



American Health Care Association



National Center for Assisted Living

**AHCA/NCAL SUMMARY OF FEDERAL GOVERNMENT MEDICARE/MEDICAID INTEGRITY PROGRAMS AND FRAUD INVESTIGATIONS AFFECTING LONG TERM CARE (LTC) PROVIDERS (JANUARY 2011)**

This chart, in the nature of a side-by-side, provides information on the array of integrity programs at the Centers for Medicare & Medicaid Services (CMS). There are several such programs for Medicare and Medicaid and others that affect both Medicare and Medicaid. There also are various CMS offices with a broad array of responsibilities for either or both programs.

Our goal is to provide members with an overview into who the reviewing entities are their roles, programs and responsibilities; specifically, what they are looking for. We intend to update this chart as we learn more and to put out targeted information on specific programs as they evolve.

If you have any questions please contact Dianne De La Mare [ddmare@ahca.org](mailto:ddmare@ahca.org) (Compliance Programs and Medicaid), and Elise Smith [esmith@ahca.org](mailto:esmith@ahca.org) (Medicare) and Priscilla Shoemaker [pshoemaker@ahca.org](mailto:pshoemaker@ahca.org) (Fraud Enforcement, Investigation and Prosecution).

| <u>Medicare:</u>  | <u>Medicaid:</u>   |
|---|--|
| <p><b><u>CMS, Medicare Integrity Program (MIP)</u></b></p> <p>“Program Integrity” refers to all CMS programs aimed at:</p> <ul style="list-style-type: none"> <li>▪ Detecting and preventing fraud in the Medicare fee-for-service, Medicare Advantage and Part D programs;</li> <li>▪ Ensuring the integrity of the Medicare fee-for service enrollment process; and</li> <li>▪ Promoting compliance with Medicare rules.</li> </ul> <p>Congress enacted a provision in HIPAA that established <b>MIP</b>. HIPAA provided CMS with dedicated funding to conduct program integrity activities. The Program Integrity Group is responsible for the goals of the MIP. It is part of the CMS Office of Financial Management (OFM) which has overall responsibility for the fiscal integrity of all CMS programs and develops and performs all benefit integrity policy and operations in</p> | <p><b><u>CMS, Medicaid Integrity Program (MIP)</u></b></p> <p>Created under the Deficit Reduction Act of 2005 (DRA), and the first comprehensive Federal strategy to prevent and reduce fraud, waste and abuse in the Medicaid program. CMS has two broad responsibilities including:</p> <ul style="list-style-type: none"> <li>▪ Hire Medicaid Integrity Contractors (MICs) to review Medicaid provider activities, audit claims, identify overpayments and educate providers/others in Medicaid integrity issues; and</li> <li>▪ Provide effective support and assistance to the States in their efforts to combat Medicaid provider fraud and abuse. The States remain primarily responsible for combating Medicaid fraud.</li> </ul> <p>Along with these responsibilities, DRA, Section 1936, requires that CMS develop a 5-year Comprehensive Medicaid Integrity Plan (CMIP) in consultation with internal/external partners. The first CMIP, covering</p> |

coordination with other CMS components.

CMS Contacts:

- Director Position currently vacant
- Peter Budetti, M.D., J.D. Deputy Administrator and Director, Center for Program Integrity, 202-205-9220, [Peter.Budetti@CMS.hhs.gov](mailto:Peter.Budetti@CMS.hhs.gov)
- Lisa Vriezen, Deputy Director (410-786-1492, [lisa.vriezen@cms.hhs.gov](mailto:lisa.vriezen@cms.hhs.gov) )

FYs 2006-2010 was published in 2006 at

<http://www.cms.hhs.gov/DeficitReductionAct/Downloads/CMIP2006.pdf>.

The Medicaid Integrity Group (MIG) is part of the CMS Center for Medicaid and State Operations (CMSO), which is the focal point for all CMS activities relating to Medicaid, Children's Health Insurance Program, Clinical Laboratory Improvement Act (CLIA), survey and certification and all interactions with States and local governments. CMSO also provides leadership to the **MIP**.

The Medicaid Integrity Group (MIG):

- Detects/prevents fraud, waste and abuse in Medicaid;
- Supports/assists the States;
- Identifies overpayments and decreases inappropriate payment of Medicaid claims;
- Educates providers/States on payment integrity and quality of care issues;
- Makes referrals of suspected practices/providers to Federal/State law enforcement agencies; and
- Conducts state-of-the-art data mining and analysis to identify emerging trends.

MIG Offices include:

- Division of Medicaid Integrity Contracting (**DMIC**): Oversees procurements, evaluation and oversight of MICs.
- Division of Fraud Research & Detection (**DFRD**): Oversees the development of strategies to review Medicaid data to assist the Medicaid Integrity Contractors (MICs).
- Division of Field Operations (**DFO**): Approximately 40 staff working in New York, Chicago, Atlanta, Dallas and San Francisco Offices. Conduct State Medicaid program integrity reviews, coordinates audits and provide support.

CMS Contacts:

- Angela Brice Smith, Medicaid Integrity Director (410-786-4340, [Angela.Brice-Smith@cms.hhs.gov](mailto:Angela.Brice-Smith@cms.hhs.gov))
- Paul Miner, Deputy Director (410-786-5937, [Paul.Miner@cms.hhs.gov](mailto:Paul.Miner@cms.hhs.gov))
- Robb Miller, Division of Field Operations (DFO) Director (312-353-0923, [Robb.Miller@cms.hhs.gov](mailto:Robb.Miller@cms.hhs.gov))

Go to <https://www.cms.gov/MedicaidIntegrityProgram/> to find all of the CMS' **MIP** documents.

**CMS, Provider Compliance Group (Medicare and Medicaid):**

The Provider Compliance Group (PRG) also is part of the CMS' OFM. However, it has responsibilities for both Medicare and Medicaid to:

- Implement/maintain Medical Review activities;
- Administer the CERT and PERM programs;
- Conduct data analysis and assesses scope and severity of suspected vulnerabilities; and
- Administer the RAC program.

CMS Contacts:

- George Mills, Director (410-786-1808, [george.mills@cms.hhs.gov](mailto:george.mills@cms.hhs.gov) )
- Bill Gould, Deputy Director (410-786-1458, [William.Gould@cms.hhs.gov](mailto:William.Gould@cms.hhs.gov) )

**Contractors/Programs:**

Technically speaking, PSCs and ZPICs are the **MIP** contractors. However, MACs can qualify as ZPICs. More importantly, there is cooperation among the various claims review contractors and **MIP** contractors. In order to meet the overall goal of program integrity, PSCs, ZPICs, Affiliated Contractors (ACs) and MACs must ensure that they pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers. CMS strategies in meeting this goal include:

- Preventing fraud through effective enrollment and through education of providers and beneficiaries;
- Early detection through, for example, medical review and data analysis; and
- Close coordination with partners, including PSCs, ZPICs, ACs, MACs, and law enforcement agencies.

Therefore, we are providing information on the principal integrity contractors and Medicare improper payment review entities that impact skilled nursing facilities. These are: PSCs/ZPICs, CERTs, MACs, RACs, and the HHS, Office of Inspector General (OIG).

**Contractors/Programs:**

CMS has established 3 different types of MICs including the Review-of-Provider MIC, Audit MIC and Education MIC.

- **Review-of-Provider MICs** analyze claims to identify potential vulnerabilities; provide leads/target audits to Audit MICs; use data-driven approaches to focus on aberrant billing practices (data mining); and work with DFRD. Review MICs, as of 1/11, are as follows:
  - **Regions I/II (CT, MA, ME, NH, NJ, NY, PR, RI, VT, USVD)**: Thomson Reuters;
  - **Regions III/IV (AL, DC, DE, FL, GA, KY, MD, MS, NC, PA, SC, TN, VA, WV)**: Thomson Reuters;
  - **Regions V/VII (IA, IL, IN, KS, MI, MN, MO, NE, OH, WI)**: AdvanceMed;
  - **Regions VI/VIII (AR, CO, LA, MT, ND, NM, OK, SD, TX, UT, WY)**: AdvanceMed; and
  - **Regions IX/X (AK, AM. Samoa, AZ, CA, Guam, HI, ID, N. Marianna Isl, NV, OR, WA)**: AdvanceMed.
- **Audit MICs** conduct post-payment audits; perform field audits and desk reviews and identify overpayments. Audit MICs make

**PSC/ZPIC -- Program Safeguard Contractor/Zone Program Integrity**

**Contractor:** The PSC and the ZPICs are responsible for preventing, detecting, and deterring Medicare fraud. The PSCs and the ZPICs identify and prevent fraud by:

- Identifying program vulnerabilities;
- Proactively identifying incidents of potential fraud that exist within its service area and taking appropriate action on each case;
- Investigating (determining the factual basis of) allegations of fraud made by beneficiaries, providers, CMS, OIG, and other sources;
- Exploring all available sources of fraud leads in its jurisdiction, including the Medicaid Fraud Control Unit (MFCU) and its corporate anti-fraud unit;
- Initiating appropriate administrative actions to deny or to suspend payments that should not be made to providers where there is reliable evidence of fraud;
- Referring cases to the OIG, Office of Investigations for consideration of civil and criminal prosecution and/or application of administrative sanctions;
- Referring any necessary provider and beneficiary outreach to the Provider Outreach and Education (POE) staff at the AC or MAC;
- Initiating and maintaining networking and outreach activities to ensure effective interaction and exchange of information with internal components as well as outside groups;

The PSCs and the ZPICs are required to use a variety of techniques, both proactive and reactive, to address any potentially fraudulent billing practices including:

- Pursuing leads through data analysis, the Internet, the Fraud Investigation Database (FID), news media, etc; and
- Generating and/or identifying leads by any internal, AC, or MAC component, and not just the PSCs and ZPICs (e.g., claims processing, data analysis, audit and reimbursement, appeals, medical review, enrollment).
- The PSCs and the ZPICs function in:
  - Seven zones based on MAC jurisdictions;
  - Five “hot spots” (CA, FL, IL, NY, TX); and
  - Two other zones which include 24 states with limited incidence of fraud. These will continue using proven PSCs.

referrals to HHS, OIG, which, in turn share with State MFCU. Audit MICs, as of 1/11, are as follows:

- **Regions I/II (CT, MA, ME, NH, NJ, NY, PR, RI, VT, USVI):** Improving Healthcare for the Common Good (IPRO);
- **Regions III/IV (AL, DC, DE, FL, GA, KY, MD, MS, NC, PA, SC, TN, VA, WV):** Booz Allen Hamilton contract re-competed (9/09) and awarded to Health Integrity;
- **Regions V/VII (IA, IL, IN, KS, MI, MN, MO, NE, OH, WI):** Health Integrity;
- **Regions VI/VIII (AR, CO, LA, MT, ND, NM, OK, SD, TX, UT, WY):** Health Management Solutions (HMS); and
- **Regions IX/X (AK, AM. Samoa, AZ, CA, Guam, HI, ID, No. Marianna Isl, NV, OR, WA):** Health Management Solutions (HMS).
- **Education MICs** will develop training materials and awareness campaigns; highlight value in preventing fraud and abuse. Contracts were awarded to Strategic Health Solutions (SHS) to:
  - create a gap analysis of existing education/training efforts; develop fraud/waste/abuse education and training materials and materials for accurate billing for services; and
  - develop educational curriculum via web-based and traditional methods; educate Medicaid providers about Medicaid Integrity and quality of care.

**MII (Medicaid Integrity Institute):** National training facility for State Medicaid program integrity employees. Established at existing DOJ prosecutor training facility. DOJ staff partners with MIG and states to design courses for State Medicaid Program Integrity employees. The goal is to meet state training needs and establish credentialing process for State Medicaid Program Integrity.

**PERM (Payment Error Rate Measurement) Program** measures improper payments in the Medicaid program and the Children's Health Insurance Program (CHIP). PERM is designed to comply with the *Improper Payments Information Act*. For PERM, CMS is using a national contracting strategy consisting of three contractors to perform statistical calculations, medical records collection and medical/data processing

**Fiscal Intermediaries (FIs) and Medicare Administrative Contractors (MACs)**

- The goal is to help prevent improper payments;
- Medicare claims processing contractor, through analysis of claims data and evaluation of other information (e.g., complaints), identifies suspected billing problems. Medical review activities are targeted at identified problem areas appropriate for the severity of the problem;
- If the MAC verifies that an error exists through a review of a small sample of claims, the contractor classifies the severity of the problem as minor, moderate, or significant and imposes corrective actions; and
- There can be pre-payment and postpayment review.

**Comprehensive Error Rate Testing (CERTs):**

- The main objective of these programs is to measure the degree to which CMS and its contractors are meeting the goal of “Paying It Right.”
- CMS established two programs to monitor the accuracy of the Medicare Fee For Service (FFS) Program: the CERT program and Hospital Payment Monitoring Program (HPMP). HPMP monitors PPS short-term and long-term acute care inpatient hospital; discharges. CERT program monitors all other claims.
- The CERT program produces a national Medicare FFS error rate as required by the Improper Payments Information Act.
- CERT monitors and reports the accuracy of Medicare FFS payments made by Carriers, Durable Medical Equipment Regional Carriers (DMERCs), FIs and the new MACs.

**Recovery Audit Contractors (RACs):**

- The goal is to detect and correct past improper payments so that CMS and carriers, FIs and MACs can implement actions that will prevent future improper payments.
- The Tax Relief and Health Care Act of 2006 made the RAC program permanent.
- RACs are required to apply statutes, regulations, CMS national coverage, payment, and billing policies, as well as LCDs that have been approved by the Medicare claim processing contractors.
- There are four RAC Regions and a different contractor for each region:
  - Region A: Diversified Collection Services, Inc. of

review of selected State Medicaid and CHIP fee-for-service (FFS) and managed care claims.

- In 2006, CMS reviewed only FFS Medicaid claims.
- Beginning in 2007, CMS expanded PERM to include reviews of FFS and managed care claims, as well as beneficiary eligibility, in both the Medicaid and CHIP programs.
- Groups of States are selected for PERM Program participation on a rotation basis once every 3 years as follows:
  - 2007 – AL, CA, CO, GA, KY, MD, MA, NE, NH, NJ, NC, RI, SC, TN, UT, VT, WV
  - 2008 – AK, AZ, DC, FL, HI, ID, IO, LA, ME, MI, MO, NE, NY, OR, SD, TX, WA
  - 2009 – AR, CO, DE, ID, IL, KA, MI, MN, MO, NM, ND, OH, OJK, PA, VI, WI, WY
  - 2010 – AL, CA, CO, GA, KY, MD, MA, NE, NH, NJ, NC, RI, SC, TN, UT, VT, WV
  - 2011 - AK, AZ, DC, FL, HI, IN, IO, LA, ME, MS, MO, NE, NY, OR, SD, TX, WA

**Database:**

**MMIS (Medicaid Management Information System)** is the master claims database, which identifies potential Medicaid claims problems. The regional office receives a subset of the MMIS database and the staff uses that subset for research to identify algorithms, etc. Once an issue is identified, the staff pulls the provider number from the subset, and the CMS Regional office sends a letter to the respective state’s OIG to ascertain whether any of the providers are already under audit/investigation. CMS has identified problems with the database including: data is stale and the database doesn’t provide a contact name/number. OIG released a report in August 2009, *MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse*, which can be found at <http://oig.hhs.gov/oei/reports/oei-04-07-00240.pdf>.

**State Medicaid Integrity Program:**

**MFCU (Medicaid Fraud Control Unit)** is a single identifiable entity of state government, annually certified by the HHS Secretary that conducts a statewide program for the investigation and prosecution of health care providers that defraud the Medicaid program. A MFCU also reviews complaints of abuse or neglect of nursing facility residents. The MFCU is

Livermore, California: ME, NH, MA, RI, CT, VT, NY, PA, NJ, DE, MD and DC.

- Region B: CGI Technologies and Solutions, Inc. of Fairfax, Virginia: MN, WI, MI, IL, IN, OH, KY.
- Region C: Connolly Consulting Associates, Inc. of Wilton, Connecticut: CO, NM, TX, OK, AR, LA, AL, FL, SC, NC, VA, TN, GA, WV and MS.
- Region D: HealthDataInsights, Inc. of Las Vegas, Nevada: AK, WA, OR, CA, NV, ID, MT, WY, UT, AZ, ND, HI, SD, NE, KS, IO and MO.

- Comprehensive information on the RACs can be found on the dedicated AHCA RAC web site. This includes up-to-date lists of all CMS approved issues for SNFs.

[http://www.ahcancal.org/facility\\_operations/MedicareRAC/Pages/default.aspx](http://www.ahcancal.org/facility_operations/MedicareRAC/Pages/default.aspx)

- In addition each RAC contractor has its own website for CMS approved issues.

- RAC Region Web Sites for Issues Approved By CMS

- Region A -- <http://www.dcsrhc.com/issues.html>
- Region B -- <http://racb.cgi.com/Issues.aspx?st=1>
- Region C -- [http://www.connollyhealthcare.com/RAC/pages/approved\\_issues.aspx](http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx)
- Region D -- <https://racinfo.healthdatainsights.com/Public/NewIssues.aspx>

- RAC CMS Project Officers

- RAC Region A -- CMS project officer: Scott Wakefield  
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- RAC Region C -- CMS project officer: Amy Reese.  
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- RAC Region D -- CMS project officers: Brian Elza,

charged with investigating fraud in the administration of the program and for providing for the collection or referral for collection to the responsible State agency.

### **Medicaid Recovery Audit Contractors (Medicaid RACs)**

- Section 6411 of the Affordable Care Act (Pub. L. 111– 148, enacted on March 23, 2010) requires states to establish programs in which they would contract with 1 or more Recovery Audit Contractors (Medicaid RACs) by December 31, 2010.
- The Medicaid RACs would review Medicaid claims submitted by providers of services for which payment may be made under section 1902(a) of the Act or a waiver of the State plan. Medicaid RACs would identify underpayments, and identify and collect overpayments from providers.
- On November 10, 2010, CMS issued a proposed rule implementing the program . AHCA submitted comments on January 10, 2011. A few of our key recommendations to CMS were as follows:
  - Exempt states from having to develop Medicaid RACs whenever possible;
  - Not require that Medicaid RACs be paid with contingency fees if the state does not wish (not just when a state statute forbids the use of contingency fees);
  - Review the states' appeals processes to determine and ensure their reasonableness.
  - Require or strongly recommend that, states require RACs to document “good cause” before the RAC reviews a claim, and establish minimum requirements for the documentation of “good cause.” Urge CMS to monitor Medicaid RACs' compliance with “good cause” documentation requirements.
  - Prohibit, or at the very least impose limitations on, extrapolation in the Medicaid RAC program.
  - Require states to institute an approval process for new issues similar to that for Medicare RACs, and to post those issues on the Internet;
  - Require each Medicaid RAC to hire a physician Medical Director to oversee the medical record review process,

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- assist nurses, therapists, and certified coders upon request, and manage quality assurance procedures.
- Mandate that a “lookback” audit period be no greater than 3 years;
- Apply the Medicare RAC improvements to the Medicaid RAC program.
- AHCA will report on the final rule when it is issued.

#### **Joint Agency Integrity Programs:**

- HHS/DOJ Health Care Fraud Prevention and Enforcement (**HEAT**), was announced in May 2009, and is a joint task force consisting of senior level leadership from both departments. In 2010, HHS/DOJ Heat held a series of Regional Health Care Fraud Prevention Summits throughout the U.S. HEAT is originally built on the successful OIG-DOJ Medicare Fraud Strike Force initiated in South FL, and has expanded to other metropolitan areas across the country. HEAT: a) enlists providers to help ensure integrity of billing practices, and will focus on both Medicare and Medicaid providers who HHS/DOJ believe are cheating the government; b) has Strike Force teams in Miami, Los Angeles, Detroit and Houston; and c) is helping State Medicaid officials conduct provider audits and monitor activities to detect fraudulent activities.
- **Medi-Medi Program:** The Deficit Reduction Act of 2005 (DRA), enacted in February 2006, established an additional activity under the Medicare Integrity Program (**MIP**), and provided \$12 million in funding for the Medi-Medi Program in fiscal year 2006.10 0Pub. L. No. 109-171, § 6034(d), 120 Stat. 4, 77 (2006) (to be codified at 42 U.S.C. § 1395ddd(b)(6) and 1395i(k)(4)(D)). This program is designed to identify improper billing and utilization patterns by matching Medicare and Medicaid claims information on providers and beneficiaries to reduce fraudulent schemes that cross program boundaries. The statute appropriates funds for CMS to contract with third parties to identify program vulnerabilities in Medicare and Medicaid through examining billing and payment abnormalities. These funds also can be used in connection with the Medi-Medi program for two other purposes: (1) coordinate actions by CMS, the states, the Attorney General, and the HHS OIG to protect Medicaid and Medicare expenditures and (2) increase the effectiveness and efficiency of both Medicare and Medicaid through cost avoidance, savings, and recouping fraudulent, wasteful, or abusive expenditures.

#### **OIG Testimony:**

### **2010**

09-22-2010

[Testimony of Daniel R. Levinson, Inspector General \(PDF\)](#), before the Subcommittee on Health of the House Committee on Energy and Commerce on cutting waste, fraud, and abuse in Medicare and Medicaid

09-15-2010

[Testimony of Daniel R. Levinson, Inspector General \(PDF\)](#), before the Subcommittee on Health of the House Committee on Energy and Commerce on the integrity of Medicare’s coverage of durable medical equipment and supplies (DME)

06-15-2010

[Testimony of Lewis Morris \(PDF\)](#), Chief Counsel to the Inspector General, before the Subcommittees on Health and Oversight of

the U.S. House Ways and Means Committee on Reducing Fraud, Waste and Abuse in Medicare

03-04-2010

[Testimony of Daniel R. Levinson, Inspector General \(PDF\)](#) before the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies of the House Committee on Appropriations on efforts to combat health care fraud, waste, and abuse in Medicare and Medicaid

[Testimony of Timothy J. Menke \(PDF\)](#), Deputy Inspector General for Investigations Before the Subcommittee on Crime, Terrorism, and Homeland Security of the House Committee on the Judiciary on law enforcement activities to combat Medicare and Medicaid fraud

[Testimony of Omar Perez \(PDF\)](#), Special Agent with the Office of Inspector General Before the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies of the House Committee on Appropriations on investigative efforts to combat Medicare and Medicaid fraud

## **2009**

06-25-2009

[Testimony of Daniel R. Levinson, Inspector General \(PDF\)](#), before the Subcommittee on Health of the House Energy and Commerce Committee on Health Care Reform: Opportunities to Address Waste, Fraud and Abuse

05-06-2009

[Testimony of Daniel R. Levinson, Inspector General \(PDF\)](#), before the Senate Special Committee on Aging on fraud in the Medicare and Medicaid programs and recommendations for reducing this fraud while maintaining a high level of services for providers and patients participating in the Medicare and Medicaid programs

04-22-2009

[Testimony of Lewis Morris \(PDF\)](#), Chief Counsel to the Inspector General, before the U.S. Senate Homeland Security and Governmental Affairs Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security on Eliminating Waste and Fraud in Medicare and Medicaid

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### **Medicare and Medicaid Fraud Enforcement , Investigation and Prosecution**

**Significance:** Medicare and Medicaid audits now are more likely to be followed by investigation and prosecution for health care fraud. Recent legislation has given both federal and state agencies a tremendous amount of power in dealing with fraud in the health care industry. Private citizens, beneficiaries and employees are being encouraged by government and plaintiffs bar to pursue civil health care fraud cases against medical providers with the lure of increased monetary incentive. Potential criminal and civil liability for a health care provider under these statutes is significant. Additionally, the government now has the ability to exclude providers from federal programs based only on certain evidence or an indictment in the absence of proven provider guilt. Because of the new federal focus on Health Care fraud, it is imperative that health care providers be aware of potential exposures to a variety of civil and criminal charges and to prepare to react and respond appropriately.

**Funding Source/Government Return on Investment:** The Health Care Fraud and Abuse Control Program, established by the Health Insurance Portability and Accountability Act of 1997, provides an annual funding stream for the DOJ to combat Medicare and Medicaid fraud. The previous level of funding to the Health Care Fraud and Abuse Account (HCFAC) was \$1.172 billion in mandatory base funding, and \$311 million in proposed discretionary funding. Following the March 23, 2010 enactment of the Patient Protection and Affordable Care Act (PPACA) funding for fraud and abuse enforcement has increased by \$100 million in additional funds at a rate of \$10 million per year for FYs 2010 through 2020. The Health Care and Education Reconciliation Act (HCERA) of 2010 added another \$250 million to the fight against Medicare and Medicaid fraud, waste and abuse. Increased funding is most likely because government return on taxpayer investment has risen significantly under law enforcement's heightened efforts. Just take recovery estimates under the federal False Claims Act as an example.

HHS and DOJ released a report, *Health Care Fraud and Abuse Control Program (HCFAC) Annual Report for FY 2010*, showing that the government's health care fraud prevention and enforcement efforts recovered more than \$4 billion in taxpayer dollars in Fiscal Year (FY) 2010. This is the highest amount ever recovered in one year. In 2009, HHS and DOJ enhanced their coordination through HEAT and have expanded Medicare Fraud Strike Force teams, as well as hosting a series of regional fraud prevention summits around the country and sending letters to state attorneys general urging them to work with HHS and federal, state and local law enforcement officials to mount a substantial outreach campaign to educate seniors and other Medicare beneficiaries about how to prevent scams and fraud. In 2010, HEAT and the Medicare Fraud Strike Force continued to expand local partnerships and helped educate Medicare beneficiaries about how to protect themselves against fraud. Also in 2010, the total number of cities with Strike Force prosecution teams was increased to seven, all of which have teams of investigators and prosecutors dedicated to fighting fraud. The Strike Force teams use advanced data analysis techniques to identify high-billing levels in health care fraud hot spots so that interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers. To obtain a copy of the report go to <http://www.oig.hhs.gov/publications/hcfac.asp>. The report also is discussed on an HHS press release on fraud and abuse enforcement efforts at <http://www.hhs.gov/news/press/2011pres/01/20110124a.html>. To obtain more information on the joint DOJ-HHS Strike Force activities, go to <http://www.StopMedicareFraud.gov/>. Additionally, from 1986 to 2008 False Claims Act (FCA) settlements and judgments amounted to \$21.6 billion and more than 66% (\$14.3 billion) of that amount has resulted from health care settlements and judgments. At the same time, the whistleblower (qui tam) recoveries under both federal and state FCA statutes have dramatically increased as well. During roughly that same period of time, the whistleblower share in health care FCA has increased dramatically as well. In 1988 whistleblowers' share in \$2.5 million in FCA recoveries was just \$88,750. In 2008 whistleblowers' share of \$1.1 billion in healthcare FCA recoveries jumped to \$183 million.

**Agency Coordination:** Primary responsibility for enforcing federal laws regarding health care fraud rests with the Department of Justice (DOJ) and United States Attorneys. The Federal Bureau of Investigations (FBI) plays a major role in assisting the DOJ in investigating and developing health care fraud cases. Within the Department of Health and Human Services, the Office of Inspector General (OIG) is responsible for investigating fraud cases and bringing enforcement actions involving administrative sanctions. Individual states have their own Medicaid Fraud Control Units (MFCU) and local prosecutors can bring such cases as well. Private companies that contract with the CMS to administer such programs as MACs, RACs, etc. have some responsibilities in this area reviewing claims, detecting upcoding and other improper billing practices, etc. and recovering overpayments. Finally in certain circumstances private parties can pursue health care fraud through a civil lawsuit, although the government has the option of taking over the case.

**Investigation and Prosecution** As of March 2010, PPACA increased the HHS Secretary's ability to conduct investigations related to issue subpoenas but also to require the attendance and testimony of witnesses and the production of any other evidence that relates to matters under investigation. Investigations into Medicare and Medicaid Fraud begin with the OIG. OIG investigators have the power to execute search warrants and serve subpoenas in connection with their investigation. In cases involving suspected Medicaid Fraud, the OIG has delegated its investigative activities to the MFCUs established by individual states. The majority of MFCUs are located within State Attorneys General offices. MFUCs have the power to issue subpoenas, serve and execute search warrants, and take sworn statements. Once investigators have reason to believe a law has been broken, the situation is reported to the U S. Attorney General (AG) and the FBI. The AG's office coordinates further investigation and determines whether to

submit the case to a grand jury. If the investigation is conducted by a Medicaid Fraud Control Unit, the MFCU has the authority to prosecute criminally, or refer the matter to the applicable district or county attorney for prosecution. The MFCU also may coordinate its activities with federal investigators.

**Choice of Law and Remedy:** In dealing with Medicare and Medicaid fraud and abuse, the appropriate law enforcement entity (ies) can choose among a wide array of criminal, civil and administrative responses. On the criminal side, offenses can be addressed with general statutes or with health care specific statutes. In addition to possible criminal liability, providers also are exposed to substantial civil liability for health care fraud under the Civil False Claims Act and the Civil Monetary Penalties Law. The government in many cases will pursue both civil and criminal liability for the same action. In 2010, the Patient Protection and Affordable Care Act (PPACA) made important changes to key fraud and abuse statutes. Specifically, certain provisions of the Federal False Claims Act (FCA) at §§ 3729, *et seq.* have been altered in a manner calculated to increase whistleblower litigation. Effective January 2011, PPACA establishes new grounds for mandatory exclusion from the Medicaid program, for individuals or entities that: (1) have been terminated from Medicare or another Medicaid program; and (2) that own, control or manage an entity that has delinquent unpaid overpayments, is suspended, excluded or terminated from participation, or is affiliated with a suspended, excluded or terminated individual or entity. New grounds for imposition of permissive exclusion include providers who make a knowing false statement, omission or misrepresentation of material fact in any application agreement, bid or contract to participate or enroll in a federal healthcare program and any provider who obstructs a program audit and/or investigation (prior law only applied to the obstruction of a criminal investigation). Two additional changes under PPACA worth noting here are the new provision that allows the government to suspend Medicare and Medicaid payments pending a “credible” investigation of fraud and the

| <u><b>Criminal:</b></u>  | <u><b>Civil:</b></u>  |
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| <p><u>General federal statutes include:</u></p> <ul style="list-style-type: none"> <li>▪ conspiracy to defraud the U.S. (18 U.S.C. Secs. 286,371);</li> <li>▪ false statements (18 U.S.C. Sec. 101);</li> <li>▪ mail fraud (18 U.S.C. Sec. 1341);</li> <li>▪ wire fraud (18 U.S.C. Sec 1343); and</li> <li>▪ money laundering (18 U.S.C. Secs. 1956, 1957).</li> </ul> <p><u>Health care specific federal statutes include:</u></p> <ul style="list-style-type: none"> <li>▪ kickbacks (42 U.S.C. Sec. 1320a-7(b));</li> <li>▪ health care fraud (18 U.S.C. Sec. 1347);</li> <li>▪ theft or embezzlement (18 U.S.C. Sec. 669);</li> <li>▪ false statements (18 U.S.C. Sec. 1035 and 42 U.S.C. Sec. 1320a-7b(a));</li> <li>▪ obstruction of criminal investigations (18 U.S.C. Sec. 1518); and</li> <li>▪ money laundering (18 U.S.C. Sec. 1956(a) (1)).</li> </ul> <p>Depending upon the statute(s) applied, those individual or entities convicted of health care fraud face punishment in terms of fines amounting anywhere from \$1,000 to \$250,000 and prison terms ranging from 5 years to a 20 years to life sentence in cases where severe bodily injury or death are attributed to the fraud and abuse.</p> | <p><u>Federal Civil statutes include:</u></p> <p>The civil False Claims Act (“FCA”), 31 U.S.C. §§ 3729-3733, is the government’s primary tool for combating fraud. The statute imposes liability on persons who (1) knowingly present false or fraudulent claims to the United States, (2) knowingly make false records or statements to get false or fraudulent claims paid, or (3) conspire to defraud the government by getting a false or fraudulent claim paid. 31 U.S.C. §§ 3729(a) (1)-(3). The statute provides for treble damages plus penalties of \$5,500 - \$11,000 for each false claim.</p> <p>In 2005, The Deficit Reduction Act (DRA)of gave states an incentive to enact laws as stringent as the federal FCA. DRA allows a state to retain an extra 10 percent of recovered Medicaid funds, which otherwise would be returned to the federal government, if the state has a false claims statute at least as effective as the federal FCA.</p> <p>The FCA permits private citizens, known as <i>qui tam</i> plaintiffs or “relators,” to hire attorneys and file actions asserting violations of the Act on behalf of the United States. Such actions are filed under seal, and the Department of Justice (“DOJ”) has the opportunity to investigate the action and decide whether to intervene in the lawsuit and take the lead in prosecuting the action. If the government declines to intervene, relators</p> |

and their attorneys can proceed with the action. The incentive for relators and their attorneys is financial – if the action is successful, the relator receives up to 30 percent of the proceeds awarded.

Recent cases involve the use of the FCA to enforce other program rules or norms including compliance with the anti-kickback and self-referral (Stark) statutes as well as quality standards.

In 2009, under the Federal Enforcement Recovery Act, Congress provided an additional \$165 million in new funding and amended the federal FCA in several significant ways:

- Expands presentment of claims to cover claims submitted to government contractors or grantees which means claims presented to Medicaid may now be subject to FCA.
- Expands liability to include failure to timely repay overpayments (“reverse” FCA).
- Allows government complaints, for the purposes of statute of limitations, to “relate back,” to the filing date of the complaint of the person originally filing the action.
- Broadens individuals who can issue a civil investigative demand (CID) to include “designees” of the AG.
- Provides that information obtained by AG or designee may be shared with relator (whistleblower).
- Whistleblower protections expanded to contractors and agents (in addition to employees).
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In 2010, PPACA dramatically altered the “public disclosure” and “original source” provisions of the FCA that may allow whistleblowers (*qui tam* plaintiffs) to more easily file a suit based on already “public” information and material with little or no first hand knowledge under very limited to no jurisdictional bar.

**Exclusion from the Medicare and Medicaid Programs:** In addition to the penalties mentioned above, the health care provider is subject to expulsion from the Medicare and Medicaid programs. 42 U.S.C.1320a-7(a) (3) now provides for mandatory exclusion upon a felony conviction of fraud in connection with the delivery of health care item or service, or with respect to any act or omission in a government health care program. Such exclusion from participation is for a period of not less than five years. Also, 42 U.S.C. §1320a-7(b) provides for the permissive exclusion of a provider for a conviction relating to the obstruction of an investigation; submitting claims for excessive charges that do not rise to the level of fraud, failure to disclose statutorily required information and failure to provide required access to records. Such exclusion is for a minimum of three years.

One of the most potent weapons in the prosecutor's arsenal, however, is the power to suspend and withhold a provider's payments under Medicare upon

indictment or other reliable evidence of fraud. Under 42 C.F.R. §405.370 and 42 C.F.R. §405.370 such payments can be suspended without a hearing once the prosecutor has obtained an indictment. As a result, the government is able to exert tremendous pressure on targeted health providers to force settlement.

### Compliance Program

**What is a corporate compliance program?** Simply stated, a corporate compliance program is a written and operational program specifying an organization's policies, procedures, and actions within a process to help prevent and detect violations of Federal and State laws and regulations. The benefits of a strong program go well beyond regulatory and legal compliance to also include operational benefits. An effective corporate compliance program will help ensure that a facility's organizational structure, people, processes and technology are all working in harmony to manage risks, improve customer satisfaction, enhance facility operations, improve quality of health care services, oversee vendors and reduce overall costs.

A lot has been discussed and written specifically about nursing facility (NF) corporate compliance since the OIG first published voluntary guidance in March 2000. In 2008, the discussion intensified when the OIG published a supplement to its 2000 NF guidance, and encouraged assisted living facility (ALF) and other long term care providers to establish and maintain effective compliance programs, with the goal to improve quality of care and services. With the passage of the Patient Protection and Affordable Care Act (PPACA), all nursing facilities must have a working compliance program by March 2013. We know from experience that one of the greatest obstacles to effective corporate compliance is company programs that are overly-complex, hard to understand and hard to manage. The OIG expects all owners, managers and employees, from owners and Board members to front-line staff, to understand the compliance program and participate in it actively. For that to happen, you have to know how to design, build and implement a compliance program; as well as understand the legal and practical benefits for implementing a program. To do that, AHCA/NCAL has sponsored monthly webinars throughout 2009 and created web-based guidance, specifically for long term care providers at [http://www.ahcancal.org/facility\\_operations/ComplianceProgram/Pages/default.aspx](http://www.ahcancal.org/facility_operations/ComplianceProgram/Pages/default.aspx).