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Fraud & Abuse Update: Be Prepared!

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October 21, 2014

Medicaid Integrity Group: MICs-Medicaid Integrity Contractors

Duties | Review of Providers

- The contractor shall use data-mining and analysis techniques to develop models that combines healthcare quality indicators, billing practices and Medicaid specific business rules to predict aberrant provider patterns to identify and rank by risk providers to be audited.
- The contractor will develop reporting tools that show ranked providers according to risk of fraud/overpayment problems with sufficient detail for auditors to begin their audits.

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Duties | Near Term Approach

- The contractor shall work … identify and apply appropriate data analysis techniques to the state's Medicaid data to identify payments and/or billing practices of Medicaid provider's and related entities at the greatest risk of being fraudulent or inappropriate.
- The contractor shall analyze data on a national level or multi-state to identify national and regional trends and patterns, which will assist the audit MICs and the State's in the identification of national issues beyond individual State's ability for identification.

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Duties | Near Term Approach

- The contractor shall work collaboratively with the MICs completing the audit function in addition to the States.
- …Contractor shall produce reports containing suspect claims and/or relevant providers, with recommendations for recovery action or audit as they deem appropriate. …[with] sufficient detail for follow-up by audit.

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Audits

Audits of Providers, Fee for Service Providers, Managed Care Entities

- The Contractor shall plan individual audits of providers, including but not limited to:
  - fee for service providers,
  - managed care entities, and
  - individual providers and institutional providers of Medicaid services within the region

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ZPICs

- As result of contracting reform, seven zones have been created based on the newly established Medicare Administrative Contractor (MAC) jurisdictions. Included in the seven zones are five high risk areas. As a result of the seven zones, new entities entitled Zone Program Integrity Contractors (ZPICs) have been created to perform program integrity for Medicare Parts A, B, C, D, Durable Medical Equipment (DME), Regional Home Health Intermediary (RHHI) and Medi-Medi…

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ZPIC Statement of Work, SOW:

1.1.4 - Fundamental Activities

- *Fundamental activities of the Zone Program Integrity Contractor (ZPIC) that will help ensure payments are appropriate and consistent with Medicare and Medicaid coverage, coding, and audit policy, and will also identify, prevent, or correct potential fraud, waste and/or abuse may include, but are not limited to, the following:*

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ZPIC Statement of Work, SOW:

- *performing BI investigations;*
- *referring cases to law enforcement;*
- *making coverage and coding determinations;*
- *review of audit, settlement, and reimbursement of cost reports;*
- *reviewing bids for participation in the prescription drug program;*
- *assisting CMS in developing a list of entities that may require future monitoring based upon past history;*
- *conducting specified audits;*

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ZPIC Statement of Work, SOW:

- *conducting specified complaint investigations (Part C and Part D only);*
- *conducting preliminary investigations into entities conducting fraudulent enrollment, eligibility determination and benefit distribution;*
- *matching and analysis of Medicare and Medicaid data;*
- *coordinating potential fraud, waste and abuse activities with the appropriate MMEs; and*
- *complaint screening (Part C and Part D only).*

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ZPIC Statement of Work

- *2.2– General*
- *The ZPIC shall review and analyze a variety of data in order to focus its program integrity efforts by identifying vulnerabilities and/or specific providers for review and investigation within its zone, referral of potential fraud and abuse cases to law enforcement, and pursuance of administrative actions, which include but are not limited to payment suspension, provider revocation and the implementation of claims processing edits that limit or stop payment to suspect providers. Further, the ZPIC shall be proactive and aggressive in pursuing many different sources and techniques for analyzing data in order to reduce any of its risks within this SOW.*

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ZPIC Statement of Work

- *1.7 – Medical Review*
- *ZPICs are authorized to conduct medical and utilization reviews (in accordance with 42 U.S.C. 1395ddd(b)(1)). These reviews, by necessity, have always included reopening the claim and obtaining and reviewing providers' medical records. (Comp. Gen. Dec. No. B-282777 at 2 (September 2, 1999)).*
- *The ZPIC shall perform:*
  - *A. Prepay medical review (MR)*
  - *B. Postpay MR*
  - *C. Medical review in support of Benefit Integrity*
  - *D. Provider Notification and Feedback*
  - *E. Coordination with POE staff at the AC or MAC on education referrals*
  - *F. Program Integrity Management Reporting (PIMR)*

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UPIC | The New Model

- CPI must seek new and innovative approaches…to swiftly anticipate and adapt to …those involved in health care fraud, waste, and abuse activities.
- CPI is developing a unified program integrity strategy ….
- The concept …involves contractors performing work across the Medicare and Medicaid program integrity continuum. The program incorporates data matching, coordination, and information sharing to identify fraudulent or wasteful billing behavior that goes undetected when the programs are reviewed in isolation.
- This approach will result in a more seamless and rigorous program integrity strategy… fostering further program integrity coordination with other private and governmental payers across the entire health care industry.

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Unified Program Integrity Contractor or UPIC

- Primary function will be to realize and execute the CPI's nationally-set priorities and goals.
- Expects the number of UPICs will fall between five and fifteen.
- Have expertise in and knowledge of auditing and health care data analysis and investigative methods, techniques, and processes used to prevent, detect, and combat fraud, waste, abuse, and overpayments in the Medicare and Medicaid programs.

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HFPP-Public Private Partners in UPIC

- The Contractor shall support CMS in the evaluation of information and data from the HFPP. The HFPP is an opportunity for public and private sectors to exchange facts and information in order to reduce the prevalence of fraud in the healthcare industry… As requested by CMS, the Contractor shall analyze and research data developed by a Trusted Third Party (TTP) (on behalf of the HFPP) and furnished to CMS. The Contractor shall develop leads referred to it by CMS identified through the HFPP.

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Protect Program Dollars

- The Contractor shall assess the results of its data analysis or investigative work and recommend the appropriate administrative action to CMS (or directly work with the MAC in keeping with CMS instructions), law enforcement (if applicable), and the State Medicaid agency.
- Administrative actions are the first step to stopping inappropriate payments to providers or removing abusive or fraudulent providers from the Medicare and Medicaid programs.
- Administrative actions that protect program dollars either by stopping future payment or recovering monies are the highest priority for CMS and its Contractors.

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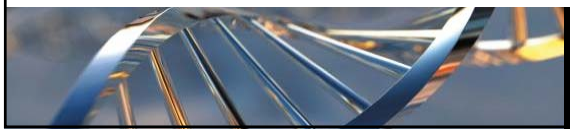
Administrative Actions – Tell All

When the Contractor recommends an administrative action to CMS (or the MAC) for a provider that is also enrolled in Medicaid, the Contractor shall notify the State Medicaid agency.

When the Contractor recommends an administrative action to the State Medicaid agency for a provider that is also enrolled in Medicare, the Contractor shall notify CMS CPI (and/or the MAC in keeping with CMS instructions).

The Contractor shall coordinate with the State Medicaid agency to identify the appropriate administrative actions available and determine how to apply the rules so the actions are applied effectively as a result of data analysis or investigative work.



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Medicare and Medicaid Payment Suspensions

i. The Contractor shall request Medicare payment suspensions in accordance with 42 CFR §§405.370-372. Medicare payments due a provider may be suspended in whole or in part when:

- CMS or a Medicare contractor (inclusive of the Contractor) has consulted with the HHS OIG (and DOJ as needed) and determined that a credible allegation of fraud exists,
- CMS or a Medicare contractor (inclusive of the Contractor) possesses reliable information from any source that an overpayment exists or that the payments to be made may not be correct (though additional information may be needed for a final determination of the payment or overpayment amount), or,
- The provider fails to file a timely cost report.

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Identify Medicare and Medicaid Overpayments

- During the course of its analysis of Medicare and Medicaid payments, resulting from an internal investigation of leads (including medical review) or structured audits of paid claims, the Contractor will identify improper payments that do not involve fraudulent intent. In such cases, the Contractor shall identify, determine, and refer the overpayments made to providers (individuals or entities) receiving Federal funds under Medicare and Medicaid.
- The Contractor shall refer Medicare overpayments to the MAC that made the initial claims payment for collection... The Contractor shall supply the required documentation supporting each overpayment to the MAC.

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More Administrative Actions and Referrals

- The range of administrative actions to be supported, developed and recommended by the Contractor to the appropriate Federal or State authority include but are not limited:
  - **Medicare payment suspensions (42 CFR §§405.370-372)**
  - **Medicaid payment suspensions (42 CFR §§455.2 and 455.23)**
  - **Medicare enrollment revocations**
  - **Medicaid enrollment revocations**
  - **Medicare and Medicaid program exclusions**
  - **Civil Monetary Penalties**
- The Contractor shall be prepared to support additional administrative actions as the Congress provides increased PI legal authorities to CMS in the coming years.
- The Contractor shall refer potential fraud cases to law enforcement and provide support, as required …

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Expected Outcomes

CMS expects the UPIC initiative to generate an increased number of proactive, high-quality, appropriate and timely administrative PI actions that are able to be sustained through any applicable administrative or legal review processes. CMS views such administrative actions, which stop inappropriate payments to providers and remove abusive or fraudulent providers from CMS programs, as a cornerstone of the agency's new PI strategy.

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Regulatory Risks to Providers

- Challenging to provider stability and viability
- Increased risks of unexpected losses caused by regulatory actions
- Increased expenses to comply
- Failure to mitigate has more drastic consequences in the new regulatory scheme
- Providers have to understand and catch up with new theories

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Creating and Protecting Attorney-Client Privilege in Internal Investigations

U.S. ex rel. Barko v. Halliburton

- D.C. District Court case sparked panic regarding internal investigations
  - KBR ordered to produce documents prepared during internal investigation including interview memos and investigation reports
- Key Holdings:
  - Reports were not prepared "solely" to obtain legal advice
  - "Instead, the reports were prepared to try to comply with KBR's obligation to report improper conduct to the Department of Defense."

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Key Takeaways

- *Barko* decision was driven by particular facts
- District Court applied an overly restrictive test, particularly in the current enforcement environment of mandated compliance and voluntary disclosures
- D.C. Circuit righted the wrong

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Scoping the Investigation

- Have written policies and procedures for investigations
- Implement reporting mechanism
- Triage
- Case by case decision whether to conduct a privileged investigation
- Think about the end result

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Involving Outside Counsel

- Most likely not needed for routine, discrete internal matters
- Often not needed if simply responding to a 3rd party document request
- Some events should immediately trigger a call to outside counsel:
  - A request for information that is not about a routine matter
  - A request for information about an event for which there was an internal investigation
  - Any investigation potentially involving the conduct of corporate officers or the Board of Directors
  - Any investigation involving high-profile Administration priorities
  - Any investigation in which in-house counsel has to make a representation to a government agent AND the company's status in investigation is not clearly and "permanently" defined

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In House Counsel's Challenge in Maintaining the Privilege

- Although the privilege applies equally to outside and inside counsel, there will be greater scrutiny of in-house communications because counsel fills multiple roles
- Burden is typically to "clearly demonstrate" the role for the specific communication
  - In-house counsel has become involved in wide range of corporate activities and must make clear showing that they are acting in legal capacity
- Position or title alone is not sufficient to establish the privilege

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To Write or Not to Write

- Interview summaries
- Reports to:
  - In-house counsel
  - Officers
  - Board
  - Board Committee
- Internal communications
- Communications among lawyers

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Life Care Centers of America: Sampling and Extrapolation In False Claims Cases

Case Background

- Life Care Centers of America operates more than 200 skilled nursing facilities across the country
- Whistleblower suit accuses Life Care Centers of billing Medicare, Medicaid, and TRICARE for unnecessary care from 2006-2012
- Government proposed to sample 400 patient medical records and then extrapolate results to more than 50,000 patient admissions

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Life Care Centers' Position

- Government is required to prove all elements of false claim for each claim
- Statistical sampling and extrapolation as to liability violates Life Care Centers' due process rights and improperly shifts the burden of proof to the defendant

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Government's Position

- Government does not have to prove elements (materiality, knowledge, etc.) on a claim by claim basis
- Statistical sampling and extrapolation are widely-accepted methods for determining overpayments

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Decision

- FCA does not explicitly bar extrapolation
- Forcing the government to prove the elements on a claim by claim basis would be too burdensome and would encourage large-scale fraud
- Life Care Centers' due process rights will be sufficiently protected by its ability to attack the government's methods and experts

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October 2014 Sunset Commission Report to OIG

- OIG has grown significantly since its creation, particularly in recent years. OIG's budget increased 30% from $37.9 M in fiscal year 2011 to $48.9 M in fiscal year 2014.
- OIG's investigative processes, especially Medicaid provider investigations, lack structure, data and performance measures needed for overall management and evaluation, resulting in limited outcomes.

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- Lack of criteria for opening or prioritizing cases.
- Poor use of data and performance measures
  - Timeframes for resolution of cases
  - Case load statistics
  - Trends in type of cases
  - Case dispositions

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- Limited Outcomes:
  - Lengthy timeframes
    - Fastest Time 421 days
    - Average Time 1,143 days
    - Slowest Time ≤ 9 years
  - Cases languishing
  - Few cases resolved
  - Limited cost recovery

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- In fiscal years 2012 and 2013, Medicaid provider investigations identified more than $1.1 billion in potential overpayments, but OIG only collected a total of $5.5 million in overpayments.

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- Absence of criteria to scale OIG's Medicaid payment recoupments to the nature of the violation contributes to large overpayment estimates and inconsistent results.

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- No Scale for enforcement actions
- Extrapolation to large overpayments
- Little oversight of sampling and extrapolation methodology

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- OIG's methods of communicating and sharing information need improvement.
  - Deficiencies in training
  - Poor communication
    - Unshared trend information
    - No systemic fraud prevention efforts
  - Lack of transparency

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- OIG's structure results in blurred accountability and little oversight of effectiveness in accomplishing its fraud, waste and abuse mission.
  - Unclear accountability
  - Little oversight
  - Questionable return on investment
  - Incentives may not encourage recovery of dollars

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Recommendations

- Remove the gubernatorial appointment of the Inspector General and require the Executive Commissioner to appoint and directly supervise the Inspector General.
- Require OIG to undergo special review by Sunset in 6 years.
- Require OIG, by rule, to establish prioritization and other criteria to guide its investigative process.

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- Require OIG to complete Medicaid provider preliminary investigations within 45 days and full investigations within 180 days.
- Require OIG, by rule, to establish criteria for scaling its enforcement actions for Medicaid provider investigations to the nature of the violations, including penalties.
- Require OIG to conduct quality assurance reviews and request a peer review of sampling methodology used in its investigative process.

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- Define OIG's role in managed care, including strengthening oversight of special investigative units.
- Remove the prohibition on participating in both Health Insurance Payment Program and Medicaid Managed Care.
- Allow OIG to share confidential drafts of investigative reports concerning child fatalities with DFPS.

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