Compliance, Medicaid Integrity, & Service Verification

Providing Community Mental Health and Substance Abuse Services in the Era of Healthcare Reform

Community Mental Health Partnership of Southeast Michigan Staff Training

Version 2015

What This Training Will Cover

- An explanation of what is Compliance and Medicaid Integrity
- Laws related to Compliance and Medicaid Integrity
- What is Considered Medicaid Fraud, Abuse, and Waste
- Providers'/Staffs' Role & Responsibility in Preventing Fraud Abuse and Waste

What is Compliance?

Meeting the requirements of the laws, regulations, standards or procedures related to your organization. For the world of Mental Health & Substance Abuse this includes:

- Fulfilling specific state and federal laws about Medicaid
- Abiding by confidentiality privacy and security laws
- Fulfilling specific state requirements about serving people in the CMH or substance abuse service system

Overview of Key Compliance Laws

- Health Information Portability and Accountability Act of 1996 (HIPAA)
- Balanced Budget Act of 1998 (BBA)
- Federal False Claims Act
- Michigan False Claims Act
- Whistleblowers Protection Act (updated)
- Anti-Kickback Act (+ Stark Law)
- Deficit Reduction Act of 2005 (DRA)
- Patient Protection & Affordable Care Act of 2010 (includes new HITECH additions to HIPAA)
- HealthCare & Education Reconciliation Act of 2010

Health Information Portability and Accountability Act (HIPAA)

Federal Protections for Health Care Information

HITECH Additions with Health Care Reform

Health Information Portability and Accountability Act (HIPAA)

- Federal law to ensure all states are providing same protections with people's Protected Health Information (PHI) in healthcare
- Has specific requirements for privacy (how information is shared, what can be shared without consent, what requires consent, need to provide Notice of Privacy Practices)
- Requires a "need to know"
- Has specific security requirements for protecting how health information is exchanged electronically
- Protections are in addition to already-existing laws (like the Michigan Mental Health Code & 42CFR Part 2 for substance abuse)
- ***Confidentiality/HIPAA is more thoroughly covered in your local HIPAA/Recipient Rights Training***

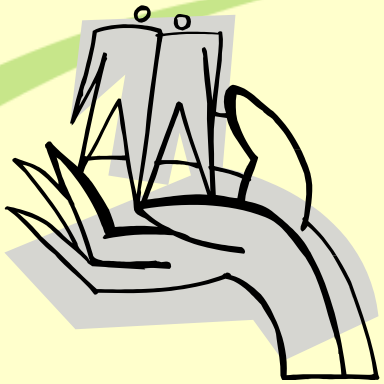
HITECH The Health Information Technology for Economic and Clinical Health Act (HITECH) Act **Additions to HIPAA**

Because 2010 healthcare reform laws gave more incentives for creating electronic health information (Electronic Health Record/EHR Personal Health Record/PHR) they created more protections and sanctions

- Specifications of how electronic health information is to be kept private and secure
- Business Associates now held to same requirements and consequences as Covered Entities in health care
- More requirements on keeping an Accounting of Disclosures (when & what you information you can disclose without specific consent), more restrictions on what can be shared as such, and increase in people's rights to access an Accounting of Disclosures related to their EHR

HITECH The Health Information Technology for Economic and Clinical Health Act (HITECH) Act **Additions to HIPAA**

- Restricts sale of Personal Health Information (PHI) without authorization specifically allowing compensation (marketing)
- Higher penalties/fines for wrongful disclosures or neglect in protecting electronic health information
- Defines a breach and peoples' right to be informed of information in their EHR is wrongfully accessed; specifies how when and what they are informed of.
- Federal government must also be notified for certain extreme breaches
- Gives people the right to get an electronic copy of their electronic health record



Balanced Budget Act (BBA)

Improving Quality of Health Care for People with Medicaid

Balanced Budget Act (BBA)

Showed greater care for the quality of healthcare services that people with Medicaid receive, including:

- Having to show how authorizations for services are decided; having a utilization management program
- Measuring the quality of services people get
- Providing specific Customer Service functions and giving people more information about their care & the system
- Giving people the right to file a grievance if they are not satisfied with the quality of their services
- Giving people the right to appeal a decision about their services
- Requiring all states are audited by an external auditor for their compliance with the BBA

Federal False Claims Act
and
Michigan's False Claims Act
The Origins of Preventing Fraud

Federal False Claims Act

The False Claims Act applies when a company or person:

- Knowingly presents (or causes to be presented) a false or fraudulent claim for payment,
- Knowingly uses (or causes to be used) a false record or statement to get a claim paid,
- Conspires with others to get a false or fraudulent claim paid,
- Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property.

Federal False Claims Act

Time Period for a Claim to be Brought

The statute of limitations for suits under the False Claims Act is the later of:

- Within six (6) years of the illegal conduct, or
- With three (3) years after the Government knows or should have known about the illegal conduct, but in no event later than ten (10) years after the illegal activity.

Federal False Claims Act

What Money Can Be Recovered:

- A person who brings a False Claims Act (or qui tam) case is entitled to a proportional share of the funds that are recovered for the government. As a part of the process, the individual must provide the government with *all* of his or her information.
- If the government joins the case – individual usually entitled to 15 – 25% of recovered funds.
- If government does not join case – individual is entitled to 25 – 30% of the recovered funds.
- Attorneys fees also…..

Federal False Claims Act

Protections for People Who Bring Qui Tam Cases:

- Anyone who lawfully acts to bring a suit to court is protected from:
  - Discharge, demotion, suspension, threats, harassment, and discrimination.
- If these protections are violated, the individual is entitled to reinstatement with seniority, double back pay, interest on back pay, compensation for discriminatory treatment and attorney's fees.

Michigan State False Claims Act

- Prohibits fraud in the obtaining of benefits or payments in connection with the medical assistance program
- Prohibits kickbacks or bribes in connection with the program
- Prohibits conspiracies in obtaining benefits or payments
- Authorizes the attorney general to investigate alleged violations of this act
- Provides for civil actions (and fines) to recover money received by reason of fraudulent conduct
- Prohibits retaliation; Prescribes remedies and penalties.

Michigan False Claims Act

- *Any person* may bring a civil action in the name of the State to recover losses
- At the time of filing, the person shall disclose, in writing, substantially all material evidence and information supporting the complaint
- Attorney general may proceed, or if not, the individual may proceed with action

If a person other than the attorney general prevails in an action that the person initiates, the court shall award that person costs, reasonable attorneys fees, & based on effort, a percentage of monetary proceeds (If attorney general intervenes, 15 – 25 %; If attorney general does not intervene, 25 – 30%)

Michigan False Claims Act
Cases that Would Not be Heard

- If court finds that the person bringing the action planned, initiated, or participated in the conduct upon which the action is brought, (if the person who made the report is found to have participated in the fraud in some way) then court may reduce or eliminate the share of proceeds. That person is also at risk of being charged with fraud.

- A person other than the attorney general shall not bring an action that is already the subject of a civil suit, criminal investigation, prosecution or administrative investigation

Michigan False Claims Act
Cases that Would Not be Heard

Frivolous Actions!

If a person proceeds with an action after the attorney general declines, and the court finds it to be frivolous, the court shall award prevailing defendant actual and reasonable attorneys fees and expenses and impose a civil fine of not more than $10,000 (against the person who tried to proceed)

Michigan False Claims Act Protections

An employer shall not:

- discharge,
- demote,
- suspend,
- threaten,
- harass, or
- otherwise discriminate

against an employee who initiates, assists, or participates in a proceeding or court action about a false claim/fraud case.

Michigan False Claims Act Protections

An employer who violates those protections, is liable to the employee for all of the following:

- Reinstatement to position without loss of seniority
- 2 X back pay
- Interest on back pay
- Compensatory damages
- Other relief as necessary to make employee whole

Whistleblowers' Protection Act

Protections for Employees Who Make Valid Reports of Fraud or Abuse

Whistleblowers' Protection Act

- Provides protection to employees who report a violation or suspected violation of state, local, or federal law
- Protects employees who participate in hearing, investigations, legislative inquiries, or court actions
- Prescribes remedies and penalties

Whistleblowers' Protection Act

Rights for people who's employer's do not uphold these protections:

"A person who alleges a violation of this act may bring a civil action for appropriate injunctive relief, or actual damages, within 90 days after the occurrence of the alleged violation."

Whistleblowers' Protection Act

- An employer is not required to compensate/pay an employee for participation in an investigation, hearing or inquiry held by a public body in accordance with this Act.
- An employer shall post notices and use other appropriate means to keep employees informed of these protections.

Anti-Kickback Law

Preventions for Benefiting from Biased Referrals

Anti-Kickback Law

- Makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration (fee) to induce (persuade) or reward referrals of items or services reimbursable by a Federal health care program.
- "Remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
- Makes it illegal to make referrals to agencies or providers and get some benefit/something of value for those referrals from that agency/provider.
- It's illegal whether one either asked for a kickback or the provider offered a kickback.
- Both parties are criminally liable when there is an impermissible "kickback" transaction.

The law prevents any Medicaid provider from getting some type of gain in controlling/limiting the choices people have about where they can get services

Examples of Illegal Kickbacks

- Buying or selling referrals; trying to get referrals and offering something in return
- Freebies, discounts, or money being paid between 2 healthcare providers
- Includes getting trips/gifts/meals from other providers or pharmaceutical companies

Deficit Reduction Act of 2005

Increasing Efforts to find Fraud/Abuse and Recoup Medicare and Medicaid Dollars

Compliance & Medicaid Integrity

In the recent past, there has been an increased focus on how Medicaid and Medicare monies are spent – essentially how government tax dollars are being spent on these programs.

Federal law has been developing ways those monies can be taken back if certain requirements aren't met, in order to help balance the federal budget.

So if Medicare/Medicaid programs or providers can't show they meet those requirements, they have to return those funds plus pay fines. Medicare was first to be reviewed, followed by Medicaid

Compliance & Medicaid Integrity

Those laws, and how federal and state governments uphold them, is the basis for Medicaid Integrity programs.

- The complexity of these requirements have increased in the recent past, and the definition of what could be a reason to take back Medicaid funds has become broader, beginning with the Deficit Reduction Act of 2005, and further developed with the Patient Protection & Affordable Care Act of 2010 and the HealthCare & Education Reconciliation Act of 2010

The Deficit Reduction Act (DRA) of 2005

- Created the new "Medicaid Integrity Program", which has requirements for making sure Medicaid monies are being used correctly for Medicaid-covered services

  DRA has ambitious financial goals. Congress expects to get back the money it appropriated for the Medicaid program through paybacks and fines.

The Deficit Reduction Act, 2005

The DRA new "Medicaid Integrity Program" activities encompass 4 areas:

1. Reviewing the actions of Medicaid providers under any type of payment system to determine if their actions have produced fraud, abuse or waste, are likely to, or may potentially result in unintended expenditures on the part of the Medicaid program.
2. Auditing of claims for payment of Medicaid services, items, or administrative services rendered including cost reporting, consulting contracts, and various risk contracts.
3. Identification of overpayments to individuals or entities receiving Medicaid Federal funds.
4. Education of providers, managed care companies, beneficiaries, and others with respect to payment integrity and quality of care.

The Deficit Reduction Act, 2005

Has Incentives for States to Create their own False Claims Acts to prevent misuse of Medicaid monies

Three important points of False Claims Acts:

1. Civil prosecutions do not require proof of fraud, but only proof that provider acted in "reckless disregard" or "deliberate ignorance." No "ostrich defense."
2. Qui tam, or "whistleblower" provisions that allow private citizens to bring suit against providers and collect a portion of monies recovered.
3. Very high penalties assessed on a per claim basis for violators. As much as $11,000 per claim!

Deficit Reduction Act (DRA) 2005

- A number of states already have a False Claims Act, **including Michigan**.
- A State False Claims Act law
- Under the Deficit Reduction Act (DRA), states that have false claims laws that are as tough as the federal law get to keep an additional 10% of recoveries. This is in addition to state share of payments! (so having a state law allows state to keep some of the Medicaid money that is taken back in audits)

Requirements of the Deficit Reduction Act (DRA)

Providers Required to Have Compliance Programs

The federal government has, for many years, encouraged health care providers and managed care plans to have compliance programs, built on the federal sentencing guidelines about Medicaid integrity. With the DRA, it is now a requirement for all providers or organizations that pay out over $5 Million a year to have a compliance program to prevent fraud abuse and waste.

Requirements of the Deficit Reduction Act

The terms of the DRA are very specific regarding compliance Education Requirements:

1. Implement employee, contractor and agent education containing "detailed" information about the federal and state False Claims Acts and all whistleblower provisions.
2. Develop written policies that include "detailed provisions" regarding the policies and procedures of the entity for detecting and/or preventing fraud, abuse and waste.
3. Include fraud and abuse laws in employee handbook.

Stiff Penalties for Non-Compliance with the DRA

- Federal penalties include up to 5 years in prison with $250,000 fine for an individual or $500,000 for an organization
- Civil penalties of up to $10,000 per claim
- Exclusion as a provider for a minimum of 5 years

What Community Mental Health Southeast Partnership of MI (Our Region) Is Doing

- CMHPSM and Local CMHSPs have a Compliance Program to include:
  - Training/education efforts with staff and contractors
  - Curriculum driven by DRA and Health Care Reform requirements
  - Updating employee handbook to include information
  - Updating Compliance Plan and related Policies & Procedures to assure adequacy
  - Publicizing internal processes for reporting
  - Monitoring Medicaid service verification of providers

CMHPSM/Local CMHSP Compliance Program (con't)

- Monitors providers regularly including a review of potential fraud/abuse/waste
- Addresses "at-risk" providers who are not fully compliant with their requirements; recommends sanctions/ board action of providers not meeting contract requirements
- Checks the state and federal sanctions list to make sure non of our consumers are being served by providers/ staff who have been found fraudulent by the state or federal government
- Oversees local compliance with all state & federal requirements/audits

Affiliation Compliance Officers

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Kathyrn Szewczuk (517) 263-8905 or KSzewczuk@LCMHA.org	Lenawee
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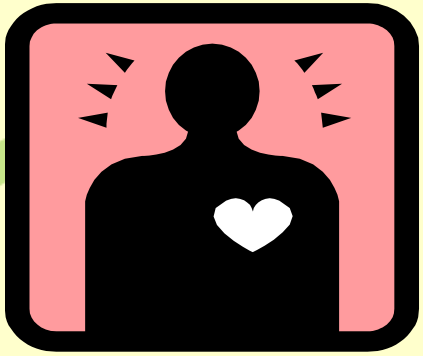
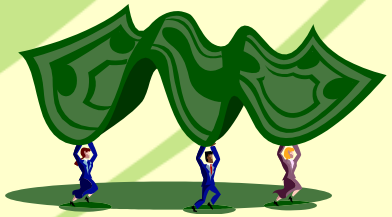
CJ Witherow 734-384-8876 or cwitherow@monroecmha.org	Monroe
Katie Snay 734-544-2958 or snayk@ewashtenaw.org	Washtenaw CSTS



Patient Protection & Affordable Care Act of 2010

HealthCare & Education Reconciliation Act of 2010



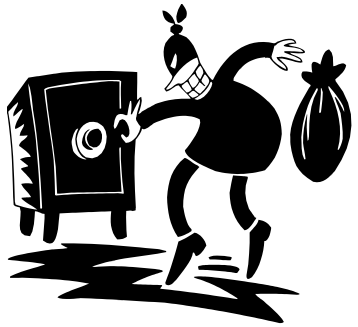
Changes Brought By Healthcare Reform Laws in 2010

- Healthcare Reform Laws of 2010 have new increased requirements for accountability and transparency in how Medicaid $ is spent, based on concerns for misspending federal funds, fraud, abuse, waste ***and whether monies were used as intended and get the desired affect***

Those concerns resulted in:

- New reporting requirements/protections
- Expanded definition of Fraud/Abuse/Waste

Fraud, Abuse, and Waste



Fraud = Intentional Deception

Abuse = Bending the Rules

Waste = Inappropriate utilization and/or inefficient use of resources

- Medically unlikely services
- Clinically unlikely services

Expanded Definition of Fraud

- " Failure to comply with <u>any</u> professional standards for health care, standards for medical necessity, or standards for billing/business operations"

  <u>Anything</u> that could result in potential false claims. Includes a broader definition of an "overpayment" of Medicaid funds…

"Overpayment" Considered Fraud

Anytime a provider submits a bill/claim and gets paid for that claim…

if they can't show the all correct documentation that they provided the service specifically the way it's supposed to be provided, THEN

the federal government considers that provider was paid for a service they cannot prove they did, was therefore "**overpaid**", and expects the provider to pay that money back.

Overpayments are also called a "Reverse False Claim"

Overpayment Examples That Could Be Seen as Fraud - Billing

- Inaccurate billing
- "Up-coding" - Billing for higher level of service than provided
- Billing for more time than the service was provided
- Billing or record-keeping errors
- Submitting a claim too late
- The service is not billable – wrong code, doesn't meet the definition of the service, or service not in biller's contract
- Billing for services not provided at all, or not provided face-to-face
- Reckless disregard of truth/falsity" – errors by not checking/ verifying what you submit
- Billing a Medicaid beneficiary for Medicaid covered services

Overpayment Examples That Could Be Seen as Fraud– Provider Qualifications

- If an individual or agency's licensed has lapsed and they continue to bill
- A mid-level practitioner who needs to be supervised and the supervision doesn't occur the way it should, the practitioner is then exceeding their scope of practice and shouldn't bill
- Practitioner not meeting licensing or certification requirements to provider certain services
- Being in business/having a contract with a provider or individual (including CMH or provider staff) who've been excluded as a Medicaid provider by the state or the federal government. Includes accepting billings and paying claims or salaries to them.

Overpayment Examples That Could Be Seen as Fraud – Plan of Service/Treatment Planning

- No current treatment plan or individual plan of service (IPOS)
- Documentation is illegible
- Missing signatures where signatures required
- Content of treatment plan/IPOS is vague
- Treatment plan/IPOS is not completed and signed by deadlines (including if needs physician/ psychiatrist signature)
- There's a mismatch between the services in the IPOS/treatment plan and the services provided (including if the treatment needs change) but the IPOS/treatment plan doesn't reflect that change

Overpayment Examples That Could Be Seen as Fraud- Documentation

- Mis-documentation (i.e. wrong date, wrong person, doesn't clearly define the service)
- Missing documentation
- Documentation is illegible
- Missing signatures where signatures required
- Missing start or stop time in the note (when required) or amount of time spent providing service
- No progress note for service billed
- The service is not billable – doesn't meet the definition of the service, or that service is not in the biller's contract

Overpayment Examples That Could Be Seen as Fraud – Service Verification

- There's a mismatch between the services in the IPOS/treatment plan and the services provided
- Not being able to show medical necessity (documentation)
- Billing for services without documented proof the services were provided exactly as they were billed/paid (date, time, practitioner providing it, etc)
- Not providing a service the way it's defined

"Overpayments" Examples Now Considered Fraud – Staff Reimbursement

- Getting reimbursed for mileage (or other accepted work-related expense) that is not related to/allowable for your job function
- Falsifying accepted work-related expenses and getting reimbursed for them
- Getting paid for hours you didn't work
- Getting reimbursed for work someone else did
- Billing for services under a different practitioner who is be reimbursed at a higher rate (individual practitioners/clinics)
- Billing a different code to get paid a higher rate (individual practitioners/clinics)

What You Can Do to Prevent Fraud/Abuse/Waste

- All staff, contractors, board members have an obligation not to engage in any fraudulent acts
- All staff, contractors, board members have an obligation to report any suspected "fraud, abuse or waste" of Medicaid
- Make sure you understand what compliance is and your role in upholding it
- Make sure you are not participating in activities that could like fraud
- If you are asked to do anything that may look like fraud, report it
- Ensure you are practicing in the scope of your license, certification, job
- Do not accept improper reimbursements (for services, mileage, salary, kickbacks)

What You Can Do to Prevent Fraud/Abuse/Waste

- Complete all documentation as required (by policy, state, or federal requirements)
- Write IPOS and treatment plans as required. Keep them up-to-date with clear goals, amount, scope, and duration
- Ensure the service is being provided the way it is required
- Report any suspicion of fraud, abuse or waste to your local Compliance CMH Liaison the Affiliation/CA Compliance Officer OR
- Report any suspicion of fraud, abuse or waste to your state or federal reporting contact
- Contact your local Compliance Officer or the Affiliation Compliance Officer with any questions you may have

If You Authorize Service(s)/Develop an IPOS

- Make sure you establish & document medical necessity for each service
- Make sure the amount, scope, and duration of each service is clearly written in the IPOS/Treatment Plan
- Make sure the goals/outcomes in the plan are clear/ measurable and the services clearly relate to the goals.
- Make sure the role of providers (how they are to provide each service) is clear in the IPOS/Treatment Plan and clear to the provider
- Make sure case managers are not in the role of authorizing services (can write/facilitate plan, can't approve the auth)

If You Provide A Service

- Make sure you have a copy of the current IPOS/Treatment Plan (& any other plans if applicable)
- Make sure staff providing the service have all the training requirements/provider qualifications and are adequately trained on the IPOS
- Make sure you provide the service(s) as written in the plan(s). If it's not clear, ask for it to be clear
- Clearly document the services you provide; all claims must have documentation to back them up.
- Make sure you know how those services are to be provided to the individuals you serve and how they relate to the individual's goals
- Know the definition of the services in your contract

Reporting Requirements

Any suspicion must be reported

There is no wrong door to reporting – can report locally, to PIHP, state/Office of Inspector General or feds

Report any suspected fraud/abuse/waste to the CMHPSM/PIHP Compliance Officer

You can also report through Local Compliance Officers who will assure the PIHP is notified and proper reporting is done to OIG

Report any suspected fraud/abuse/waste to the CMHPSM/PIHP Compliance Officer
You can also report through Affiliation Compliance Officers who will assure the PIHP is notified

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Katie Snay 734-544-2958 or snayk@ewashtenaw.org	Washtenaw

Federal and State Fraud Reporting Information

Federal Reporting (Office of Inspector General)

1-800-436-6184 or online

https://oig.hhsc.state.tx.us/chiefcounsel/tpr.aspx

State Reporting (Michigan Medicaid Integrity Program)

1-866-428-0005 or Online:

http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-220188--,00.html

Where to Go For More Information

Medicaid Integrity/Reporting Information:

https://oig.hhsc.state.tx.us/Fraud_Report_Home.aspx

http://www.cms.gov/MedicaidIntegrityProgram/

http://www.whistleblowerlaws.com/

HIPAA and HITECH Information:

http://hipaasurvivalguide.com/

http://www.cms.gov/HIPAAGenInfo/

CMHPSM Policies & Procedures:

http://www.cmhpsm.org/policies

Relevant Sites/Information All Providers Need To Know

Medicaid Provider Manual – defines Medicaid covered services* and medical necessity*. Updated quarterly so check it January April, July, October. Key Sections to know: General Information for Providers, Mental Health/Substance Abuse*, Healthy Michigan.

http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

Affiliation Policies - policies you are held to by contract with the CMHPSM or a CMH in our affiliation http://www.cmhpsm.org/policies

Sanctioned Providers Search – providers sanctioned by federal or state

https://www.epls.gov/ (Excluded Parties List System – federal)

http://oig.hhs.gov/exclusions/index.asp (Office of Inspector General Exclusion List – federal)

https://www.sam.gov/portal/SAM/ Combined Federal Exclusion Database

http://michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-16459--,00.html (MI state list of sanctioned providers/individuals)