts, and Services Act"; establish the Medicaid Fraud Control Unit attached to the Department of Justice; prescribe the powers and responsibilities and operating guidelines of said unit, and for other related purposes.



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Purpose



- + With the approval of the Act. No. 154-2018 the Government seek to reduce the fraudulent conduct of the individuals and/or program participants who submit false information in order to receive benefits, whether as a service provider or a beneficiary of the program, that cause every year million dollars in losses for the Government.
- + Through this Law the Government seek to establish the framework for the civil prosecution of fraud in Government Programs and service contracts. This mechanism shall establish a procedure in the Courts whereby the Government is able to bring action so that persons who defraud the Government are imposed a monetary penalty for their acts. Citizen involvement in these proceedings shall be likewise promoted by creating a Qui Tam Provision whereby these persons shall be compensated for the information they furnish.
- + Also, through this Law the Government creates the Medical Fraud Control Unit (MFCU) to investigate and prosecute violations of the applicable laws relating to Medicaid fraud and provide Department of Justice with the necessary tools to operate such unit.
- + The creation of the MFCU provides additional allocation in Medicaid funds of one point two billion dollars (\$1,200,000,000) if the Government show that they have taken the necessary and appropriate steps for the creation of the Medicaid Fraud Control Unit in Puerto Rico.

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CHAPTER I. GENERAL PROVISIONS

Section 1.01.- Title

Section 1.02.- Definitions

Section 1.03.- Declaration of Public Policy and Rules of Construction

It shall be the public policy of the Government to prevent and act on fraud in Government Programs, Contracts and Services, including the Medicaid Program as well as any conduct that is detrimental to the sound use and management of funds allocated for such programs, contracts, and services. The eradication of such conduct is a priority in the agenda of this Government Administration, since we are aware of the consequences of fraud in the services provided in Puerto Rico, including health services and, most of all, Medicaid Program services. We certainly recognize that the availability of such funds is contingent on the Government's ability to detect and prevent fraud, and to facilitate the subsequent criminal prosecution and/or the pertinent collection actions.

In accordance with the foregoing, the Government shall make all the necessary efforts to strengthen the structures to investigate and/or prosecute fraudulent actions, and the dynamic and efficient development of such investigations and proceedings. Pursuant to the foregoing, this legislation shall be construed so as to promote and facilitate the investigation and criminal prosecution and civil actions that are appropriate in order to minimize the impact of fraudulent and unlawful conduct on programs, contracts, and services provided in Puerto Rico, including the Medicaid Program.

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CHAPTER II: CREATION OF THE FRAUD CONTROL UNIT

Section 2.01.- Medicaid Fraud Control Unit

- + The Medicaid Fraud Control Unit is hereby created attached to the Department of Justice for the purpose of conducting a program for investigating and prosecuting, or referring for prosecution, violations of all applicable state laws pertaining to fraud in the administration of the Medicaid Program in Puerto Rico, the provision of medical assistance, or the activities of providers of medical assistance under the state Medicaid Program.
- + The unit shall also review complaints alleging abuse and/or neglect of patients in health care facilities receiving payments under the state Medicaid Program and may review complaints of the misappropriation of patient's private funds or property in such facilities.

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- + For such purposes, the Unit shall conduct investigations and bring civil and criminal actions, as appropriate, for the collection and/or restitution of losses and damages caused to the Medicaid Program, including, but not limited to actions under the False Claims Act or any similar statute.
- + The Unit shall have autonomy and independence from other offices of the Department of Justice, and shall be completely independent from the State Medicaid Agency and the Health Insurance Administration (ASES). The Unit, however, shall establish a referral system and ensure compliance with the parameters established in Section 455.21(a)(2) of Title 42 of the Code of Federal Regulations.

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CHAPTER II: CREATION OF THE FRAUD CONTROL UNIT

Section 2.02.- Organization of the Medicaid Fraud Control Unit

The Unit shall operate under the general supervision of the Secretary, and a Director selected by the Secretary shall be charged with the immediate direction of the Unit. The Unit's staff shall comprise attorneys, investigators, and auditors as well as the administrative staff as deemed necessary by the Secretary. All the staff of the Unit shall be engaged solely to address the matters for which the Unit was created. Attorneys shall be experienced in the investigation or prosecution of fraud, capable of providing effective prosecution and giving informed advice on applicable law and procedures.

Auditors attached to the Unit shall be capable of supervising the review of financial records and data, and advising or assisting in the investigation of alleged fraud.

The Unit shall also have a senior investigator with substantial experience in commercial or financial investigations who shall supervise and direct the investigative activities of the unit.

The rest of the staff shall also be knowledgeable about the legislation that regulates the Medicaid Program and about the operation of health care providers.

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CHAPTER II: CREATION OF THE FRAUD CONTROL UNIT
Section 2.03.- Duties and Powers of the Essential Personnel of the Unit

- + The attorneys of the Unit shall be empowered by law to conduct criminal investigations as Prosecutors and to bring civil and administrative actions as deemed necessary to enforce the purposes for which this Unit was created. Furthermore, in order to carry out the task entrusted thereto, the investigators of the Unit shall be empowered to investigate, report, arrest, serve orders, possess and carry firearms, administer oaths, and issue subpoenas and/or civil investigative demands.

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CHAPTER III. MEDICAID FRAUD
Section 3.01.- Referrals and Investigations

- + The Unit shall receive referrals of suspected or potential fraud in the Medicaid Program in Puerto Rico from the State Medicaid Agency, the Health Insurance Administration, affected beneficiaries and/or outside sources. Depending on the nature of the allegations, the Unit Director shall order an investigation, refer the matter to the competent body, or order the dismissal thereof if he determines that no further action is required. The Unit shall notify in writing the decision of whether to accept or deny a referral. If the initial review of the referral does not show sufficient basis for criminal prosecution, the Unit shall transfer the matter to the appropriate agency for analysis and determination. Likewise, the Unit shall have access to the Medicaid Management Information System (MMIS) of Puerto Rico as part of the investigative duties thereof. The Units shall also have access to the Prescription Drug Monitoring Program (PDMP) for the same purposes.
- + The Unit may also refer to both the State Medicaid Agency and ASES for the potential suspension of payment to any provider with respect to which an investigation has been initiated for material and credible allegations of Medicaid fraud. Likewise, if in the discharge of the delegated duties relating to the initial review, the Unit finds that there was an overpayment in favor of a healthcare facility or another provider of medical assistance under the Medicaid Program, the Unit shall initiate the pertinent collections actions or refer the matter to the appropriate agency.

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CHAPTER III. MEDICAID FRAUD

Section 3.02.- Investigation; Demands; Procedure

- + Whenever the Secretary has reason to believe that any person and/or entity has possession, custody, or control of any documentary material and/or information relevant to an investigation about potential Medicaid fraud, the Secretary may require in writing the production of documentary material and/or information, and/or access for the examination and investigation thereof through a civil investigative demand. This includes the healthcare service provider or organization that, in accordance with 42 C.F.R. §431.107, shall furnish information and/or records related to the services provided to beneficiaries. The Secretary may require information about the owner or holder of stocks or of any other financial interest to the members of the Board of Directors, administrators, or any other employee of a company.

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The civil investigative demands shall:

- ① Establish the nature of the conduct constituting the alleged fraudulent acts in connection with the Medicaid Program which is being investigated under this Act or other applicable provisions of law;
- ② Describe the class or classes of documentary material to be produced with such definiteness and certainty as to permit such material to be fairly identified;
- ③ Prescribe a return date for each such class which shall provide a reasonable period of time within which the material so demanded may be assembled and made available for inspection, copying, and/or reproduction; and
- ④ Identify the custodian to whom such material shall be delivered.

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No person having custody of documentary material relevant to an investigation about potential Medicaid fraud, including records of services provided to beneficiaries may deny access thereto under the right of privacy of the beneficiary, under any of the privileges of the beneficiary against disclosure or use, nor under any other privilege or right in accordance with the exclusions of the general privacy rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104-191, as amended.

The Unit shall respect the privacy and the right thereto of individuals and shall establish safeguards to prevent the wrongful use of the information under its control.

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CHAPTER III. MEDICAID FRAUD Section 3.03.- Service of Demand

- a) Service of any civil investigative demand or of any petition filed under this Section may be made in any of the following manners:
- ① Delivering an executed copy to any partner, officer, agent, or general agent or to any agent authorized by law to receive service of process on behalf of such person, and/or directly to the person;
 - ② Delivering an executed copy to the principal office or place of business; or
 - ③ Depositing an executed copy by certified mail with a return receipt requested, addressed to the person to his principal office or place of business.

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- b) A verified return by the individual serving any civil investigative demand setting forth the manner of such service shall be prima facie evidence of such service. In the case of service by registered or certified mail, such return shall be accompanied by the return post office receipt of delivery thereof. Any person upon whom any civil investigative demand for the production of documentary material has been served under this Section shall make such material available for inspection, copying, and reproduction to the investigator at the principal place of business of such person, or at such other place as the investigator and the person thereafter may agree and prescribe in writing, or as the Court may direct. An investigator who receives any documentary material as prescribed in this Section shall take physical possession thereof and shall be responsible for the use made and for the return thereof as provided herein. While in the possession of such investigator, such documentary material shall not be available for examination by any individual other than the Secretary, the person to whom he delegates, or the Unit's staff, unless consent is given by the person who produced such documentary material. Under such terms and conditions as the Secretary shall prescribe, documentary material in the possession of the investigator shall be available for examination by the person who produced it or by an authorized agent of that person.

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CHAPTER III. MEDICAID FRAUD

Section 3.04. - Account Freeze and Property Forfeiture

Upon petition of the Secretary or the person to whom he delegates in the Unit, the Court may enter a temporary injunction or a preliminary restraining order to freeze bank accounts, require the execution of a performance bond for real property, or take any action to preserve the availability of property described in Section 3.02 available so as to guarantee the subsequent forfeiture thereof if appropriate under this Section, according to any of the following alternatives:

- ① Upon the filing of an indictment or information charging a violation of this Act and alleging that the property with respect to which the order is sought would, in the event of conviction, be subject to forfeiture under this section; or
- ② A temporary restraining order may be entered without notice or opportunity for a hearing when an information or indictment has not yet been filed with respect to the property, if the Prosecutor demonstrates that there is probable cause to believe that the property with respect to which the order is sought would, in the event of conviction, be subject to forfeiture and that provision of notice shall jeopardize the availability of the property for forfeiture. The temporary order shall expire not more than ninety (90) days after the date on which it is entered, unless extended for good cause shown. A hearing requested concerning an order entered under this subsection shall be held by the Court at the earliest possible time and prior to the expiration of the temporary order.
- ③ At any hearing held pursuant to this section the Puerto Rico Rules of Evidence shall not apply.

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CHAPTER III. MEDICAID FRAUD Section 3.05.- Noncompliance with Demands

Whenever any person fails to comply with any civil investigative demand for the production of documentary material issued under this Act, or whenever satisfactory copying or reproduction of any material requested in such demand cannot be done and such person refuses to surrender such material, the Secretary may file with the Court a petition for the enforcement of the provisions of this Act. Any disobedience of any order entered under this section by any court shall be punished as a contempt of the court and shall be the basis for the suspension of any license, permit, or authorization that has been granted to the person or business under investigation. Within twenty (20) days after the date of service of the civil investigative demand, or at any time before the return date specified in the demand, whichever date is earlier, the person may file a petition for a Court order to modify or render it without effect. During the pendency of the petition in the Court, the Court may stay the running of the time allowed for compliance with the demand. The petition shall specify the grounds therefor, and may be based upon any failure of the demand to comply with the provisions of this Act and/or upon any constitutional or other legal right.

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CHAPTER III. MEDICAID FRAUD Section 3.06.- Return of Material

Upon the completion of the investigation or of any case or proceeding arising out of such investigation, the investigator shall return the documentary material to the person who produced them, other than the copies made by the Secretary. If no case or proceeding has been commenced within a reasonable time after completion of the examination and analysis of all the evidence assembled in the course of such investigation, the person who produced such evidence shall be entitled, upon written request to the Secretary, to have such documentary material returned to him. In the event of the death, disability, or separation from service of the custodian of any documentary material produced pursuant to a civil investigative demand under this Act, or in the event that the investigator is relieved from responsibility for the custody of such material, the Secretary shall promptly: (1) designate another investigator from the Unit to serve as custodian of such material, and (2) notify in writing to the person who produced such material, the name and address of the successor so designated. Any person who is designated to be a successor shall have, with regard to such material, the same function, duties, and responsibilities as were imposed by this Act upon that person's predecessor in office, except that the successor shall not be held responsible for any negligence which occurred before that designation.

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CHAPTER III. MEDICAID FRAUD

Section 3.07.- Medicaid Fraud and Penalties

- A. Shall incur in Medicaid Program Fraud, any person who willingly and knowingly:
- 1) Presents and/or causes to be presented a claim to the Medicaid Program, knowing that it is partially or completely false.
 - 2) Makes or causes to be made a false statement or representation for the purpose of obtaining or attempting to obtain an authorization to offer a good or service under the Medicaid Program, knowing that the false statement or representation is partially or completely false.
 - 3) Makes or causes to be made a false statement or representation to be used by another person to obtain a good or service under the Medicaid Program, knowing that the false statement or representation is partially or completely false.
 - 4) Makes or causes to be made a false statement or representation in order to be used to qualify as provider of a good or service under the Medicaid Program, knowing that the false statement or representation is partially or completely false.
 - 5) Charges to any beneficiary or person who acts on behalf of a beneficiary, money or other consideration at a rate in excess of the rates agreed with the Managed Care Organization, any health service organization and/or insurer, regardless of the healthcare delivery model.
 - 6) Except as otherwise authorized under the Medicaid Program, pays, charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under the Medicaid Program any gift, money, donation, or other consideration or bribe in connection with the goods or services paid or claimed by a provider under the Medicaid Program.

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- 7) Knowingly presents or causes to be presented a claim for payment under the Medicaid Program for:
 - (a) A good or service that has not been approved or acquiesced in by a treating physician or a health care professional;
 - (b) A good or service that is substantially inadequate or inappropriate when compared to generally recognized standards within the particular discipline or within the health care industry; or
 - (c) A product that has been adulterated, debased, mislabeled, or that is otherwise inappropriate;
 - (d) A good or service that has not been provided as claimed; and/or
 - (e) A good or service that is not medically necessary.
- 8) Is a Managed Care Organization, a health service organization and/or insurer regardless of the healthcare delivery model and knowingly:
 - (a) Fails to provide to an individual a health care benefit or service that the entity is required to provide under the contract;
 - (b) Fails to provide to the commission or appropriate state agency information required to be provided by law, regulation, or contractual provision; or
 - (c) Engages in a fraudulent activity in connection with the enrollment of an individual eligible under the Medicaid Program in the organization's managed care plan or in connection with marketing the organization's services to an individual eligible under the Medicaid Program;
 - (d) Commits a violation of any of the provisions of this Act to receive or cause to be received an unauthorized payment or benefit under the Medicaid Program.

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B. Penalties for Medicaid Fraud

Any person who violates any of the provisions of this Act to receive or cause to be received an unauthorized payment or benefit under the Medicaid Program shall be guilty of a Medicaid Fraud offense and shall be punished as follows:

- a) Any person who commits Medicaid Fraud shall be guilty of a felony if the total amount of the payments unlawfully claimed or obtained is less than two thousand five hundred dollars (\$2,500), and upon conviction, shall be punished by imprisonment for a fixed term of three (3) years. If there are aggravating circumstances, the punishment shall be increased to up to five (5) years; if there are mitigating circumstances, the punishment shall be reduced to a minimum of one (1) year. Likewise, such person shall pay a fine not to exceed three (3) times the amount of the payments unlawfully claimed or obtained, or a fine of one thousand dollars (\$1,000), whichever is higher.
- b) Any person who commits Medicaid Fraud shall be guilty of a felony if the total amount of the payments unlawfully claimed or obtained is two thousand five hundred dollars (\$2,500) or more, and upon conviction, shall be punished by imprisonment for a fixed term of five (5) years. If there are aggravating circumstances, the fixed punishment shall be increased to up to eight (8) years; if there are mitigating circumstances, the punishment shall be reduced to a minimum of three (3) years. Likewise, such person shall pay a fine not to exceed three (3) times the amount of the payments unlawfully claimed or obtained, or a fine of ten thousand dollars (\$10,000), whichever is higher.
- c) If the person that committed Medicaid Fraud is an entity or juridical person rather than an individual, such person shall be punished with a fine not to exceed fifty thousand dollars (\$50,000) for each offense under subsection (a), and not to exceed two hundred fifty thousand dollars (\$250,000) for each offense under subsection (b).

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CHAPTER IV: FALSE CLAIMS

Section 4.01.- Violations.-

Subject to subsection (2) of this Section, any person who:

1.
 - a. Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval of benefits under any Government Program or under a service contract;
 - b. Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim under any Government Program or under a service contract;
 - c. Conspires to commit a violation of paragraphs 1(a) and 1(b), of this Section; and/or
 - d. Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property, relating to any Government Program or any service contract, as defined in this Act, shall be liable to the Government for a civil penalty of not less than eleven thousand one hundred eighty-one dollars (\$11,181) and not more than twenty-two thousand three hundred sixty-three dollars (\$22,363). These penalties shall be adjusted automatically every year in accordance with the provisions of the Federal Civil Penalties Inflation Adjustment Act of 2015 to be consistent with those authorized under the Federal False Claims Act, 31 USC §3729(a). In addition to this civil penalty, said person shall be subject to three (3) times the amount of damages which the Government sustains because of the fraudulent acts of that person.

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2. However, if the Court finds that:

- a. The person committing the violation of paragraphs 1(a) through 1(d) of this Section, furnished officials of the Government responsible for investigating false claims violations with all information known to such person about the violation within thirty (30) days after the date on which the date such person first obtained the information;
- b. Such person fully cooperated with any state or federal investigation of any violation of paragraphs 1(a) through 1(d) of this Section, as certified by the Department of Justice; and
- c. At the time such person furnished the Government with the information about the violation of paragraphs 1(a) through 1(d) of this Section, no criminal prosecution, or civil action, or administrative action had commenced under this Act, and the person did not have actual knowledge of the existence of an investigation against him for such violations.

In these cases, the Court may reduce from three (3) to two (2) times the amount of damages which the Government sustains because of such acts.

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3. A person violating paragraphs 1(a) through 1(d) of this Section shall also be liable for attorney's fees and the costs incurred to recover any such civil penalty and/or damages.

4. Any person who agrees or intends to perform any act described in paragraphs 1(a) through 1(d) of this Section shall be brought before the Court of First Instance, San Juan Part, in a complaint filed by the Secretary or the person designated by him. Said complaint shall be filed on behalf of the Government and shall be granted if it clearly shows that the rights of the Government have been violated by said person or entity and that the Government shall sustain imminent and irreparable damage, harm, or loss pending a final judgment resolving the dispute, or that the acts or omissions of such person or entity render inefficient said final judgment. The Court may enter judgments or orders, including the appointment of a receiver, as necessary to prevent any of the acts described in paragraphs 1(a) through 1(d) of this Section by any person or entity, or as necessary to return to the Government any money or real or personal property that may have been acquired through such acts.

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CHAPTER IV: FALSE CLAIMS

Section 4.02.- Civil Actions; Who May Bring Civil Actions.

1. If the Secretary or his designee finds that a person has violated or is violating Section 4.01 of this Act, the Secretary or his designee may bring a civil action against the person.
2.
 - a. Any person may bring a civil action and file a complaint in his capacity as Relator for a violation of Section 4.01 of this Act in the name of the Government. All actions shall be brought in the name of the Government. Such action may be dismissed without prejudice only if the Secretary or his designee give written consent to the dismissal and their reasons for consenting.
 - b. A copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the Government, through the Secretary, on the filing date thereof, by the person who filed the complaint with the Court on behalf of and in the name of the Government. The complaint shall be filed with the Court of First Instance, shall remain under seal for at least sixty (60) days, and shall not be served on the defendant until the court so orders. In the complaint, the Relator shall certify under penalty of perjury that he did not obtain information from the persons precluded from filing a complaint under Section 1.02(g) of this Act. The Government may elect to intervene in the process, substitute the complainant and proceed with the action within sixty (60) days after it receives the complaint and the necessary evidence and information for the Secretary to investigate the information reported. The Court may extend the sixty (60)-day term for the Government to issue its decision whether or not it shall intervene; provided, that the Secretary or his designee requests such extension showing good cause to continue the investigation before deciding whether to intervene.

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c. Before the expiration of the sixty (60)-day period or of any extension, the Government may:

- i. Proceed with the action, in which case it shall be conducted by the Government.
 - ii. Notify the Court that it shall not assume jurisdiction of the civil action, in which case, the person bringing the action shall conduct the action.
 - iii. The Secretary or his designee shall have full discretion to make a decision of whether to intervene in any case brought under this Act by any private citizen, and such decision shall not be subject to judicial review nor challenge by the petitioner.
- d. When a private person brings an action, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action.
3. If the Government proceeds with the action, it shall have the primary responsibility for prosecuting the action, and shall not be bound by an act of the person who originally brought the action.
- a. The Government may dismiss the action at any time pursuant to subsection 2(a) of this Section notwithstanding the objections of the person initiating the action. A copy of the motion stating the reasons for the dismissal of the action must be served on the person who brought the action. Upon notice of the motion, the person who brought the action shall have fifteen (15) days to oppose the dismissal of the action. In this case, the Court shall hold a hearing within a term of twenty (20) days after the objection of the person who brought the action is received and notified.
 - b. The Government may settle the action with the defendant notwithstanding the objections of the person bringing the action if the court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable.

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4. If the Government elects not to proceed with the action, the Secretary may allow the person who initiated the action to conduct the action before the Court on behalf and in favor of the Government. If the Relator is authorized to proceed with the action, he shall not be authorized to settle the claim on behalf of the Government, until the settlement proposal or motion to dismiss is filed with the Secretary or his designee for approval. Any payment for a Transaction shall be made to the name of the Secretary of the Treasury of Puerto Rico. Any compensation awarded to a Relator shall be subject to agreement between the Relator and the Government. If the Government elects not to proceed and allows the Relator to continue with the litigation, the Secretary may require to be served of all pleadings filed and be supplied with copies of all the evidence presented, including deposition transcripts at the Relator's expense. If the Relator prevails in the action, in addition to the compensation awarded to him for the referral and transaction, the Relator may request the reimbursement of necessary and reasonable expenses which he has incurred and have not been awarded by the Court as attorney fees and costs. If the Government elects not to proceed and the Relator continues with the litigation, the Government shall not be liable to the Relator nor the defendant for any attorney fees. Once the cause of action is initiated, the Court may permit the Government to intervene at a later date upon showing good cause and through an express request from the Secretary or his designee. The Court shall not have jurisdiction to require the Secretary or his designee to intervene in certain action. Likewise, the Government may request the Court to limit the number of the Relator's witnesses, testimonies, and cross-examination if the Government believes that the Relator's unrestricted participation would affect a criminal investigation related thereto or if it believes that not doing so would result in repetitious or irrelevant testimonies or would unduly delay the process.

Whether or not the Government or the person who brought the action proceeds with the action, the Court, at the request of the Government, may stay discovery for a period of not more than sixty (60) days if the Government shows that all or part of discovery would interfere with an investigation or prosecution of a criminal or civil matter arising out of the same or similar facts. The hearing to request the stay of discovery shall be held in camera. The sixty (60)-day period may be extended at the request of the Government if the Court determines that it has acted in good faith and that continuing with discovery shall interfere with other ongoing investigations.

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CHAPTER IV: FALSE CLAIMS

Section 4.03.- Compensation

1. If the Government proceeds with an action, the person who brought the complaint or the Relator shall be entitled to receive at least fifteen percent (15%) but not more than twenty-five percent (25%) of the proceeds of the action received by the Government for violations of the Government Program or service contract, as the case may be. Provided, that the Relator shall be entitled to such compensation once the Government enforces the judgment or settlement agreement and has received the payment. Until the Government receives payment, the Relator shall not be entitled to collect his share of the proceeds. Absent an agreement between the Government and the Relator, the Court shall establish the percentage of the proceeds set forth in this Section that the person who brought the complaint shall receive.
2. If the Court finds that the participation of the person who brought the action or the Relator was based on information readily accessible to any person rather than a rigorous investigation, it may fix a compensation of ten percent (10%) of the amount received by the Government under the judgment or settlement agreement.
3. Any payment to the person bringing the action on behalf of the Government shall be made from the proceeds of the judgment or settlement agreement. Except that, if the Government receives partial payments under a judgment or settlement agreement, the Relator may only be entitled to receive the percentage awarded as compensation from the payment received. The Court may impose additional fees to the defendant for reasonable additional costs which the person bringing the action had incurred, such as attorney fees. The person bringing the action shall file with the Court an itemization of the expenses incurred, within fifteen (15) days after the date of the judgment or settlement agreement.

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4. If the Government does not proceed with an action, the Relator shall receive not less than twenty-five percent (25%) and not more than thirty percent (30%) of the amount of the judgment as determined by the Court, in addition to any reasonable and necessary expenses incurred in the litigation, under the same collection parameters for the Government stated in the above subsection. The Relator shall file with the Court an itemization of such expenses, within fifteen (15) days after the date of the judgment or settlement agreement.

5. Regardless of whether it was the Government or the Relator that conducts the action, if the Court finds that evidence was presented indicating that the Relator conspired, participated, or aided in the commission of the violation of the Government Program or service contract, the share from the proceeds of the judgment or settlement agreement shall be reduced by five percent (5%). If, as a result of the conspiracy, participation, or aid in the commission of the violation of the Program or service contract, the Government files criminal charges against the person bringing the action, the Relator shall be dismissed from the action as the Government's representative and shall not receive any share of the proceeds of the judgment or settlement agreement arising from his referral. The Government may, however, continue with the cause of action at the discretion of the Secretary or his designee.

6. If the Government does not proceed with an action and the Court finds that it lacks merit, the Court shall impose fees for recklessness, as necessary, on petitioner. The defendant shall have fifteen (15) days from the date the Court enters or dismisses the action to submit to the Court an itemization of the reasonable fees and expenses incurred.

7. The Government shall never be liable for expenses incurred by the Relator in bringing the action or conducting the action in benefit of the Government. If the Relator prevails in the action, the Relator may be reimbursed such necessary and reasonable expenses in connection with the action, excluding any sums for attorney's fees incurred by the Relator which shall not be reimbursable by the Government.

8. No Relator shall be compensated by the Government for having referred a fraud or false statements for investigation, which has not been brought in Court as a Qui Tam action.

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CHAPTER IV: FALSE CLAIMS

Section 4.04.- Collateral Estoppel

1. In no event may a person bring an action which is based upon allegations or transactions which are or were the subject of a civil suit or an administrative civil money penalty proceeding in which the Government was already a party.
 - a. The court shall dismiss an action if the allegations or transactions as alleged in the action or claim, series of events, or actors are substantially the same. In these cases, the Government may bring the action at its discretion.

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CHAPTER IV: FALSE CLAIMS

Section 4.05- Rights of the Relator.

Any person, employee, contractor, or agent shall be entitled to bring a complaint as Relator if he knows of the existence of a violation of this Chapter of this Act, unless expressly prohibited by Section 1.02(g) of this Act. If such employee, contractor, or agent is discharged, demoted, suspended, threatened, or otherwise discriminated against in the terms and conditions of employment for bringing an action, such employee shall be entitled to the protections of Title IV of Act No. 2-2018, known as the "Anti-Corruption Code for a New Puerto Rico," and the applicable Federal Laws.

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CHAPTER IV: FALSE CLAIMS

Section 4.06.- Subpoena and Statute of Limitations.

1. A subpoena requiring the attendance of a witness at a proceeding arising from the provisions of this Act may be served in Puerto Rico or any other state or territory of the United States of America, as provided in the Puerto Rico Rules of Civil Procedure.
2. A civil action under the provisions of this Act may not be brought:
 - a. Six (6) years after the date on which the violation of the Government Program or the service contract is committed, in accordance with the provisions of this Act.
 - b. Within three (3) years after the date when the allegations of potential violations are known by the Government, regardless of the fact that the six (6)-year term of paragraph (a) has elapsed, but in no event more than ten (10) years after the date on which the violation is committed.
 - c. If evidence is presented indicating that the violation constituting fraud or a false statement occurred during a conspiracy, the statute of limitations shall begin to elapse when the last act of the conspiracy takes place.

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CHAPTER IV: FALSE CLAIMS

Section 4.07.- Criminal Action

- + A civil action under the provisions of this Act shall not preclude the Government from bringing a criminal action based on the same facts of the civil action or to proceed with administrative remedies before the concerned government entities.

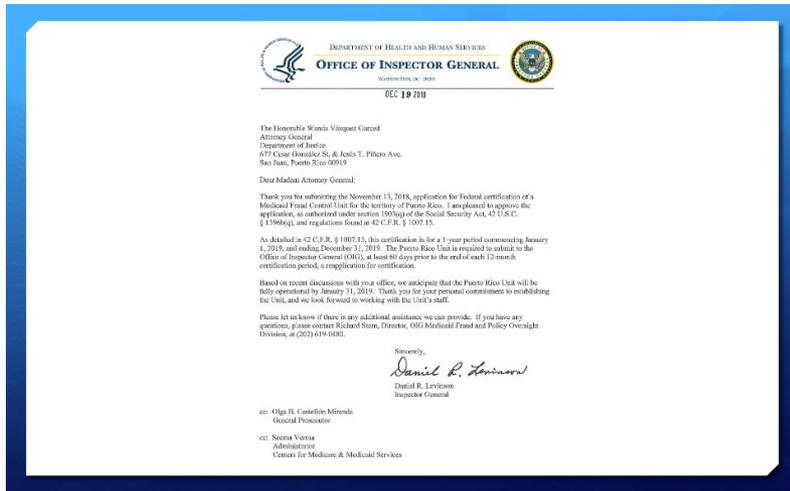
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CHAPTER V: FINAL GENERAL PROVISIONS

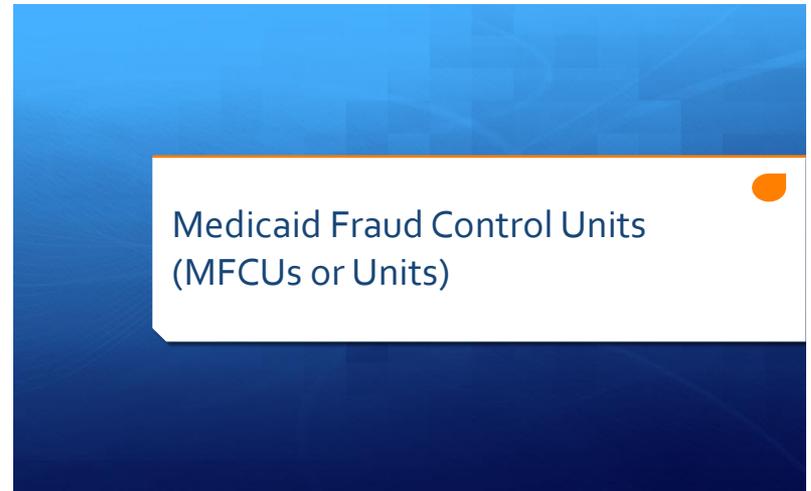
Section 5.1.- Jurisdiction and Competence

- + The Court of First Instance, Superior Part of San Juan, shall be the primary and exclusive forum where criminal actions shall be brought by the Medicaid Fraud Control Unit. In addition, it shall be the forum where complaints for violations of Government Programs or service contracts shall be brought under the provisions of this Act, regardless of the judicial region where the fraud or false statement occurred.

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Medicaid Fraud Control Units (MFCUs or Units)

- + Medicaid Fraud Control Units (MFCUs) investigate and prosecute Medicaid provider fraud as well as patient abuse or neglect in health care facilities and board and care facilities. MFCUs operate in 49 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. The MFCUs, usually a part of the State Attorney General's office, employ teams of investigators, attorneys, and auditors; are constituted as single, identifiable entities; and must be separate and distinct from the State Medicaid agency. OIG, in exercising oversight for the MFCUs, annually recertifies each MFCU, assesses each MFCU's performance and compliance with Federal requirements, and administers a Federal grant award to fund a portion of each MFCU's operational costs.

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Medicaid Fraud Control Units (MFCUs or Units)

- + The Department of Health and Human Services Office of Inspector General is the designated Federal agency that oversees and annually approves Federal funding for MFCUs through a recertification process. For this report we analyzed the annual statistical data on case outcomes—such as convictions; civil settlements and judgments; and recoveries—that the 50 MFCUs submitted for fiscal year 2017.

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Medicaid Fraud Control Units (MFCUs or Units)

- + The function of Medicaid Fraud Control Units (MFCUs or Units) is to investigate and prosecute Medicaid provider fraud and patient abuse or neglect.
- + The Social Security Act (SSA) requires each State to effectively operate a MFCU, unless the Secretary of Health and Human Services determines that (1) the operation of a Unit would not be cost-effective because minimal Medicaid fraud exists in a particular State and; (2) the State has other adequate safeguards to protect beneficiaries from abuse or neglect.
- + Currently, 49 States and the District of Columbia (States) operate MFCUs. MFCUs are funded jointly by Federal and State Governments. Each of the 50 MFCUs receives Federal reimbursement equivalent to 75 percent of its total expenditures, with State funds contributing the remaining 25 percent. In fiscal year (FY) 2017, combined Federal and State expenditures for the Units totaled approximately \$276 million, \$207 million of which represented Federal funds.

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- + Units must meet a number of requirements established by the SSA and Federal regulations. For example, each Unit must:
 - + be a single, identifiable entity of State Government, separate and distinct from the State Medicaid agency;
 - + employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney;
 - + develop a formal agreement, such as a memorandum of understanding, describing the Unit's relationship with the State Medicaid agency; and
 - + have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority.

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Medicaid Fraud Control Units (MFCUs or Units)

- + MFCU cases typically begin as referrals from external sources or are generated internally from data mining. MFCU staff review referrals of possible fraud and patient abuse or neglect to determine their potential for criminal prosecution and/or civil action. If the Unit accepts a referral for investigation, the case may result in various possible outcomes, such as convictions; civil settlements or judgments; and monetary recoveries. The Office of Inspector General (OIG) has the authority to exclude convicted individuals and entities from any federally funded health care programs on the basis of convictions referred from MFCUs. Units may also make program recommendations to their respective State Governments that help strengthen program integrity and efforts to fight patient abuse or neglect.

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Medicaid Fraud Control Units (MFCUs or Units)

- + OIG oversees the MFCU grant program by recertifying Units, conducting onsite reviews of Units, providing technical assistance to Units, and maintaining key statistical data about Unit caseloads and outcomes. Further, OIG has identified enhancing Medicaid program integrity—including efforts to maximize the effectiveness of MFCUs—as an OIG Priority Outcome.

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Medicaid Fraud Control Units (MFCUs or Units)

- + Annually, OIG approves each Unit's application for recertification, which is necessary for the Unit to receive Federal reimbursement. To recertify a Unit, OIG assesses the Unit's compliance with the Federal requirements for MFCUs contained in statute, regulations, and OIG policy transmittals. OIG also examines the Unit's adherence to 12 performance standards, such as those regarding staffing, maintaining adequate referrals, and cooperating with Federal authorities.

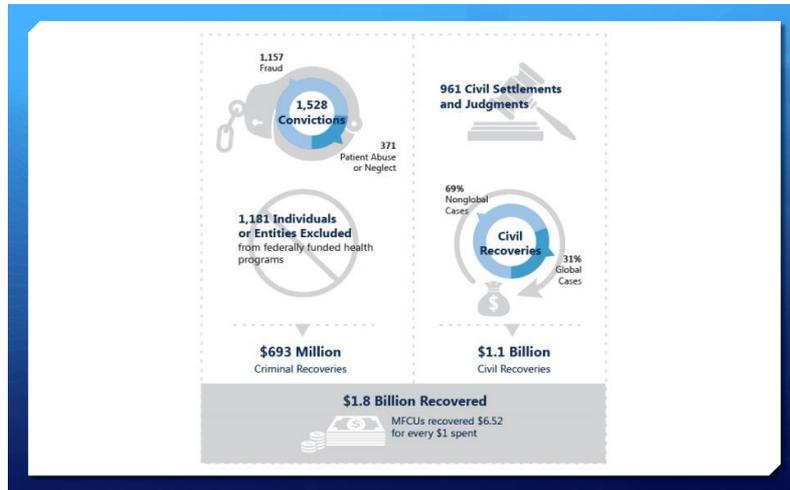
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A significant outlier for recovery amounts was Florida, where the MFCUs recovered \$101,059,813 in Medicaid fraud, the highest by far of any state in the country

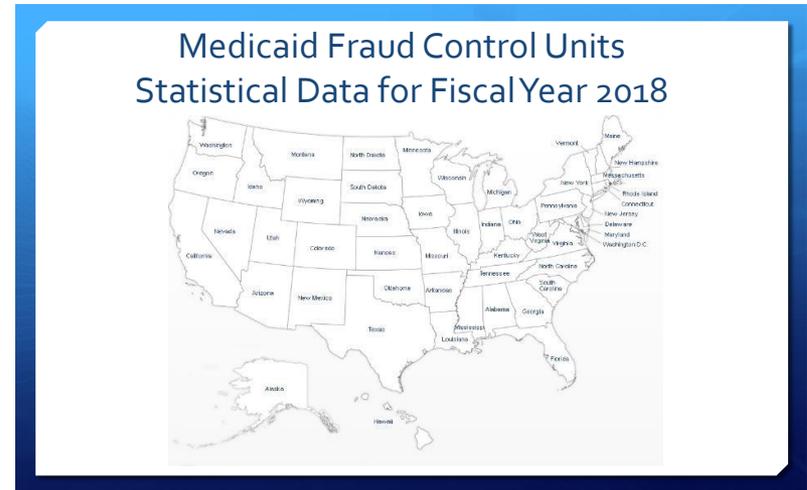
"We work with the Florida MFCU quite a bit. And there are several cases that come immediately to mind. First, working with the Florida MFCU, we charged 10 owners of a Miami-Dade county Assisted Living Facility with health care fraud and receiving illegal cash kickbacks in return for referring residents to a specific pharmacy," said Shimon Richmond, Special Agent in Charge in Miami.

"The pharmacy owner was sentenced not long ago, to federal prison and ordered to pay back more than a million dollars to the Florida Medicaid program. This ring was exposed by joint efforts between OIG agents and MFCU agents working in undercover capacity."

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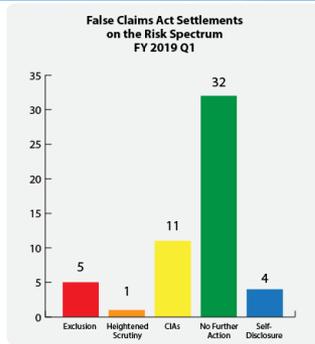


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False Claims Act Settlements on the Risk Spectrum FY 2019 Q1



OIG State Enforcement Actions

Office of Attorney General Maura Healey of the
Commonwealth of Massachusetts

PRESS RELEASE

**Newton Doctor to Pay \$680,000 to Resolve Allegations
That He Overbilled MassHealth for Services at Nursing
Homes**

FOR IMMEDIATE RELEASE
2/21/2019

Office of Attorney General Maura Healey

MEDIA CONTACT

Alex Bradley

Office of Attorney General Letitia James
Maura Healey of New York, NY

**Attorney General James Announces Conviction Of
“Three-Quarter House” Director Charged With
Defrauding Medicaid Through A Kickback Scheme**

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State Enforcement Actions | Medicaid Fraud Control Units |
Office of Inspector General | U.S. Department of Health
and Human Services

March 2019

March 20, 2019; Louisiana Attorney General

Across Louisiana, Arrests Made for Medicaid Welfare Fraud

- + BATON ROUGE, LA - Five Louisiana Medicaid recipients have been arrested on charges related to welfare fraud, announced Louisiana Attorney General Jeff Landry. The arrests come after investigations by the Louisiana Bureau of Investigation, the Louisiana Department of Health, and the Louisiana Legislative Auditor's Office.

March 18, 2019; Nevada Attorney General

Attorney General Ford Announces Sentencing of Medicaid Provider

- + Las Vegas, NV - Nevada Attorney General Aaron D. Ford announced that Felecia Bluntson, 34, of Las Vegas, was sentenced today in a Medicaid fraud case involving false billing for medical services to Medicaid recipients. The fraud occurred between May 2016 and September 2016.

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March 15, 2019; New York Attorney General

Attorney General James Announces Sentencing Of Owner Of Three Manhattan Pharmacies For Defrauding Medicaid

- + NEW YORK - Attorney General Letitia James today announced the sentencing of licensed pharmacist Hin T. Wong ("Wong"), 50, of Manhattan, the owner of three Manhattan pharmacies in connection with a multi-million dollar Medicaid fraud scheme involving HIV drugs. Wong was sentenced today before Manhattan Supreme Court Justice Mark Dwyer to a term of incarceration of two to six years in state prison. Wong additionally forfeited over \$3,600,000 as restitution to the New York State Medicaid program.

March 4, 2019; Massachusetts Attorney General

Brockton Adult Foster Care Provider Resolves Allegations of MassHealth Fraud

- + Boston - Victory Human Services Inc. (Victory) will pay more than \$548,000 to resolve allegations that it fraudulently charged the state's Medicaid program (MassHealth) for Adult Foster Care (AFC) services, Attorney General Maura Healey announced today.

March 1, 2019; Tennessee Department of Finance and Administration

Hamilton Co. Woman Charged with ID Theft, TennCare Fraud

- + NASHVILLE, Tenn. -- A Hamilton County woman is charged with TennCare fraud in connection with using another person's identity in order to obtain controlled substances.

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Dialysis Services Provided by Atlantis Health Care Group of Puerto Rico, Inc., Did Not Comply With Medicare Requirements Intended To Ensure the Quality of Care Provided to Medicare Beneficiaries

12-28-2018 | Audit (A-02-16-01009) | [Complete Report](#) | [Report in Brief](#)

- + Atlantis Health Care Group of Puerto Rico, Inc., claimed dialysis services that did not comply with Medicare requirements during all 100 beneficiary-months that OIG sampled. For example, Atlantis claimed reimbursement for dialysis services for which (1) beneficiaries' medical information was not adequately supported, (2) plans of care or comprehensive assessments did not comply with Medicare requirements, and (3) physicians' orders did not meet Medicare requirements.
- + These errors occurred because Atlantis' electronic health records system and related procedures were not adequate to ensure that certain end-stage renal disease measurements and comorbidities documented in beneficiaries' medical records were correctly reported on their associated Medicare claims. Additionally, while Atlantis had policies and procedures in place to ensure that dialysis services were properly ordered and adequately documented, and that plans of care and comprehensive assessments contained all required elements, these policies and procedures were not effective, not followed, or did not meet Medicare requirements.
- + OIG estimated that Atlantis received unallowable Medicare payments of at least \$403,000 for dialysis services that did not comply with Medicare requirements. Many of the deficiencies we identified did not affect Atlantis' Medicare reimbursement for the services since they were reimbursed on a bundled per treatment basis or related to Medicare conditions for coverage. However, the deficiencies could have a significant impact on the quality of care provided to Medicare beneficiaries and could result in the provision of inappropriate or unnecessary dialysis services.
- + OIG recommended that Atlantis refund an estimated \$403,000 to the Medicare program. OIG also made a series of recommendations to strengthen Atlantis' policies and procedures for ensuring that dialysis services comply with Medicare requirements. Atlantis concurred with OIG findings and recommendations and described actions it has taken or planned to take to address them.

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EL VOCERO

22/02/2018

Sentencian a 48 meses de cárcel a mujer por fraude Medicaid

Melissa Correa Velázquez, EL VOCERO 22/02/2018



EL VOCERO / Archivo.

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January 1, 2019

U.S. Attorney Rosa E. Rodriguez-Velez warned that the Elderly Task Force has been established to prosecute relatives, administrators of senior centers and anyone who commits a crime against senior citizens.

April 22, 2019

U.S. Attorney Rosa Emilia Rodriguez Velez announced a campaign to prevent mistreatment against senior citizens and prosecute people or entities for that practice. Also join the campaign the Department of Justice, Department of Family, the OPP, and the entity AARP.

Federales entrarán a castigar el maltrato a los viejitos

Por Frances Rosario / frances.rosario@fmedia.com

12/2/2019 11:45 p.m.



En Puerto Rico, los últimos años del Censo para el año 2017 establecieron que había 1,178,898 personas de 60 años o más. (usa.censusbureau.gov/mexico.com)

Crean un Elderly Task Force para comenzar a procesar al que cometa crímenes contra los adultos mayores.

Estatales y federales pendientes al maltrato contra adultos mayores

La mayoría de los incidentes de maltrato que enfrentan los adultos mayores son, el físico y la explotación financiera.

Por Qüemas
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CGS ADMINISTRATORS, LLC, MADE MEDICARE PART B PAYMENTS FOR THERAPEUTIC SHOES FURNISHED TO BENEFICIARIES IN PUERTO RICO THAT GENERALLY DID NOT COMPLY WITH FEDERAL REQUIREMENTS

- + Department of Health and Human Services, Office of Inspector General
- + Report made by James P. Edert, Regional Inspector General, June 2013 / A-02-11-01001

Summary: *CGS Administrators, LLC made payments for therapeutic shoes furnished to Medicare beneficiaries in Puerto Rico that generally did not comply with Federal requirements.*

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Why OIG did this Review

- + Medicare Part B covers durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), including therapeutic shoes for individuals with diabetes. CGS Administrators, LLC (CGS) contracts with the Centers for Medicare & Medicaid Services (CMS) to process and pay Medicare Part B claims for DMEPOS including therapeutic shoes and inserts (therapeutic shoes).
- + This review was performed as a result of Medicare program integrity efforts that identified suppliers who were improperly billing for therapeutic shoes furnished to beneficiaries (beneficiaries) in Puerto Rico. In addition, a prior Office of Inspector General review of DMEPOS claims determined that suppliers did not always have required documentation on file.
- + The objective was to determine whether Medicare Part B claims processed and paid by CGS for therapeutic shoes furnished to beneficiaries complied with Federal requirements.

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Background

- + Medicare Part B provides for the coverage of DMEPOS. CMS, which administers the Medicare program, contracts with durable medical equipment Medicare administrative contractors (DME MAC) to, among other things, process and pay claims for therapeutic shoes. CGS is the DME MAC for the Commonwealth of Puerto Rico.
- + A physician who is treating a beneficiary's systemic diabetic condition must certify the need for therapeutic shoes to treat qualifying foot conditions and the shoes must be ordered by a podiatrist or other qualified physician. In addition, therapeutic shoe suppliers must add a KX modifier to the claims attesting that required documentation, including the signed and dated physician's order and proof of delivery, is on file. Claims submitted without the KX modifier will be denied for payment.

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How OIG Conducted the Review

- + During the period January 1, 2009, through June 30, 2010, CGS processed approximately \$1.5 million in Part B claims for therapeutic shoes supplied to 6,269 beneficiaries. OIG selected a stratified random sample of 100 beneficiaries and for each sampled beneficiary we obtained and reviewed the supporting documentation maintained by the therapeutic shoe supplier.

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What OIG found?

Most Medicare Part B claims processed and paid by CGS for therapeutic shoes furnished to beneficiaries did not comply with Federal requirements. For the 100 sampled beneficiaries in our stratified random sample, CGS correctly processed and paid claims for therapeutic shoes for 38 of the sampled beneficiaries. However, for the remaining 62 sampled beneficiaries, CGS processed and paid claims for therapeutic shoes totaling \$13,906 in unallowable payments to suppliers that did not comply with Federal requirements. Specifically:

- + For 43 sampled beneficiaries, physician's orders were missing or incomplete.
- + For 37 sampled beneficiaries, the physician's certification for therapeutic shoes was missing or incomplete.
- + For two sampled beneficiaries, the supplier did not maintain proof of delivery documentation.

The total exceeds 62 because we found more than 1 deficiency for 19 sampled beneficiaries.

On the basis of our sample results, we estimated that CGS paid \$781,751 in unallowable Medicare payments for therapeutic shoes furnished to beneficiaries during our January 1, 2009, through June 30, 2010 audit period.

Suppliers included in our sample attributed the unallowable payments to clerical errors and a lack of knowledge of applicable Medicare requirements. Moreover, CGS did not review these claims to determine if they were allowable. Rather, CGS relied on training and guidance provided to suppliers and the required the usage of the KX modifier to ensure claims complied with Federal requirements.

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What OIG recommended?

We recommend that CGS:

- + recover the \$13,906 in identified overpayments;
- + determine the additional amount of unallowable payments in the population, estimated to be \$767,845 (\$781,751 less \$13,906); and
- + use the results of this audit in its supplier education activities.

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CGS Comments

- + In written comments on our draft report, CGS concurred with our first and third recommendations. Regarding our second recommendation, CGS stated that it would consider conducting a statistical review of claims for therapeutic shoes. CGS also stated that it was aware of vulnerabilities associated with claims for therapeutic shoes and described corrective actions that it has taken to address those vulnerabilities.

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OIG Finds Weaknesses in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse

Daniel R. Levinson, Inspector General, OEI-02-15-00260, July 2018

- + The Department of Health and Human Services (HHS) Office of Inspector General (OIG) released a report finding weaknesses in Medicaid managed care organization (MCO) efforts to identify and address fraud and abuse.
- + The report is based on a survey requesting 2015 data from the largest MCO (by expenditures) in 38 states as well as interviews with select MCO and state officials. Key findings include:
 1. some MCO's identified and referred few cases of suspected fraud or abuse in 2015;
 2. not all MCOs used proactive data analysis;
 3. MCOs did not typically inform states when acting against providers suspected of fraud or abuse; and
 4. MCOs did not always identify and recover overpayments. The OIG concluded that the weaknesses it identified "suggest that MCOs need additional incentives to identify and refer cases and identify and recover overpayments."

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- + The OIG issued 8 recommendations for action by the Centers for Medicare & Medicaid Services (CMS), working with states, to:
 1. improve MCO identification and referral of cases of suspected fraud or abuse,
 2. increase MCO reporting to the State of corrective actions taken against providers suspected of fraud or abuse,
 3. clarify the information MCOs are required to report regarding providers that are terminated or otherwise leave the MCO network,
 4. identify and share best practices about payment-retention policies and incentives to increase recoveries,
 5. improve coordination between MCOs and other State program integrity entities,
 6. standardize reporting of referrals across all MCOs in the State, (7) ensure that MCOs provide complete, accurate, and timely encounter data, and
 7. monitor encounter data and impose penalties on States for submitting inaccurate or incomplete encounter data.”
- + CMS concurred with all recommendations except recommendation #6 regarding standardized reporting of referrals. CMS emphasized the need for state flexibility to determine if standardization would be effective in the state. The OIG countered that it “continues to support working with States to develop a standardized template for MCOs, which can reduce provider burden and improve the quality and consistency of referrals.”

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¡Muchas Gracias por su Atención!

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