

# Prevention of Medicaid Waste, Fraud, and Abuse

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# What we will cover

- Definitions
- Potential Penalties
- Prevention
- Reporting



# Intended Audience

Any HCBS Waiver or Habilitation Staff (General Overview)



# State Administered Medicaid Programs

Federal and State Governments jointly fund and administer Medicaid programs

Each State administers its Medicaid program in accordance with a CMS-approved State plan

States have considerable flexibility in designing and operating Medicaid programs, but all programs must comply with Federal requirements, including those pertaining to Waste, Fraud, and Abuse.





# What is Medicaid Fraud?

“An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.” (42 CFR Part 455.2)

# What is Medicaid Abuse?

“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 costs to the Medicaid program.” (42 CFR Part 455.2)

# Types of Fraud and Abuse



# Medical Identity Theft

“the appropriation or misuse of a patient’s or [provider’s] unique medical identifying information to obtain or bill public or private payers for fraudulent medical goods or services.”



# Billing for unnecessary services or items

Under Section 1902(a)(30)(A) of the Social Security Act, States are required to “provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan ... as may be necessary to safeguard against unnecessary utilization of such care and services ...”[6] States may “place appropriate limits on a service based on such criteria as medical necessity ...”[7] Providers are responsible for ensuring that authorized services meet the definition of medical necessity.

# Billing for services or items not rendered

To be covered by Medicaid, the billed service or supply must in fact be furnished.

- Billing Medicaid for a covered service or item that is not provided is fraudulent
- Providing different services or supplies is no justification for submitting a bill for a service or supply that was not provided.

# Upcoding

Is a term that is not defined in Federal Medicaid regulations, but it is generally understood as billing for services at a level of complexity that is higher than the service actually provided or documented

# Unbundling

“Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code.”



# Billing for non-covered services or items

Fraud and abuse may involve services that are provided but are not covered by Medicaid. Providers should only bill for the medically necessary or otherwise authorized services or items actually furnished to beneficiaries, and should ensure that proper documentation is in place.

# Kickbacks

Kickbacks can be defined as offering, soliciting, paying, or receiving remuneration (in kind or in cash) to induce, or in return for referral of patients or the generation of business involving any item or service for which payment may be made under Federal health care programs.[12, 13] Rewarding sources of new business may be acceptable in some industries but not when Federal health care programs and beneficiaries are involved



## What is Medicaid Waste?

Waste goes beyond fraud and abuse, and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight.

## More about Waste

For purposes of enforcement, there is a difference between unintentional mistakes and fraudulent or abusive behavior. For example, submitting an erroneous claim for payment is different from submitting the same claim with actual knowledge, reckless disregard, or deliberate ignorance of its falsity.[8] An honest mistake should lead to the return of funds to Medicaid. Providers who improperly bill for services risk losing continued eligibility to participate in the Medicaid program and may face criminal and civil monetary penalties.[9]

# Improper Medicaid Payments

Improper payments arise as a result of clerical errors, misinterpretation of program rules, or inadequate or poor record keeping. Improper payments include both overpayments and underpayments. While some improper payments are fraud, most are not fraudulent. The vast majority of providers are honest in their billings for Medicaid reimbursement.

# Examples of Improper Medicaid Payments

- Services not adequately documented
- Incorrect coding when billing
- Service documentation not meeting Iowa's reimbursement rules and regulations
- Failure to document time in and out, date of services, location, interventions, staff signature
- Errors in calculating units, over or under billing
- Billing for supports and services that are prohibited by rules
- Billing when the individual was hospitalized for 24 hours in a calendar day
- Completing documentation before providing services



# Corrections of Improper Documentation

- Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.
- A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.
- Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.



# Corrections of Improper Documentation

- If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.
- Improper documentation that cannot be reliably and/or accurately corrected must be paid back to the DHS per 79.2(10).



# Penalties

Providers who engage in fraud and abuse are subject to sanctions under a number of Federal and State laws. Sanctions under Federal law, for example, can take the form of administrative, civil, and criminal penalties. These penalties range from monetary fines and damages to prison time and exclusion from the Federal healthcare programs, including Medicaid.

The federal False Claims Act allows the government to recover money stolen through fraud by government contractors. Anyone who knowingly submits, or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages, or loss, to the government, plus civil penalties of \$5,500 to \$11,000 per false claim.



# Penalties

The HHS-OIG State Medicaid Fraud Control Units Report for 2017 showed:

- More than \$2.6 billion was recovered
- 818 civil settlements and judgments against providers
- 1,557 criminal convictions --45% involved personal care services attendants and agencies
- Convictions led to 3,635 individual and entity exclusions
- Department of Justice opened 975 new criminal investigations and 930 new civil investigations



# Whistleblowers

The federal False Claims Act also contains provisions to protect individuals who report in good faith an act of fraud or waste to the government, or files a lawsuit on behalf of the government. These individuals are referred to as “whistleblowers”. Whistleblowers are protected from retaliation from their employers and under Qui Tam provisions may be entitled to a percentage of the funds recovered by the government.



# Prevention

- Know the laws
  - <http://oig.hhs.gov/compliance/provider-compliance-training/files/HandoutLegalCitations508.pdf>
- Screen for Excluded individuals
- Implement a Compliance Program



# Exclusions

Under Section 1128 of the Social Security Act, HHS-OIG has authority to exclude individuals from participating in Federal healthcare programs, including Medicaid, for various reasons



# Mandatory Exclusions

- Convictions of program-related crimes
- Convictions relating to patient abuse
- Felony convictions relating to health care fraud
- Felony convictions relating to controlled substances



# Discretionary Exclusions

- Losing a state license to practice
- Failing to repay student loans
- Conviction of certain misdemeanors
- Failing to provide quality care

# Screening for Exclusions

As a Federal health care program, Medicaid will not pay for items or services furnished, ordered, prescribed, or supplied by an excluded individual or entity.



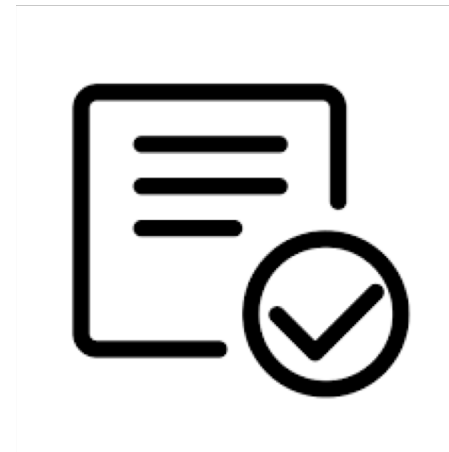
# Screening for Exclusions

CMS advises states to require providers screen their employees and contractors for exclusions by checking the database LEIE and SAM on a monthly basis.

# Screening for Exclusions

The List of Excluded Individuals/ Entities (LEIE) database is available at  
<http://exclusions.oig.hhs.gov/>

In addition to checking the LEIE, providers should check the Exclusions Extract on the System for Award Management(SAM)website at:  
<https://www.sam.gov/>



# Iowa Medicaid Provider Agreement

Comply, to the extent required, with 42 U.S.C. § 1396a(a)(68), and the requirements of the False Claims Act by:

- 1.10.1 Establishing written policies for all employees that include detailed information about the False Claims Act and the other provisions set forth in 42 U.S.C. § 1396a(a)(68). The policies must include detailed information about the Provider's policies and procedures for detecting and preventing waste, fraud, and abuse.

# Iowa Medicaid Provider Agreement

- 1.10.2 Including in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers, and a specific discussion of the Provider's policies and procedures for detecting and preventing fraud, waste, and abuse.

# All Providers Must Develop a Strong Medicaid Compliance Program

- Develop a strong corporate compliance policy with codes of ethical conduct set forth in 42 U.S.C. § 1396a(a)(68).
- Monitor for Medicaid waste, abuse, fraud, and take appropriate corrective actions if problems are identified.

# All Providers Must Develop a Strong Medicaid Compliance Program

- Monitor to ensure program integrity, compliance with state HCBS rules, and take appropriate corrective actions if problems are identified.
- Provide information and updated staff training on corporate compliance policy, codes of ethical conduct, and Chapter 79.3(3) documentation requirements.

# All Providers Must Develop a Strong Medicaid Compliance Program

- **REMOVAL OF THE ANNUAL COMPLIANCE TRAINING REQUIREMENT**

Previously, providers were required to train staff annually, but that has been changed. Compliance training is, however, still required of providers. Medicaid is obligated under their contracts with CMS to conduct routine monitoring, auditing and oversight of their providers to ensure providers are aware of the rules around waste, fraud, and abuse.

# All Providers Must Develop a Strong Medicaid Compliance Program

December 14, 2018 Effective Immediately

- Previously, providers were required to submit copies of these policies annually. Effective immediately, providers are not required to send copies of their policies, but must complete and return the Attestation of Compliance with Section 6032 of The Federal Deficit Reduction Act1form annually.
- For the federal fiscal year ending September 30, 2018, the form must be received by the IME by December 31, 2018.





# Compliance Program

HHS-OIG has recommended seven basic elements of a compliance program:

1. Conducting internal monitoring and auditing
  - Create an audit plan and re-evaluate it regularly.
  - Identify your organization's risk areas.

# Compliance Program, con't

- Use your networking and compliance resources to get ideas and see what others are doing.
- Don't only focus on the money – also evaluate what caused the problem.
- Create corrective action plans to fix the problem.

# Compliance Program, con't

## 2. Implement written standards and procedures

- Regularly review and update with department managers and Compliance Committee.
- Assess whether they are tailored to the intended audience and their job functions.
- Ensure they are written clearly.



# Compliance Program, con't

3. Designate a compliance officer or contact(s) to monitor compliance
4. Conduct training and education on standards and procedures
  - Regularly review and update training programs.
  - Make training completion a job requirement.



# Compliance Program, con't

(4 con't)

- Test employees' understanding of training topics.
- Maintain documentation to show which employees received training.
- Train your Board.
- Train yourself and your compliance staff.



# Compliance Program, con't

5. Respond appropriately to detected violations
6. Develop open lines of communication
  - Have open lines of communication between Compliance Officer (CO) and employees.
  - Maintain an anonymous “hotline” to report issues to you.
  - Enforce a non-retaliation policy for employees who report potential problems.

# Compliance Program,con't

(6 con't)

- Establish a direct line of communication between CO and the Board.
- Use newsletters or internal websites to maintain visibility with employees.
- Regularly meet with the Board and brief them on the compliance program.



# Compliance Program, con't

7. Enforcing disciplinary standards through well-publicized guidelines.
  - Delegate/empower teams closest to the issues to perform reviews
  - Act promptly, and take appropriate corrective action.
  - Create a system or process to track resolution of complaints.
  - Enforce your policies consistently through appropriate disciplinary action



# Reporting Suspected Medicaid Fraud, Waste, or Abuse

- Contact the Medicaid Managed Care Organization(s) associated with the Medicaid recipient and/or provider involved:
  - Amerigroup: Phone 800.454.3730; Fax 800.964.3627; Mailing Address: ATTN: MSIU Amerigroup Iowa, Inc., P.O. Box 62509, Virginia Beach,, VA 23466; Website: <https://providers.amerigroup.com/ia>. and access form by selecting Waste, Fraud, & Abuse at the bottom of the page

# Reporting Suspected Medicaid Fraud, Waste, or Abuse

- Iowa Total Care (Centene): TBD
- UnitedHealthCare: Phone 844.359.7736 or 866.242.7727 or 888.650.3462 (will need your provider ID); Website: [uhc.com/fraud](http://uhc.com/fraud); Quick Reference Guide: <https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/ia/forms/IA-UHCCP-FraudWasteAbuse-QRG.pdf>

## How MCOs handle WF&A

Each MCO has its own team of investigators. Allegations and findings of their investigations are shared with DHS and other regulatory and law enforcement agencies, as appropriate. The MCO may take additional actions, for example, issue warnings, provide education, conduct audits, perform specialized claims reviews, and recover overpayments.



# Reporting Suspected Medicaid Fraud, Waste, or Abuse

If no MCO is involved or if you want to also report allegations to the state, contact the Iowa Medicaid Fraud Control Unit (MFCU); Mailing Address: Department of Inspections and Appeals (DIA), Lucas State Office Building - 3rd floor, 321 E 12th Street, Des Moines, Iowa 50319-0083; for allegations against providers call 515.281.5717; for allegations against Medicaid recipients call 800.831.1394 (Monday - Friday, 7 am - 6 pm)



# Reporting Suspected Medicaid Fraud, Waste, or Abuse

You could also provide the information from the DHS Fraud and abuse webpage:

<https://dhs.iowa.gov/report-abuse-and-fraud> and DIA Medicaid Fraud Control Unit

Webpage: <https://dia.iowa.gov/investigations/medicaid-fraud-control-unit>

# How do you report suspected Medicaid fraud, waste, or abuse?

You may also report allegations to the Health and Human Services Office of Inspector General; phone number 1.800.hhs.tips; online link: <https://forms.oig.hhs.gov/hotlineoperations/nothhsemployeeen.aspx>; Mailing Address: US Department of Health and Human Services, Office of Inspector General, ATTN.: OIG HOTLINE OPERATIONS, PO Box 23489, Washington, DC 20226



# Questions

