



FRAUD ,WASTE & ABUSE, THE PPACA AND IMPLICATIONS FOR HEALTH PLANS

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New Authority § 1128(b)(16)

- MAKING FALSE STATEMENTS OR MISREPRESENTATION OF MATERIAL FACTS.
- Any individual or entity that knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program (as defined in section 1128B(f)), including Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, Medicaid managed care organizations under title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans.

Abuse

- “Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.” 42 CFR 455.2

Fraud Enforcement and Recovery Act - FERA

- “a false record or statement material to a false or fraudulent claim”, where a *claim* includes “any request or demand” related to a government program and which will be paid from funds supplied by the government.

PPACA and Program Integrity

- \$250M increased funding over 10 years
- Focus on overpayments
- Medicare and Medicaid RAC
- Repayment requirements
- Provider review (DME) and exclusion
- Medicare and Medicaid Integrity Program reporting

Program Integrity Provisions

- 3 Most Important:
 - Mandatory reporting, repayment, and explanation of overpayments by “Persons”
 - Retention of overpayment beyond 60 days is a FALSE CLAIM
 - Mandatory compliance plans

Program Integrity

PPACA §6402

- “(d) *REPORTING AND RETURNING OF OVERPAYMENTS—*
- “(1) *IN GENERAL — If a person has received an overpayment, the person shall—*
- “(A) **report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and**
- “(B) **notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.**

Definition: Overpayments

- “(B) OVERPAYMENT—The term “overpayment” means any **funds** that a **person** receives or retains under title XVIII (Medicare) or XIX (Medicaid) to which the person, after applicable reconciliation, is **not entitled** under such title”
- “**funds**” not “**benefit**”

Overpayments

- “Not Entitled” includes:
 - Kickbacks
 - Payments Prohibited by Stark Regulations
 - Ineligible for Payment
 - Conditions of Payment

Kickback vs Stark Self-Referral

- The Stark Law – Social Security Act §1877
- Prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare or Medicaid to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies.
- Prohibits the entity from presenting or causing to be presented claims to Medicare or Medicaid (or billing another individual, entity, or third party payer) for those referred services.
- Establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse (safe harbors).

The Stark Law

Designated Health Services

- Clinical laboratory services.
- Physical therapy services.
- Occupational therapy services.
- Outpatient speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.
- Durable medical equipment and supplies.
- Parenteral and enteral nutrients, equipment, and supplies.
- Prosthetics, orthotics, and prosthetic devices and supplies.
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services.

Eligibility

- The PPACA requires States to terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another State's Medicaid program.

Definition: Persons

- A “person” (which includes corporations and partnerships) who has “received” or “retained” the overpayment
- Focus on “receipt”; payment need not come directly from Medicaid; if “person” “retains” overpayment due the program, violation occurs
- “person” includes a managed care plan or an individual program enrollee as well as a program provider or supplier

Overpayment Return

- Requires that overpayments be reported and returned within 60 days from the date the overpayment was **identified** or by the date a corresponding cost report was due, whichever is later.
- Identified – simply the fact that an overpayment exists – not a determination or calculation of the amount

Some “Identification” Scenarios

- Outside source informs of overpayment
 - Whistleblower or other legal action
 - UM vendor
 - RAC
 - Patient
 - Discovery of excluded provider
 - Other notice of service not delivered (e.g. deceased patient; impossible claim)
- Internal source
 - Credit balance audit - *credit balance transfers

Some Additional Thoughts on Overpayment Returns

- Begin to toll at time of identification, not receipt of overpayment
- What if allegation of overpayment is incorrect?
- “Old” overpayment

If It's Not Documented...

- Demonstrate “good faith”
- Organizational commitment to identification, recovery, and repayment of overpayments
 - Policies & Procedures
 - Documentation of each identification
 - Burden of proof

Reason for Overpayment

- “(B) notify the *Secretary, State, intermediary, carrier, or contractor* to whom the overpayment was returned in writing of the reason for the overpayment.

Examples of Overpayment Explanations

- Service not rendered (not provided, deceased patient)
- Payment exceeds UCR
- Incorrect provider paid
- Excluded provider paid
- Non-covered service (medical necessity)
- Non-covered beneficiary
- Other coverage
- Duplicate payment
- Credit balance
- System edit error

More Examples...

- No physician order for service
- Provider billing on behalf of non-eligible provider
- Billing for “never events”
- Transfer/billing errors
- Inaccurate POA reporting
- Drug billing errors (inpt/outpt, 340B)
- Fraud

And if I don't report...?

- *PPACA 6402(d)(3) “ENFORCEMENT” — Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an **obligation** (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title. (False Claims Act)*
- False Claims Act imposes liability for a person who “knowingly conceals or knowingly and improperly avoids or decreases an **obligation** to pay or transmit money or property to the Government” **new** 31 U.S.C. 3729(a)(1) (G) added by FERA
- “knowingly” includes reckless disregard, deliberate ignorance
- An overpayment which is timely reported and explained will not give rise to FCA liability even if the provider is unable to repay it within 60 days, unless there is evidence of improper “avoidance”

Fraud Enforcement and Recovery Act

1. Expand FCA liability to indirect recipients of federal funds
2. Expand FCA liability for the retention of overpayments, even where there is no false claim
3. Add a materiality requirement to the FCA, defining it broadly
4. Expand protections for whistleblowers
5. Expand the statute of limitations
6. Provide relators with access to documents obtained by government

FERA

- A person violates the FERA if that person “knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government” **new 31 U.S.C. 3729(a)(1) (G)**

Civil Monetary Penalties

- New and Amended CMPs

- any person that “orders or prescribes a medical or other item or service during a period in which the person was excluded from a Federal health care program (as so defined), in the case where the person knows or should know that a claim for the medical or other item or service will be made under such a program.”
- “knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under a Federal health care program (as so defined), including Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, Medicaid managed care organizations under title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans.”

Civil Monetary Penalties

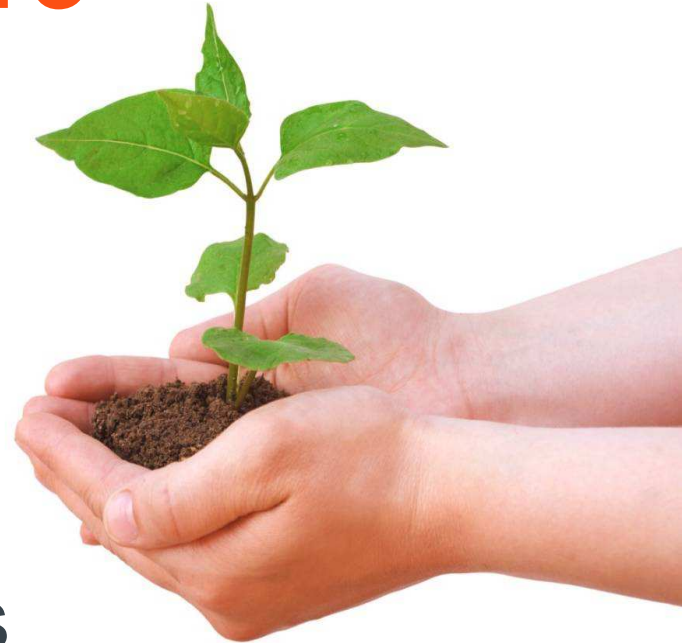
- any person “that knows of an overpayment (as defined in paragraph (4) of section 1128J(d)) and does not report and return the overpayment in accordance with such section.”
- persons who knowingly present, or cause to be presented, claims for medical or other items or services furnished during a period in which the person “was excluded...pursuant to a determination by the Secretary under [list of statutory provisions].” Section 6402(d)(2)(A)(i) of the PPACA amends this provision by deleting the list of statutes under which a person could have been excluded, and replacing the list with “from the Federal health care program (as defined in section 1128B(f)) under which the claim was made pursuant to Federal law.”

Civil Monetary Penalties

- New § 1128A(a)(8) (as added by § 6408 of the PPACA) imposes CMPs on a person that “knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program.”
- New § 1128A(a)(9) (as added by § 6408 of the PPACA) imposes CMPs on a person that “fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services.”

The “New” Health Care

- Reduce Costs
- Increase Coverage
- Preserve/Improve Quality
- Don't Bankrupt the Payors
- Don't Bankrupt the Providers

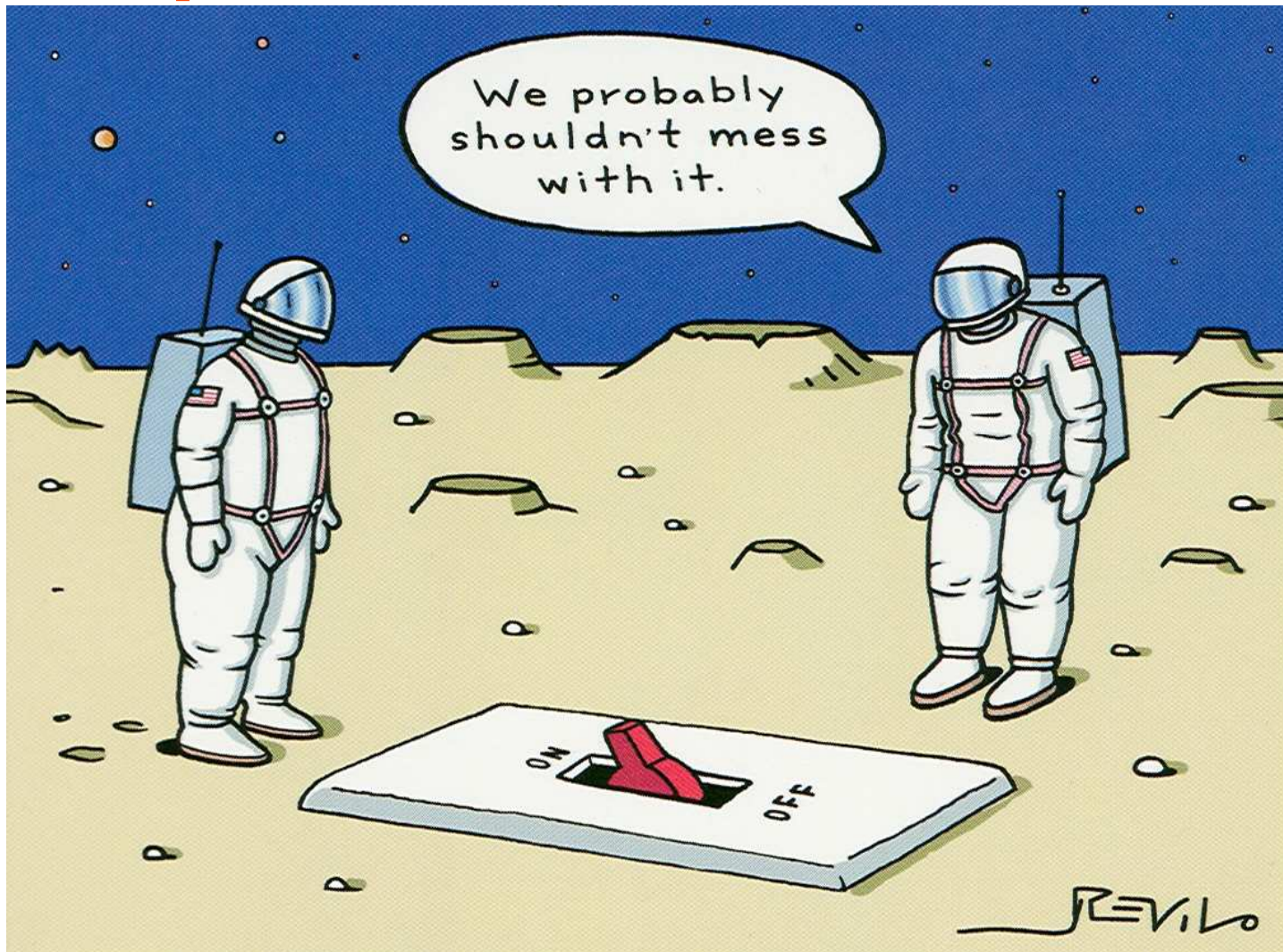


...and just *how* are we supposed to do this?!

Program Integrity

- Fraud, Waste & Abuse
 - Fraud accounts for *at least* 10% of our national health care expenditure, maybe a lot more!
 - Waste & Abuse probably another 10%

Compliance: What do we do?

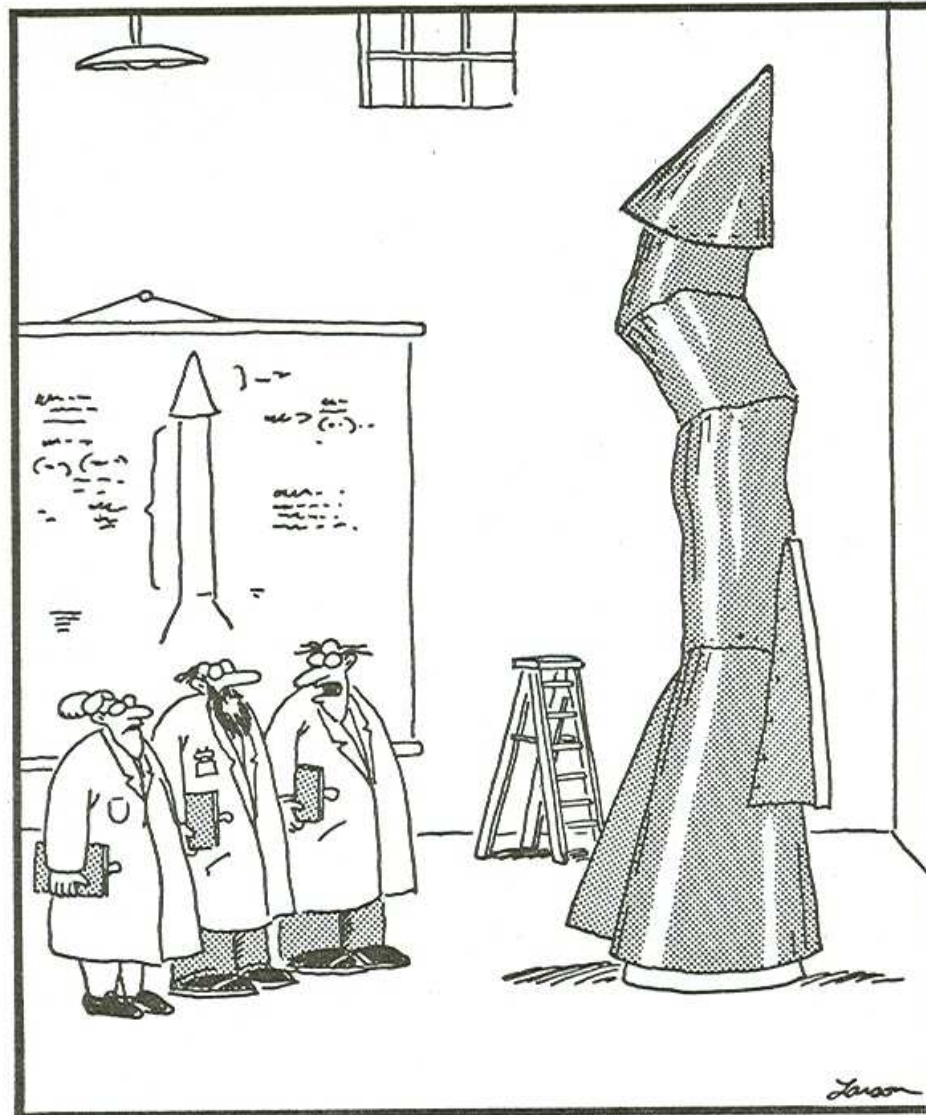


Compliance Best Practices

Document, document,
document

Compliance Best Practices

- Robust programs:
 - Medical Necessity
 - Appropriateness of setting
 - Coding validation
 - Billing errors
 - Credit balance audits
 - Credentialing
 - Eligibility verification
- Demonstrate “good faith effort”



“It’s time we face reality, my friends. ... We’re not exactly rocket scientists.”

The “5 Rights”

The right
care



In the right
amount



At the
right time



For the
right patient



In the right
setting.



Compliance Best Practices

- Clinical determinations must:
 - Be made by clinicians
 - Include rationale
 - Be evidence-based
- How will CER be used in your organization?

Efficiency: the “flip side” of abuse

- “Broad adoption and meaningful use of health information technology by providers is essential to creating an efficient, high-performing 21st-century health care system” - Ignagni

Electronic Health Records

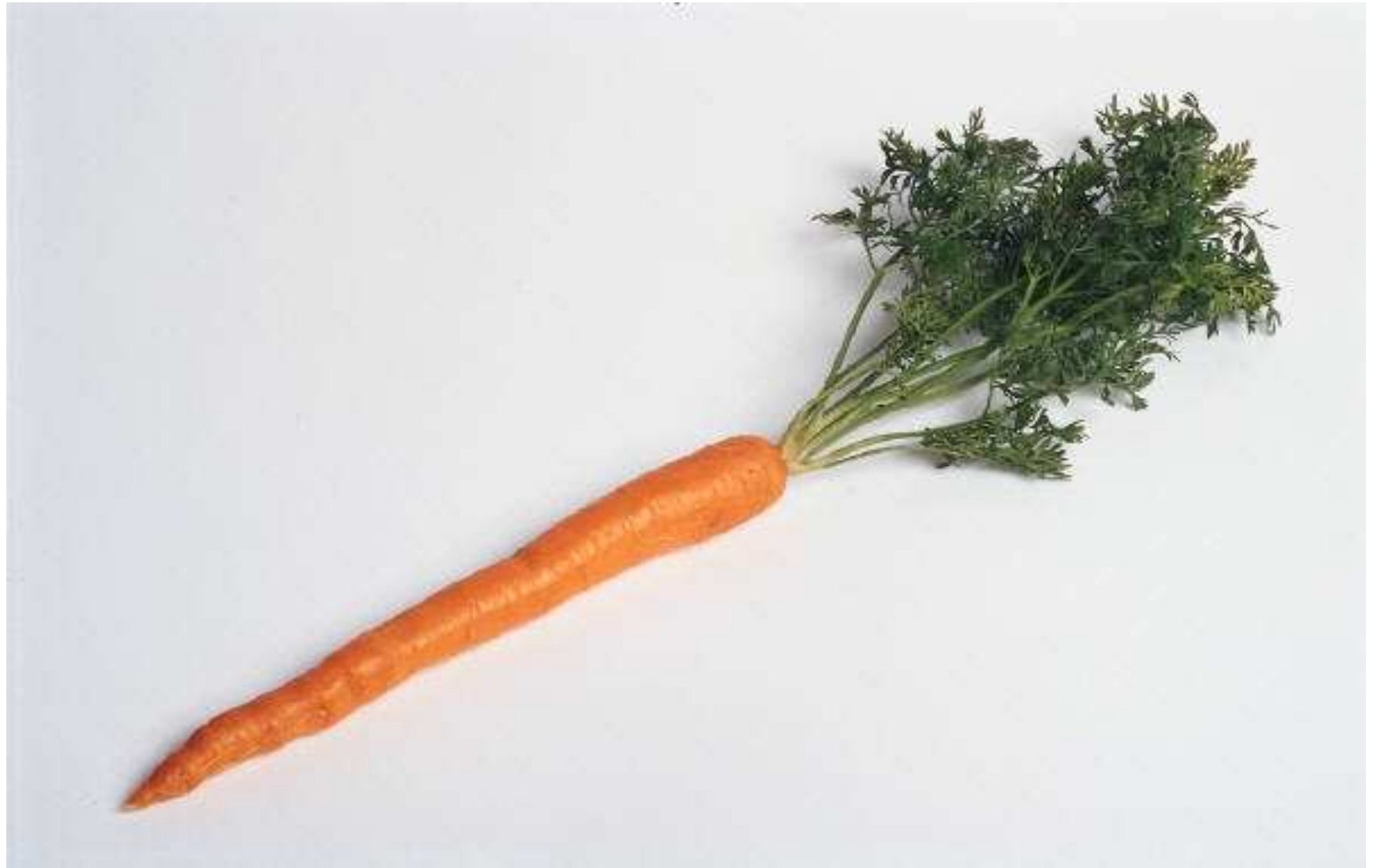
- ARRA - \$27B
- HITECH – meaningful use
- Pros:
 - Accuracy and error checking, drug interactions
 - Reporting, data analysis, decision support
 - Medical knowledge base
 - “Intelligent EHR” - realtime
- Cons:
 - Trust
 - Privacy
 - Security
 - Liability

Connected Health

- Always on, always active, always aware
 - VA pilot projects
 - Medication compliance
 - Mobile apps
 - e-visits

Scorecard

- Health Care Reform \$980B
- Fraud \$200B
- Waste & Abuse \$200B
- Quality improvements \$300B



References

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- http://www.dwt.com/portalresource/lookup/wosid/intelliun-1501-27602/media.name=/05-10_Fraud_and_Abuse_HC_Reform.pdf
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Questions



Thank you!

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