Congressional Perspectives on Fraud and Abuse

Key Issues for the 112th Congress

Health Care Compliance Association Compliance Institute

April 11, 2011

Kimberly Brandt, Senate Finance Committee Minority Staff
Michael Park, Alston & Bird, LLP and former Senate Finance Committee Minority Staff

Key Fraud and Abuse Issues

- Permissive Exclusion
- Data Availability/Use/Integration
- Reducing Improper Payments
- CMS Contractor Oversight
- Expanded Fraud and Abuse Measures
- Increased Congressional Oversight of Administration F/W/A efforts
- Fraud and Abuse Implications of Accountable Care Organizations (ACOs)
Fraud and Abuse Key Focus in 112th Congress

- To date, at least 8 different hearings between the House and Senate focused on various aspects of fraud, waste and abuse.
- Focus has been on:
  - Implementation of health reform anti-fraud provisions,
  - Additional budget need for anti-fraud initiatives; and
  - Administration efforts to reduce improper payments.

Permissive Exclusion

- Re-introduction of Strengthening Medicare Anti-Fraud Measures Act (H.R. 675) by Reps. Herger and Stark
  - Expands OIG authority to exclude from federal health programs:
    - Affiliated entity of sanctioned entity (e.g., parent company)
    - Individuals (e.g., owner or officer) controlling sanctioned entity or affiliated entity even if they leave entity before it is convicted or excluded; and
  - Proposals are included in Senate bill (S.454)
Permissive Exclusion, cont.

- **What Does This Mean To You?**
  - Due diligence on prospective employees by doing a thorough background check
  - Senior executives need to get more involved in compliance programs and understand all potential risks when certifying reports or other public submissions of information

---

Data Issues

- Sens. Grassley and Wyden introduced The Medicare Data Access for Transparency and Accountability Act, or DATA Act, on April 7, 2011, to make Medicare claims and payment data available to the public.
- Series of articles in Wall Street Journal involving issues identified using these data.
- Physician Payments Sunshine Act– CMS in process of implementing
Data Issues, cont.

- CMS currently implementing multiple provisions of laws, including health reform, dealing with data including:
  - Predictive modeling,
  - Use of commercial edit software, and
  - Continued development of the integrated data repository.
- Discussion at hearings thus far about need for further database integration (i.e., combining licensure and exclusion information) and more tools to assist in more effective use of data.

Data Issues, cont.

- Additional discussions at various hearings about the need by law enforcement and private sector for additional data to more effectively identify improper payments and fight fraud (i.e., Drug Enforcement Administration data, casualty insurer data, private insurer data).
Data Issues, cont.

- What does this mean to you?
  - Providers need to be more vigilant in using data analytics to track and monitor their claims submission patterns. If not, the government will likely find things before you do and not give you a chance to correct them.
  - Greater focus on transparency not only with respect to claims information, but also financial relationships covered by the Physician Payments Sunshine Act.

Reducing Improper Payments

- Congress exercising vigilant oversight in ensuring CMS is reducing improper payments. Sens. Carper and Coburn are two of the more active advocates in this area
- Administration goal of reducing Medicare improper payments by 50% by July 2012
- Efforts to fight fraud are also tied to improper payment reduction as it puts more money back into the Medicare trust fund
Reducing Improper Payments, cont.

- Focus on implementation of The Improper Payments Elimination and Recovery Act of 2010, which was introduced by Sen. Carper and Rep. Murphy and enacted in July 2010
- Law requires:
  - Agency production of audited corrective action plans with targets to reduce overpayment errors;
  - Agency spending of more than $1 million to perform recovery audits on all their programs to actually recoup the overpayments; and
  - Penalties for agencies that fail to comply with current accounting and recovery laws.

Reducing Improper Payments, cont.

- What does this mean to you?
  - Increased focus on ensuring claims are paid properly
  - Audits will continue and possibly increase as CMS and other agencies work to aggressively reduce their improper payment rate
  - Need to be vigilant in communicating when you find issues that are being audited which are incorrect so CMS can properly instruct the contractors
CMS Contractor Oversight

- Conflict of Interest issues are a key area of focus
  - Sens. Grassley, Baucus, Carper and McCaskill all have publicly opined on this
- Contractor operations and performance issues will continue to be closely monitored as well
- Discussion regarding changes to contracting structure (i.e., separating provider enrollment)

Enhanced Anti-Fraud Legislation

- Strengthening Program Integrity and Accountability in Health Care Act of 2011 (S.454) introduced by Sen. Grassley
- Key provisions:
  - Provides CMS more time to pay Medicare claims when F/W/A suspected;
  - Enhances coordination among federal agencies responsible for fighting medical identity theft
  - Prohibits Medicaid payments for illegal, unapproved drugs;
  - Expands OIG permissive exclusion authority like in H.R. 675; and
  - Requires Medicare claims and payment data to be available to the public.
Enhanced Anti-Fraud Legislation

- Other legislation could be introduced to address issues such as:
  - CMS contractor performance and conflict of interest;
  - Easing restrictions on data sharing; and
  - Additional guidance on improper payments.

Implementation of F/W/A provisions of Health Reform

- Congress closely monitoring implementation of the following provisions:
  - Screening provisions
  - Application fees
  - Enrollment moratoria
  - Suspension of payments
  - Mandatory compliance programs
  - RACs for Medicaid and Medicare Parts C and D
Congressional Oversight

- Joint letter from Sen. Baucus and Hatch to OIG and CMS requesting quarterly reports beginning May 20, 2011, on spending and metrics related to implementation of various health reform provisions
- Closely watching to assess any negative impact on providers and to see which measures are most effective

Impact on Providers

- What does all of the preceding mean to you?
  - Increased Congressional oversight on CMS contractor operations and implementation issues means better responsiveness to issues identified by providers
  - Goal is to ensure effective implementation of provisions while maintaining a fair playing field and appropriate due process for all providers
ACOs and Medicare Shared Savings Program

- CMS Proposed Rule for the Medicare Shared Savings Program/ACOs
  - Comments due June 6, 2011
- Joint CMS and OIG Notice with comment period on waiver designs addressing proposed waivers of the Civil Monetary Penalties (CMP) law, Federal Anti-Kickback Statute, and the Physician Self-Referral law
  - Comments due June 6, 2011

ACO Program Integrity Reqmts

- Agreement Provisions: ACO must agree and must require ACO participants, providers/suppliers, and contracted entities performing functions or services on behalf of the ACO to agree, or to comply with
  - Federal criminal law;
  - False Claims Act;
  - Federal Anti-Kickback Statute;
  - CMP law; and
  - Physician self-referral law
ACO Program Integrity Reqmts

- Compliance Plan: ACOs must have a compliance plan that includes at least the following:
  - Designated compliance official or individual who is not legal counsel and who has the ability to report directly to the ACO’s governing body;
  - Mechanisms for identifying and addressing compliance problems related to the ACO’s operations and performance;
  - Method for employees or contractors of the ACO, ACO participants, and ACO providers/suppliers to report suspected problems related to the ACO;
  - Compliance training; and
  - Requirement to report suspected violations of law to an appropriate law enforcement agency

ACO Program Integrity Reqmts

- Compliance With Program Requirements: Notwithstanding any relationships the ACO may have with other entities related to ACO activities, the ACO maintains ultimate responsibility for compliance with all terms and conditions of its agreement

- Conflict of Interest: ACO governing body must have a conflicts of interest policy that applies to members of the governing body
ACO Program Integrity Reqmts

- Screening of ACO Applicants: CMS soliciting comments on the nature and extent of such screening and the screening results that would justify rejection of an application or increased scrutiny

- Prohibition on Certain Required Referrals and Cost-Shifting: CMS considering prohibition of ACOs and ACO participants from conditioning participation on referrals of federal health care program business that the ACO or ACO participants know or should know is being provided to beneficiaries who are not assigned to the ACO

OIG and CMS Notice

- HHS OIG and CMS describes waivers for ACOs participating in the Medicare Shared Savings Program and seeks comments on waivers and related issues
- These waivers would apply uniformly to all qualified ACOs and participants in the Medicare Shared Savings Program during the term of an ACO’s agreement
- OIG anticipates issuing waivers applicable to participating ACOs concurrently with CMS's publication of final regulations
OIG and CMS Notice

Waiver of application of the Physician Self-Referral Law to distributions of shared savings:

- Among ACO, participants, and providers/suppliers; or
- For activities necessary for and directly related to the ACO's participation in and operations under the Shared Savings Program

OIG and CMS Notice

Waiver of application of the Anti-Kickback Statute with respect to:

- Distributions of shared savings: (1) among ACO participants and providers/suppliers; or (2) for activities necessary for and directly related to an ACO's participation in the Shared Savings Program
- Any financial relationship between or among the ACO, participants, and providers/suppliers necessary for and directly related to the ACO's participation in and operations under the Shared Savings Program that implicates the Physician-Self Referral Law and fully complies with an exception
OIG and CMS Notice

- Waiver of application of prohibition on hospital payments to physicians to induce reductions or limitation of services with respect to:
  - Distributions of shared savings from a hospital to a physician, provided that: (1) The payments are not made knowingly to induce the physician to reduce or limit medically necessary items or services; and (2) the hospital and physician are ACO participants or providers/suppliers
  - Any financial relationship between or among the ACO, participants, and providers/suppliers necessary for and directly related to the ACO’s participation in and operations under the Shared Savings Program that implicates the Physician-Self Referral Law and fully complies with an exception

Contact Information

Michael.Park@Alston.com or 202/239-3300

Kim.Brandt@finance.senate.gov or 202/224-4515