Provider Fraud from the Government’s Perspective

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Dept. of Health and Human Services, Office of Inspector General

Who are we?
Who Performs Health Care Fraud Investigations?

**Medicaid Fraud Control Unit**
- The MFCU investigates and prosecutes medical assistance provider fraud and patient abuse and neglect within the state Medicaid system.
- The MFCU is a self-contained unit located within the Office of Special Prosecutions in the Criminal Division of the Department of Law.

**HHS, Office of Inspector General**
- Among other responsibilities, OIG investigates allegations that health care providers have submitted claims to HHS-funded health care programs (e.g., Medicare, Medicaid, CHIP) which are false or for worthless services.
- OIG is independent from the rest of HHS.
Federal Structure
- Similar to State structure and process, except more agencies and programs
- Also, must consider administrative sanctions and penalties

**Department of Justice**

**United States Attorney’s Offices**

**Federal Bureau of Investigations**

**U.S. Dept. of Health and Human Services, Office of Inspector General**

**U.S. Dept. of Health and Human Services, Centers for Medicare and Medicaid Services**

**Department of Defense, Office of Inspector General (Defense Criminal Investigative Service)**

**Department of Defense, Defense Health Agency (TRICARE)**

**Office of Personnel Management, Federal Employee Health Benefits**

Investigations and Litigation

**What we do.**
Where do cases come from?

- Private citizens
  - Provider competitors
  - Provider employees
  - Beneficiaries
- Police and other governmental entities
  - Survey organizations
  - Including, from contractors who pay claims
- Data mining
- News reports

Qui Tam Complaints

- Private persons, known as relators, may file lawsuits against individuals and entities that defraud the government by submitting false or fraudulent claims under State Medicaid programs.
- The government is required to investigate the relator’s allegations and may intervene and take over the prosecution of the action.
- If government chooses not to intervene, the relator has the right to conduct the action.
- Relator is entitled to percentage of the proceeds of the action or settlement of the claim depending on the extent to which the relator substantially contributed to the case.
Federal Investigations

- Federal agents investigate...
  - Criminal violations
  - Civil violations
  - Administrative violations

- Criminal and civil violations enforced by the United States Attorneys Offices and Department of Justice

- Administrative violations enforced by Health and Human Services (both Office of Inspector General and Centers for Medicare and Medicaid Services), and other agencies with health programs
Joint Investigations

• Federal and state investigators may work together or share information, as permitted by law

• Resolutions may occur at the federal level, state level, or both

Authorities
Federal Criminal Laws

Includes
- Health Care Fraud, 18 U.S.C. § 1347
- Attempt or conspiracy to commit health care fraud, and conspiracy to defraud the United States, 18 U.S.C. § 1349 and 18 U.S.C. § 371
- Criminal False Claims, 18 U.S.C. § 287
- Theft or Embezzlement in Connection with Health Care, 18 U.S.C. § 669
- Unlawful Use of Health Information, 42 U.S.C. § 1320d-6
- False Statements Relating to Health Care Matters, 18 U.S.C. § 1035
- The Anti-kickback Statute, 42 U.S.C. § 1320a-7b(b)
- Aggravated Identity Theft, 18 U.S.C. § 1028A

<table>
<thead>
<tr>
<th>Violation</th>
<th>Statute</th>
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</thead>
<tbody>
<tr>
<td>Preparation/Submission of Claim Reckless Disregard Not Entitled to Property Illegal remunerations</td>
<td>AS 47.05.210(a)(3)</td>
</tr>
<tr>
<td>B Felony Benefit/Claims ≥ $25,000</td>
<td>AS 47.05.210(a)(1)-(2) Up to 10 years jail; $100,000 fine ($2.5m for corp.)</td>
</tr>
<tr>
<td>C Felony Benefit/Claims ≥ $500</td>
<td>AS 47.05.210(a)(3) Up to 5 years jail; $50,000 fine ($2.5m for corp.)</td>
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<tr>
<td>A Misdemeanor Benefit/Claims &lt; $500</td>
<td>AS 47.05.210(a)(3) Up to 1 year jail; $25,000 fine ($500,000 for corp.)</td>
</tr>
<tr>
<td>Failure Produce Medical Records to Person Authorized Knowingly Making False Entry in Medical Asst. Record Knowingly Tampers with Medical Asst. Record (destroy, conceal, remove)</td>
<td>AS 47.05.210(a)(4)-(6)</td>
</tr>
<tr>
<td>A Misdemeanor</td>
<td>AS 47.05.210(a)(7) Up to 1 year jail; $25,000 fine ($500,000 for corp.)</td>
</tr>
<tr>
<td>B Misdemeanor</td>
<td>AS 47.05.210(a)(7) Up to 10 days jail; $2,000 fine ($75,000 for corp.)</td>
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</tbody>
</table>
Alaska Criminal Laws: General Fraud

<table>
<thead>
<tr>
<th>Violation</th>
<th>Statute</th>
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<tbody>
<tr>
<td><strong>THEFT</strong></td>
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<tr>
<td>First Degree B Felony</td>
<td>AS 11.46.120 - 11.46.150</td>
</tr>
<tr>
<td>Second Degree C Felony</td>
<td></td>
</tr>
<tr>
<td>Third Degree A Misdemeanor</td>
<td></td>
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<tr>
<td><strong>FORGERY</strong></td>
<td></td>
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<tr>
<td>Second Degree C Felony</td>
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<tr>
<td>Third Degree A Misdemeanor</td>
<td></td>
</tr>
<tr>
<td><strong>OBTAINING A SIGNATURE BY DECEPTION</strong></td>
<td></td>
</tr>
<tr>
<td>Second Degree C Felony</td>
<td>Commercial Instrument/Public Record</td>
</tr>
<tr>
<td>Third Degree A Misdemeanor</td>
<td>Any document</td>
</tr>
<tr>
<td><strong>SCHEME TO DEFRAUD</strong></td>
<td></td>
</tr>
<tr>
<td>B Felony</td>
<td>AS 11.46.500 - 11.46.510</td>
</tr>
<tr>
<td><strong>FALSIFYING BUSINESS RECORDS</strong></td>
<td></td>
</tr>
<tr>
<td>(C Felony) Intent to defraud</td>
<td>AS 11.46.630</td>
</tr>
<tr>
<td><strong>COMMERCIAL BRIBERY/RECEIVING BRIBE</strong></td>
<td></td>
</tr>
<tr>
<td>C Felony</td>
<td>VIOLATION OF DUTY incl. physicians and corp. officers</td>
</tr>
</tbody>
</table>

Alaska Criminal Laws
Patient Abuse and Neglect

<table>
<thead>
<tr>
<th>Violation</th>
<th>Statute</th>
<th>Class</th>
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</thead>
<tbody>
<tr>
<td><strong>Assault and Reckless Endangerment</strong></td>
<td>AS 11.41.200 - 250</td>
<td>Felony/Misd.</td>
</tr>
<tr>
<td><strong>Sexual Assault and Abuse</strong></td>
<td>AS 11.41.410 - 460</td>
<td>Felony/Misd.</td>
</tr>
<tr>
<td><strong>Criminally Negligent Homicide</strong></td>
<td>AS 11.41.130</td>
<td>C Felony</td>
</tr>
<tr>
<td><strong>Endangering the Welfare of Vulnerable Adult</strong></td>
<td>AS 11.51.200 - 210</td>
<td></td>
</tr>
<tr>
<td>First Degree</td>
<td>C Felony</td>
<td>A Misdemeanor</td>
</tr>
<tr>
<td>Second Degree</td>
<td></td>
<td></td>
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<tr>
<td><strong>Harassment</strong></td>
<td>AS 11.61.110-120</td>
<td></td>
</tr>
<tr>
<td>First Degree</td>
<td>A Misdemeanor</td>
<td></td>
</tr>
<tr>
<td>Second Degree</td>
<td>B Misdemeanor</td>
<td></td>
</tr>
</tbody>
</table>
Federal False Claims Act

- It is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent
  - Knowledge includes deliberate ignorance or reckless disregard of the truth or falsity of the information
- Claims may be “tainted” (false) by violation of the anti-kickback statute or physician self-referral law
- Treble damages plus penalties on a per-claim basis
  - each instance of an item or a service billed to Medicare or Medicaid, each line item counts as a claim
- 31 U.S.C. §§ 3729-3733

Illegal Arrangements

<table>
<thead>
<tr>
<th>Anti-Kickback Statute</th>
<th>Physician Self-Referral (Stark) Law</th>
</tr>
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<tbody>
<tr>
<td>42 U.S.C. § 1320a-7(b)</td>
<td>42 U.S.C. § 1395nn</td>
</tr>
<tr>
<td>Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal health care program business</td>
<td>prohibits physicians from referring patients to receive &quot;designated health services&quot; payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless exception applies</td>
</tr>
<tr>
<td>Remuneration = anything of value</td>
<td>Strict liability; CMPs and program exclusion for knowing violations</td>
</tr>
<tr>
<td>Up to five years in prison per violation; $50,000 CMP for each violation</td>
<td>Up to $15,000 CMP for each service</td>
</tr>
<tr>
<td>Voluntary safe harbors</td>
<td>Mandatory exceptions</td>
</tr>
</tbody>
</table>
Alaska Medical Assistance False Claim and Reporting Act  
**SB74** *(2016 SLA ch. 25, §§ 16, 18, 51)*

- Passed in 2016
- Generally modeled after the Federal False Claims Act with some material differences.
- Creates a civil action that is enforceable by Attorney General and/or Private Party (relator)

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**False Claims Act Penalties**  
*(currently)*

<table>
<thead>
<tr>
<th>State</th>
<th>$5,500 to $11,000</th>
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<tbody>
<tr>
<td>Federal</td>
<td>$11,181 to $22,363</td>
</tr>
</tbody>
</table>

(c) In addition to any criminal penalties under AS 47.95, a medical assistance provider or medical assistance recipient who violates (a) or (b) of this section shall be liable to the state in a civil action for:

- a civil penalty of not less than $5,500 and not more than $11,000;

Overpayments

“Any funds a person has received or retained under title XVIII of the Act to which the person, after applicable reconciliation, is not entitled under such title.”

60 Day Overpayment Rule
• Liability for knowing retention of an overpayment
• ACA Section 6402(a) (42 U.S.C. § 1320a-7k(d))
• Tolling: OIG & CMS Self Disclosure Protocols

Civil Monetary Penalties

• Under the CMPL, 42 U.S.C. § 1320a-7a(a), penalties and damages for:
  • Submission of false claims; creating false record to support false claim
  • Claims submitted with a false certification of physician license
  • Presentation of claims by an excluded party; ownership or control of a participating entity by an excluded party; employing or contracting with excluded party; ordering or prescribing while excluded
  • Remuneration offered to induce program beneficiaries to influence choice
  • Pattern of claims for medically unnecessary services and supplies
  • Knowing provision of false or misleading information to influence hospital discharge
  • Violation of the anti-kickback statute
  • False statements or omissions in an enrollment application
  • Knowing retention of an overpayment
• Violation of the physician self referral law, 42 U.S.C. § 1395nn(g)(3)
• Misuse of Departmental symbols or emblems, 42 U.S.C. § 1320b-10(b)
Exclusion from Federal programs

- **Mandatory Exclusion:** minimum 5-year exclusion for conviction of certain offenses (e.g., program-related crimes, patient abuse, felony health care fraud, or felony convictions relating to controlled substances).
- **Permissive Exclusion:** OIG may exclude under 16 additional authorities (e.g., losing a state license to practice, failing to repay student loans).
- **Effect:** Federal health care programs will not pay for items or services furnished, ordered, prescribed, or supplied by an excluded individual or entity.
  - The list of excluded individuals and entities (LEIE) is updated monthly, and provides constructive knowledge of excluded status.
- **Violation of Exclusion:** OIG may impose civil monetary penalties of up to $10,000 per item or service claimed while excluded and an assessment of three times the amount claimed.

42 U.S.C. § 1320a-7

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Corporate Integrity Agreements

- OIG negotiates corporate integrity agreements (CIA) with health care providers and other entities as part of the settlement of Federal health care program investigations in exchange for a release of OIG’s permissive exclusion authority.

What’s in a CIA?
- Based on the seven elements of a compliance program
- Each one addresses the specific facts at issue in the investigation
- Requires review by independent organization or monitor
Case Example

Arc of Anchorage

This settlement was the result of a coordinated effort by the Alaska Medicaid Fraud Control Unit (MFU), the Office of Inspector General (OIG), the Alaska Medicaid Program, and the cooperation of the Arc of Anchorage.

The State contends the Arc submitted or authorized the submission of false claims to the Alaska Medicaid Program. Specifically, the State contends the Arc billed for services not provided, and billed for overlapping services with the same provider. The State further contends that the Arc failed to repay money owed to the Medicaid Program identified in audits performed by the Arc.

The settlement requires the Arc to enter into a five year Corporate Integrity Agreement with OIG, which calls for the Arc to comply with specific terms set by OIG that guarantee there will be no waste, fraud, and abuse in the future.

An Anchorage nonprofit that serves people with developmental or intellectual disabilities has agreed to settle allegations about false Medicaid claims.

The Arc of Anchorage will pay the Alaska Medicaid Program nearly $2.3 million, according to a statement the Alaska Department of Law released Tuesday.
Arc of Anchorage

• Alaska investigated Arc of Anchorage for knowingly submitting false or fraudulent claims to the Alaska Medicaid program and for knowingly retaining an overpayment.

• OIG and Alaska allege that, during the period January 1, 2012 through December 31, 2016, Arc of Anchorage knowingly submitted or authorized the submission of claims to the Alaska Medicaid program claims for items or services that Arc of Anchorage knew or should have known were not provided as claimed and were false or fraudulent.

• OIG and Alaska also allege that, as of November 2015, Arc of Anchorage knowingly retained an overpayment owed to the Alaska Medicaid program which was identified in audits performed by or at the direction of Arc of Anchorage.

Arc of Anchorage

• Alaska releases Respondent from any claims or causes of action it may have against Respondent under Alaska Statute 09.58.010 and Alaska Statute 47.05.210.

• OIG releases Respondent from any claims or causes of action it may have against Respondent under 42 U.S.C. §§ 1320a-7a and 1320a-7(b)(7).
Compliance Generally

Compliance Resources

To help healthcare providers such as hospitals and physicians comply with relevant Federal health care laws and regulations, OIG creates compliance resources, which are often tailored to particular providers.

OIG’s compliance documents include special fraud alerts, advisory bulletins, podcasts, videos, brochures, and papers providing guidance on compliance with Federal health care program standards. OIG also issues advisory opinions, which address the application of the Federal anti-kickback statute and OIG’s other fraud and abuse authorities to the requesting party’s existing or proposed business arrangement.
Compliance Resources

Seven Fundamental Elements
1. Written policies and procedures
2. Compliance professionals
3. Effective training
4. Effective communication
5. Enforcement of standards
6. Internal monitoring
7. Prompt response
Self-Disclosure to OIG

- Benchmark 1.5 multiplier
  - Claims Calculation
    - All claims or statistical sample of 100 claims minimum
    - Use point estimate (not lower bound)
  - Excluded persons — salary and benefits-based
  - AKS — remuneration-based
- Presumption of no CIA
- Six-year statute of limitations
- Tolling of the 60-day period after submission
Tribal Health
Compliance Resources

- On April 27, 2017, OIG held a conference Protecting Indian Health and Human Services Programs and their Beneficiaries: The Basics of Health Care and Grants Management Compliance for Indian Health Services and tribal employees in Crazy Horse, South Dakota.

- Our website has audit reports, information regarding enforcement actions, and compliance resources.

- More conferences and materials are forthcoming.

Compliance Training Conference

On April 27, 2017, OIG held a conference Protecting Indian Health and Human Services Programs and their Beneficiaries: The Basics of Health Care and Grants Management Compliance for Indian Health Services and tribal employees in Crazy Horse, South Dakota. Below are the materials handed out to attendees:

- Fall Conference Packet
- General Overview and Compliance Programs, Ambwaa Jay Mazumdar, Deputy Branch Chief, Office of Counsel to the Inspector General and Andrea Treece Berlin, Senior Counsel, Office of Counsel to the Inspector General
- Internal Controls - Case Studies, Patrick Cogdill, Regional Inspector General for Audit Services, Kansas City, Office of Audit Services, Ambwaa Jay Mazumdar, Deputy Branch Chief, Office of Counsel to the Inspector General and Andrea Treece Berlin, Senior Counsel, Office of Counsel to the Inspector General and Ondra Keasing, Assistant Regional Inspector General for Audit Services, Denver, Office of Audit Services. Moderated by Marissa Haverty, Assistant Director for Grants and Internal Audits Division, Office of Audit Services
- Documentation: Lucia Fort, Senior Advisor to the Chief of Staff and Lisa Re, Assistant Inspector General for Legal Affairs, Office of Counsel to the Inspector General
- Single Audits - Quality Matters, Tamara Brewer, NEAIR Audit Manager, National Single Audit Coordinator, Office of Audit Services
- The Office of Investigations: Charles Haldeman, Assistant Special Agent in Charge, Kansas City Regional Office, Office of Investigations and Curt Muller