

MEDICAID COMPLIANCE NEWS

Timely News and Practical Strategies for Hospitals, Health Systems and Other Providers

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Providers Need to Be Ready for Onslaught Of Federal and State Medicaid Enforcement

Powerful audit and enforcement forces have emerged in the Medicaid compliance world that all providers need to be aware of and take seriously. According to Frank Sheeder, an attorney with the law firm Jones Day, these new laws have created the “perfect storm” for providers, and it will probably be “messy.”

Sheeder told attendees at the annual Fraud and Compliance Conference, sponsored by the Health Care Compliance Association and the American Health Lawyers Association, in Baltimore Sept. 24 that “Medicaid now needs to be a part of a provider’s risk assessment.” Providers usually focus on Medicare. Now, they need to “flip it,” he said — “Medicaid should be [a] higher” priority.

Sheeder advised doing a specific risk assessment on Medicaid and incorporating it into audit procedures. One problem that providers face, he said, is that hospital coders haven’t been trained in Medicaid. When CMS comes in to conduct an audit, it will see “reactive training” based on found errors, but Sheeder recommended instead doing “proactive training.”

Brian Flood, former Medicaid Inspector General for Texas and now a managing director for consulting firm KPMG, LLP, provided attendees with a “snapshot” of the laws and enforcement they now face under Medicaid (see chart, p. 11). Providers

continued on p. 10

Chargemaster Needs More Compliance Attention Given Payment Rule Variations

In one of health care’s paradoxes, the payer that generally pays the least — Medicaid — sometimes is the most labor-intensive in terms of solving reimbursement riddles. In particular, the chargemaster is a bone of contention under some Medicaid programs. One reason: For some services, providers must use different codes for Medicaid than for Medicare and other payers.

According to Katie LeBlanc, director of revenue services for Catholic Healthcare West (CHW), and Cathy Smeed, CHW’s corporate charge description master (CDM) manager, this means maintaining and updating a parallel set of chargemaster items. “Our biggest struggle is with Medi-Cal,” LeBlanc says, referring to California’s Medicaid program. “Medi-Cal has its own sets of codes” for most goods and services. That makes billing compliance a lot more difficult.

For example, Medi-Cal may soon require hospitals and pharmacies to use National Drug Codes (NDCs) to report the use of medications (see story, p. 5). That would cause big problems because the chargemaster is not set up based on NDCs, LeBlanc explains. NDCs exist for every pharmaceutical, including plain old aspirin and aspirin equivalents sold by vendors. Hospitals would have to itemize their chargemaster for every vendor’s version of various painkillers. “It would either expand our chargemaster exponentially or cause us to make significant changes to the pharmacy systems and associated interfaces to the billing systems, both of which will require significant time and resources,” she says.

continued

The reason California is considering NDCs is because states get rebates from the drug companies if they adopt NDCs and get pharmacy-level data, LeBlanc says. But there is a steep price to pay, she notes.

Generally, it's a struggle to keep up with Medicaid billing and coding changes in some states. "We jump through a lot of hoops for Medi-Cal," LeBlanc says. It uses many of its own unique codes rather than adopting CPT codes universally, like Medicare has done for the most part, she says. Eschewing most CPT codes makes chargemaster compliance even more formidable, LeBlanc says. Hospitals must work overtime to keep their chargemasters updated, LeBlanc says. "If items are changed but [that hasn't been addressed] in your chargemaster, it could hit an edit requiring intervention on the claim, and that creates costs on the back end," she says. The biller has to go back to the relevant department and determine whether the code is no longer applicable for Medicaid, and that incurs costs for the hospital on the back end.

Keeping up with codes — which is essential to chargemaster compliance — is tricky with Medi-Cal. While CMS updates its CPT code usage every quarter, Medi-Cal only sometimes adopts Medicare's coding

schemes and sometimes uses its own, Smeed says. Sometimes the updates are monthly, sometimes they're not. "And you may get a bulletin — or not." When Medi-Cal does adopt CMS coding, there is always a lag time resulting in the chargemaster having to maintain two sets of codes until Medi-Cal adopts the CMS code.

As a result, health systems create two sets of charges in order to accommodate the Medi-Cal coding requirements and maintain compliance.

For example, for surgery, Medicare pays a per-procedure fee, regardless of how much time it takes, with CPT codes used to report the procedures. Other payers usually base payments on CPT codes. But Medi-Cal goes its own way, Smeed says. Medi-Cal pays hospitals based on the time patients spend in the operating room (OR) having the surgery. Medi-Cal's system of Z codes applies to surgery: Z7506 is for the use of the first hour of the OR, Z7508 is for use of the OR for the first subsequent half hour, and Z7510 is for the sequential subsequent half hour.

As a result, billers usually have to enter Medi-Cal charges manually for surgery, whereas surgery charges covered by other payers can be hard-wired into the chargemaster. "You have to do it manually just for Medi-Cal," Smeed says.

Rehab is another example of Medi-Cal chargemaster challenges. Some rehab procedures are time-based in California Medicaid. While Medicare wants these procedures reported in 15-minute blocks using CPT codes, Medi-Cal has created its own set of X codes that providers must use to bill for the initial 30 minutes of a rehab procedure. X codes are also required when reporting an additional 15 minutes, Smeed says.

As a result, therapists must immediately find out which insurer covers the patient, a question they wouldn't otherwise have to ask, so they know how to track time and check off the charge sheet properly. That's unfortunate, because it shifts some of the therapist's focus from patient care to payer issues, Smeed notes.

"If everyone honored Medicare codes, you would have one charge sheet and fill out the assessment and do it the same way every time the patient comes in. Then you could focus on patient care and not on charges," she says.

Since that's not how things work, CHW had to create a second chargemaster item for X codes for therapy provided to Medi-Cal patients.

Modifiers Are Medicaid Hassle

Smeed says Medicare and Medi-Cal don't always recognize the same modifiers. For example, with imaging, Medicare considers it double billing if providers charge double for bilateral tests. Instead, Medicare directs providers to attach modifier 50 when billing bilateral images, Smeed says. That tells Medicare to pay more than it would pay for a single image but less than double.

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However, Medi-Cal doesn't recognize modifier 50 (bilateral modifier). It instructs providers to bill images twice when two limbs are imaged, for instance. That means providers have to establish two sets of charges, which, again, is a deviation from other payers and therefore a hassle (and Medicaid still pays much less in the aggregate).

For example, when Medicare patients need an arthrogram on both knees, providers would bill Medicare CPT 72580 — the same CPT code whether one knee or two knees receive the procedure, and then add modifier 50 when two knees are tested. Medicare increases payment somewhat when modifier 50 is appended to reflect the fact that a second knee was subject to the arthrogram, but the payment is not doubled. "However, Medi-Cal says if you do one image twice, you have to charge a quantity of two," she says. "You are setting yourself up to not bill all payers the same. It causes problems in our trying to be compliant," Smeed explains.

CHW, which has 42 hospitals, has created a database that houses its corporate chargemaster standard (the way CHW has databases for all corporate stan-

dards). This standard is the baseline that all facilities chargemasters are derived from. On a monthly basis, CHW checks to ensure each hospital's chargemaster is up-to-date — codes have been deleted, added, etc.

Every month, the corporate CDM department gets the facility's chargemaster and runs it against the corporate standard. "We built a database that take extracts of patient accounting systems [from each hospital] and run it through a program to look for any variance," LeBlanc says. "We are taking their complete chargemaster and bumping it up against our corporate standard."

The report that is generated will identify incorrect codes (e.g., CPT, revenue code assignment) and highlight discrepancies in descriptions of chargemaster items.

"It significantly reduces the effort it takes to keep the chargemaster compliant at each facility," LeBlanc says. "If you never clean up your chargemaster, the 10,000 lines [of items] will reach 20,000. You need to continually do maintenance."

Contact LeBlanc at Katie.LeBlanc@chw.edu and Smeed at Cathy.Smeed@chw.edu. ♦

STATE MEDICAID COMPLIANCE NEWS

◆ **Effective in September, the North Carolina Division of Medical Assistance (DMA) has begun notifying providers if they have received at least \$5 million in Medicaid payments during the last fiscal year.** A provider that receives such notice must submit a letter of attestation showing it is in compliance with the federal Deficit Reduction Act within 30 days of receipt of the notification. Beginning Nov. 1, provider enrollment application packets sent to the DMA must include a signed letter of attestation. The letter of attestation, along with a list of Medicaid providers identified as having received the minimum amount of payments can be found at www.ncdhhs.gov/dma/fca/falseclaimsact.html.

◆ **The Texas Attorney General's office has settled a Medicaid fraud case for \$1.86 million with Seattle-based Emeritus Corp., a large national assisted-living facility operator that serves Texas.** Under the settlement, which resolves claims that the company falsely and inaccurately billed Medicaid for services never rendered, Emeritus must pay 150% of the funds it improperly received from the state. According to the attorney general's office, Emeritus deprived its residents of legally required amenities and services. "State contractors have a legal obligation to accurately bill for services actually rendered," said Attorney General Greg Abbott

(R). The attorney general's Medicaid Fraud Control Unit and Civil Medicaid Fraud Section, along with the Texas Department of Aging and Disability Services, uncovered improper billing practices at 11 of Emeritus' 19 facilities in Texas. More information may be obtained from the attorney general's Web site at www.oag.state.tx.us.

◆ **New York state overpaid approximately \$10 million to Medicaid providers between 2001 and 2006 for home care and transportation for patients who never got the services, according to an audit conducted by the state comptroller's office.** According to Comptroller Tom DiNapoli (D), in at least eight cases, payments were made to care for people who were dead. The biggest culprit identified by the audit was Concepts of Independence, a nonprofit home-care referral service operator, which allegedly billed Medicaid more than \$448,000 over a five-year period for home-care aides' wages during times when patients were admitted to hospitals and didn't need home care. According to the comptroller's office, the case has been referred to the state Medicaid Inspector General for further action. Concepts of Independence did not furnish a comment for MCN by press time. For more information, go to www.osc.state.ny.us/press/releases/aug07/082807.htm.

Sample DRA Compliance Policy

The following is a new compliance policy created by the University of Louisville Health Sciences Center, Office of Compliance. Pursuant to the requirements in the Deficit Reduction Act, it describes the federal False Claims Act and policies and procedures for detecting and preventing fraud, waste and abuse. The policy is posted on the university's Web site, and employees are required at initial orientation training to visit the Web site and view the compliance plan and policies and procedures. Each of the university's 56 entities is responsible for informing their vendors of the policy and where it is located. For more information, contact Debra Troklus at debbietroklus@louisville.edu.

University of Louisville Health Sciences Center Office of Compliance

POLICY DESCRIPTION: Prevention of Fraud, Waste and Abuse	POLICY #: EXT006
AFFECTED DEPARTMENTS: HSC employees; associated vendors/contractors	APPROVED:
EFFECTIVE DATE: 9/1/07	REVISED DATE:

BACKGROUND: The Deficit Reduction Act (DRA) of 2005 requires entities who receive \$5,000,000 in Medicaid revenue to establish written policies for all employees, and for any contractor or agent of the entity, that include detailed information about the False Claims Act (FCA). Detailed information is required about the policies and procedures for detecting and preventing waste, fraud and abuse.

PURPOSE: To detect, correct and avoid circumstances under which fraud, waste, and abuse could occur in the Health Sciences Center and the clinical practice entities.

POLICY: Departments/Entities will comply with the statutes, regulations, directive and standards related to health care reimbursement and the prevention of fraud, waste and abuse.

PROCEDURE:

- HSC departments/entities shall comply with all applicable State and Federal health care programs requirements and will report any fraudulent or abusive activities thru the appropriate reporting channels. The HSC Compliance program will engage in specific monitoring efforts to detect and prevent fraud, waste and abuse.
- The HSC Compliance program will provide education to HSC employees related to the prevention and reporting of fraud, waste and abuse
- The HSC Compliance program will provide internal and external mechanisms for reporting fraud, waste and abuse.

GENERAL INFORMATION:

- **The False Claims Act (FCA)** – The federal False Claims Act (FCA) imposes civil penalties on individu-

als and companies who knowingly submit a false claim or statement to a federally funded program, or otherwise conspire to defraud the government, in order to receive payment. The term “knowingly” is defined as a person, with respect to information, that has actual knowledge that a claim is false, knowingly ignores facts which may reveal false information or disregards the need to check the truth or accuracy of the information. The FCA extends to any payment requested of the federal government. More specifically, the FCA applies to billing and claims sent from HSC to any government payor including, but not limited to, Medicare, Passport (state health plan) and Medicaid. Under the FCA any individual or company that submits a false claim or statement to the government may be fined between \$5,500 and \$11,000 for each such claim submitted, regardless of the size of the false claim. The person or company may also be required to pay an additional fine of three times the value of any charges. The FCA also includes provisions intended to protect individuals who report suspected fraud. The FCA also protects individuals from being retaliated against, demoted, suspended, threatened, or harassed for making a report. The FCA also protects individuals who assist in an investigation, provide testimony, or participate in the government’s handling of a false claim.

- **Qui Tam Lawsuit (Whistleblower)** – The FCA provisions are generally enforced by the United States Department of Justice. Any person with direct and independent knowledge, otherwise known as “original source” knowledge, of false claims to the government may initiate a formal complaint or “qui tam” lawsuit on behalf of the government. The plaintiff must notify the United States Department of Justice

Sample DRA Compliance Policy (continued)

of all information regarding the fraudulent activity. If the Department of Justice accepts the case and fraud is proven, the qui tam plaintiff is entitled to a portion of the funds recovered by the government. Under the FCA a "qui tam" plaintiff is protected from retaliation that may result from his or her involvement in the case. If the Department of Justice declines the case, the individual may still proceed with the case on his or her own, unless the allegation involves a state agency, but without the government's assistance, and at his or her own expense. A private legal action under the FCA must be brought within six years from the date that the false claim was submitted to the government (A government-initiated claim may be brought up to ten years after the false claim, depending on the circumstances).

- **The Federal Program Fraud Civil Remedies Act** – Persons or companies that commit fraud against the federal government, by false claim or statement, can be assessed money penalties in addition to the penalties of the FCA according to a law called the **Program Fraud Civil Remedies Act (PFCRA)**. Specifically, PFCRA penalties of \$5,000 per false claim or statement apply if a person or company submits a claim to the Federal government that: the person or company knows or has reason to know is false, fictitious, or fraudulent; includes or is supported by written statements that omit a material fact, which causes the

statements to be false, fictitious, or fraudulent, and the person submitting the statement has a duty to include the omitted fact; or is for payment of property or services that are not provided as claimed. The \$5,000 penalty also applies if a person or company provides written back-up or materials relating to the claim in which the person or company asserts a material fact that is false, fictitious or fraudulent; or omits a fact that the individual had a duty to include, the omission causes the statement to be false, fictitious, or fraudulent, and the statement contains a certification of accuracy.

- **Kentucky State Law** – It is a crime in Kentucky to bill Medicaid or the general assistance program fraudulently. Anyone who provides services to a state Medicaid beneficiary and seeks or accepts payment for unnecessary or improper services is subject to possible imprisonment and/or criminal fines under state law.

RESPONSIBILITIES: HSC employees; associated vendors/contractors

REFERENCES: HSC Compliance Plan; HSC Code of Conduct; Non-Retaliation/Non-Retribution (CPP-006-Att B); Hotline Policy (INT018REP); Hotline Brochure; Section 6032 of the Deficit Reduction Act of 2005; U.S.C. subsec 3729-3733; 31 U.S.C. subsec 3801-3812

Tracking, Reporting NDC Would Be Huge Financial Burden on Hospitals

Hospitals and other health-service providers have "a lot of concerns" about CMS' s requirement that they begin reporting the National Drug Code (NDC) on Medicaid claims for certain drugs by Jan. 1, 2008. According to David Chen, a spokesperson for the American Society of Health-System Pharmacists (ASHP), the burden on hospitals is much greater than CMS has estimated, and it is "clearly an undue financial hardship."

Under the Deficit Reduction Act (DRA), providers must begin reporting by Jan. 1, 2008, the NDC for certain drugs and biologicals provided to patients for claims paid by Medicaid. An NDC is a unique identifier assigned to each drug or biologic product approved by the Food and Drug Administration (FDA). The NDC is found on the package and/or vial of medication in an 11-digit format.

The DRA amended the Medicaid Rebate Act to require that states collect rebates on certain physician-administered drugs as a condition of federal financial participation in the Medicaid program. To receive federal participation funds, states must require providers to submit claims for physician-administered single-source drugs as of Jan. 1, 2007. And for 20 multiple-source physician-administered drugs that have the highest dollar value under Medicaid, states must require providers to submit claims using NDC numbers as of Jan. 1, 2008.

Some states have already implemented these requirements. For example, in Florida providers must report the NDC on all claims with J, Q or S drug codes received on and after Jan. 7, 2007, regardless of the date of service. Any claims with missing NDCs will be denied after April 1, 2007, and claims for dually eligible Medicaid-Medicare recipients are denied beginning June 1, 2007.

In North Carolina, effective with dates of service on or after Dec. 28, 2007, drugs administered by physicians

in offices, clinics, or outpatient dialysis facilities must include the NDC on submitted claims. The state has told its affected providers that they must implement a process to record and maintain the NDCs of the drugs administered to the recipient as well as the quantity of the drugs given. These providers also must modify their billing software programs to include the required NDC-related fields.

Tracking System Would Require Big Investment

The requirement to provide NDCs for certain drugs doesn't take into account the way hospitals are built or how they dispense medications to patients, Chen tells *MCN*. A hospital's focus should be on "safety and accuracy," he says. "Knowing what product is on the shelf is not the priority." Chen argues that "hospitals should not have to do this and can't do it halfway."

In a survey of 3,200 ASHP members in February 2007, 700 hospitals responded from every state except Alaska, indicating that 60% of facilities did not have information systems that can store and cross-reference alternate NDC numbers for the same generic entity, Chen says. Survey respondents were from facilities with an average daily census ranging from less than 50 to greater than 500, and outpatient visits ranged from 12,000 to 180,000 a year.

Chen describes the NDC system tracking requirements as "unrealistic" in the hospital setting. On hospital shelves, there are multiple vials of multiple-strength pharmaceuticals from multiple companies manufacturing the same generic drug, he explains. Hospitals cannot track or bill an alternate NDC number in the event that a therapeutically equivalent generic entity is administered because they have integrated inpatient and outpatient pharmacy billing systems, and both rely on the same drug product inventories that may include multiple generic suppliers (each with a separate NDC number) of the same medication, according to Chen.

Setting up a system to address these various drugs, he adds, would be a "huge investment" and require a large amount of "manpower." This manpower, says Chen, would need to be reallocated from other areas in the hospital to focus on "billing accuracy," diverting staff from accurate dispensing and administration.

ASHP also says that there would be a significant cost per claim. CMS estimated in its rule that it would cost 9 cents per claim. This is "not accurate," Chen says, because it does not take into account the costs associated with making various changes that would be required throughout the institution with respect to the entire medication-use process.

According to Chen, there is a range of steps required before filing a claim, including recording and tracking

the NDC number from order entry to preparation and administration, as well as finance and patient billing. According to the respondents in ASHP's survey, the cost per claim is \$10.80, and each claim takes an average of 24 minutes.

Chen says that these institutions need bar coding at the point of administration to be able to implement the NDC requirement feasibly. However, only 6% of the survey respondents indicated they used bar coding for outpatient medication doses. Thus, existing systems will not be able to use this solution in the near future. For bar coding to serve as a solution to providing the unique NDC number, it must be fully implemented throughout all the institution's information systems, including point of administration, ASHP argues.

Chen explains that the NDC reporting requirement is tied to Medicaid reimbursement. Thus, there is the risk of an audit finding fraudulent billing if providers do not adhere to the requirement.

Contact Chen at (301) 664-8671. ✧

With Potential Hike in FCA Lawsuits, Providers Must Enhance Compliance

There are now 20 states with False Claims Acts (FCAs), and more are on the way, according to industry insiders. All of this is incentive for providers to beef up and "evolve" their Medicaid compliance programs, Keith Korenchuk, an attorney with the law firm Covington & Burling, told listeners during an Aug. 15 audioconference, "State False Claims Acts," sponsored by FDANews.

Under Section 6031 of the Deficit Reduction Act, states that enact FCAs modeled after the federal FCA will receive an increased percentage — 10% — of any recovery from a state Medicaid judgment or settlement arising out of the FCA or state law. Jim Sheehan, New York state's Medicaid Inspector General, calls this "significant." Until recently, the jurisdiction of Medicaid fraud control units (MFCUs) was limited to criminal cases, he tells *MCN*. But recently — starting shortly before DRA's enactment — MFCUs in a number of states have expanded into civil cases. That means "MFCUs will get involved in these state FCA cases," Sheehan says.

In order to take advantage of this potential increase in revenue, it is likely that states will look closely at existing laws to ensure compliance with the DRA's requirements. As a result, providers will likely be defending *qui tam* actions under both state and federal laws and facing increased penalties. Affected entities that now have compliance policies and procedures should review those policies and procedures to determine whether they contain the level of specificity required by the DRA, and

particularly by the HHS Office of Inspector General (OIG).

Under the DRA, a state's FCA must: (1) establish liability that benefits the state Medicaid program based on false or fraudulent Medicaid claims, as described in the federal FCA; (2) contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions (i.e., whistle-blower suits) as those in the federal FCA; (3) provide for filing an action under seal for 60 days with review by the state attorney general; and (4) impose a civil penalty in an amount equal to or greater than the amount authorized by the federal FCA.

States were required to have their FCAs enacted by Jan. 1, 2007, to be eligible to receive the increased recovery amount. However, according to Richard Liner, an attorney with the law firm Arent Fox, states may enact a law before, on or after Jan. 1, 2007. As long as a state's law meets the enumerated requirements on or after Jan. 1, and the recovery from the action brought under the qualifying law is received by the state on or after Jan. 1, the state will qualify for a 10% increase in its share of the amount recovered, he says.

The OIG set forth guidance to inform states of the factors it would review in determining whether a state FCA was compliant with the DRA. The OIG said that the guidelines are not "model statutory provisions" and do not "require any specific language to be included in State False Claims Acts." Instead, the guidelines should be used to understand what the OIG considers relevant for determining if a state law meets the DRA requirements.

Providers Should Follow OIG Guidelines

Rebecca Rohr, an attorney with Covington & Burling, said the OIG guidelines elaborate on the DRA provisions. But she also pointed out that parts of the guidelines are actually "requirements, not just guidelines."

Liner says that Medicaid providers required under the DRA to implement a false claims compliance policy and educational program "would be wise to consider carefully the OIG's guidelines when developing their policies." He tells *MCN* that the OIG guidance "explains in more detail the four requirements listed in the DRA."

For instance, the DRA says that a state FCA must establish liability based on false or fraudulent Medicaid claims, as described in the federal FCA with respect to Medicaid expenditures, whereas the OIG's guidance more specifically describes the liability provisions the state law must include:

◆ ***Knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval to the Medicaid program.***

◆ ***Knowingly making, using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Medicaid program.***

◆ ***Conspiring to defraud the Medicaid program by getting a false or fraudulent claim allowed or paid.***

◆ ***Knowingly making, using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Medicaid program.***

Moreover, says Liner, the DRA requires state FCAs to include provisions that are at least as effective in rewarding and facilitating *qui tam* actions as in the federal FCA, whereas the OIG's guidance specifies the actual threshold provisions that must appear in the state law. Under the OIG guidelines, state FCAs must have civil penalties of at least \$5,000 and no more than \$10,000 per violation; a percentage of the whistle-blower's share as generous as that under the federal FCA; bases of liability as strict as the federal FCA; intervention by the attorney general at a later date for good cause; and allowing the whistle-blower to continue with the action even if there is government intervention.

States Should Mirror Federal FCA

Rohr suggested that state statutes should mirror the federal FCA to be safe. Although many states already had state FCAs in place before the DRA went into effect, 13 states that either did not have laws or had laws that did not follow the federal FCA have submitted laws to the HHS Office of Inspector General (OIG) for approval.

Frank Sheeder, an attorney with the law firm Jones Day, told attendees at the annual Fraud and Compliance Conference, sponsored by the Health Care Compliance Association and the American Health Lawyers Association, in Baltimore Sept. 24 that some states took a shot on whether their FCAs matched up with the federal FCA and submitted them to OIG as they were. For example, he said that Texas' FCA was originally denied by OIG when first submitted. It is not surprising that state FCAs don't match up. "They are not designed that way," Sheeder said.

He described the DRA provisions as a "perfect storm" for defenders of providers. These providers will be subject to multiple whistle-blower suits in multiple jurisdictions or subject to just state suits, he said.

Sheehan, who spoke at the AHILA/HCCA conference in Baltimore Sept. 24, advised providers to have effective compliance programs and to warn employees when they violate compliance policies. "Failure to act" or telling employees to do nothing about disregarded compliance requirements can lead to whistle-blower suits brought under FCAs. Good prosecutors will tell

whistle-blowers to go through the organization with complaints, explained Sheehan. But if the whistle-blower is ignored, the next call will be to the government.

Korenchuk recommended providers approach state FCAs as they would state reporting requirements — look at the business process.

Contact Korenchuk and Rohr at (202) 662-6000, Liner at (202) 857-8972, Sheeder at (214) 969-2900, and Sheehan at JGS05@omig.state.ny.us. ♦

CMIP Gives Integrity Program Agenda, Goals for Next Five Years

CMS mapped out the course of the Medicaid Integrity Program (MIP) for the next five years with the August release of its Comprehensive Medicaid Integrity Plan (CMIP), which some in the industry say is evidence that CMS is moving into real-time Medicaid enforcement operations. Though the plan covers the remainder of 2007 through 2011, CMS says the CMIP will be revised and published annually since “Medicaid fraud, waste and abuse [is] continuously evolving.”

Responsibility for implementing the plan falls to the Medicaid Integrity Group, including the tasks of filling remaining staff positions, managing contractors, procuring the Medicaid Integrity Contractors (MIC) to perform audits, and conducting reviews of and providing assistance to state Medicaid programs, the CMIP says.

According to the CMIP, tasks slated for fiscal year (FY) 2007 include developing protocols for reviewing providers and auditing claims; testing information collection from state Medicaid integrity programs; and working with the HHS Office of Inspector General to develop a procedure for referring potential cases to OIG.

“The MIP has spent FY 2006 and will continue to spend most of FY 2007 implementing the program,” the CMIP says. “We anticipate that by the time the third CMIP is published next year we will have awarded our initial Medicaid Integrity contracts and held a number of meetings and conferences with our stakeholders and partners that facilitate the improvement, coordination and effectiveness of Medicaid integrity activities nationally.”

The MIP was appropriated \$5 million for FY 2006, its first year of operations. During that year, MIG hired 12 staff members. At the time the plan was published, that number was at 28, including all of the management positions. The total will be 79, which MIG expects to fill by the end of the year, it says.

Congress appropriated \$50 million for FY 2007 and 2008, and \$75 million in FY 2009 and each year after, the CMIP explains. There was \$2.2 million carried over from

2006, it adds. As of August 2007, the MIP audit program has already spent \$4 million on audit activities, according to the report.

Among its goals for 2007, MIG will continue to collaborate with the state program integrity officials and Medicaid Fraud Control Units representing 16 states (known as the MIP Advisory Committee), the plan says. It met with these officials in December 2006 to “brief members on its [State Program Integrity Assessment] and [Audit Program Development] activities to date and obtain their input on future planning efforts,” the report says. The committee met again in March 2007.

CMS to Support and Assist States

According to key messages from one of those meetings that were included in the CMIP, “opportunities for CMS to provide support and assistance to states include:

- ◆ *Creating a ‘level playing field.’* No one state program is the same.
- ◆ *Assisting states in getting additional state funding.* Every state lacks resources (e.g., staffing, technology, training) to provide support via staff training.
- ◆ *New opportunities and tools exist to look at program integrity (e.g., getting beyond the ‘SURS’ (State Utilization Review and Subsystem) approach, assisting states with placing a greater emphasis on planning).’*

The CMIP says that state program integrity reviews were conducted in the spring in Arkansas, Connecticut, Michigan and Nevada. More were scheduled for Delaware, Virginia, Oregon and Missouri in the summer, the report says.

MIG has developed statements of work and requests for proposals (RFPs) to award MIC contracts. “Based on the extensive time commitment required to openly and competitively procure the activities, develop audit protocols, and include stakeholder input into the process, we now plan to: (1) conduct test audits in FY 2007 and (2) begin to review proposals in response to the MIC RFPs published in July 2007,” the plan says.

Julie Chicoine, compliance director at The Ohio State University Medical Center, says the CMIP shows that CMS is “moving from development to real-time operations.” She says she was struck by CMS’s inclusion in the report of a quote by author Malcolm Sparrow. “The fraud control game is dynamic, not static...a set of fraud controls that is perfectly satisfactory today may be of no use at all tomorrow, once the game has progressed a little,” the quote says.

“I think that this is a pretty strong statement, as most cases arise from mistakes involving complicated and convoluted rules governing reimbursement. Very few

people wake up with the express intent to commit fraud," Chicoine contends.

"However, one has to understand the environment that drives this perception....The Medicaid program is a linchpin of sorts in our health care system, covering millions of individuals. Medicaid is complicated in that unlike Medicare, a nationally funded and administered program, Medicaid essentially operates as 50 separate programs, tailored to each state's unique health care needs. Because of this complexity, the state Medicaid programs have not been subject to the same

level of scrutiny that the Medicare program faces. That's where the DRA [i.e., Deficit Reduction Act] came in," she says.

CMS is "bringing substantial resources to bear" with its plan to hire 79 full-time staff members, she says. "This is going to enable them to go into their core functions and investigations," she says.

For more information, contact Chicoine at chicoine@osumc.edu. Read the report at www.cms.hhs.gov/DeficitReductionAct/Downloads/CMIPupdateaugust2007final.pdf. ♦

Provider Groups Urge Delay in New Rx Pad Rule

The National Association of State Medicaid Directors (NASMD) and the American Public Human Services Association (APHSA) have asked Congress to delay implementation of the requirement that Medicaid providers use tamper-resistant prescription pads as of Oct. 1 for all written, non-electronic prescriptions. And the Senate seems to agree, as it passed a bill (S. 2013) Sept. 26 that would delay the implementation of the requirement by six months. A similar bill is making its way through the House of Representatives.

A little publicized section of the U.S. Troop Readiness, Veterans' Health Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007, requires providers, including long-term care facilities, hospitals, and other health care institutions, to use tamper-resistant prescription drug pads for non-electronic prescriptions written for Medicaid enrollees beginning Oct. 1. As of that date, CMS will deny federal participation in the Medicaid program to all providers who write covered outpatient prescriptions on traditional prescription pads.

CMS released guidance to state Medicaid directors on Aug. 17, detailing what it considered to be "tamper resistant" as of Oct. 1. To be considered tamper resistant on Oct. 1, a prescription pad must contain at least one of the following three characteristics:

- ◆ one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
- ◆ one or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; and
- ◆ one or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

After Oct. 1, 2008, in order to be considered tamper resistant, a prescription pad must contain all of the previous three characteristics, the guidance said. According to the agency, states that fail to enforce this requirement may lose federal financial participation in their Medicaid programs.

Despite this guidance, NASMD, APHSA and 108 other health care and human service groups argue that "uniform compliance with the Oct. 1 implementation date...is impossible due to the tight time frame" — six weeks from when the CMS guidance was issued — not giving states enough time to notify providers and pharmacies.

Moreover, the groups argue that even with CMS's guidance, there is still "considerable unease among the groups [as to] what qualifies as tamper-resistant." States also contend that "supplies are inadequate to meet the requirements of the new law."

In a "Dear Colleague" letter being circulated in the House of Representatives on behalf of the American Society of Health-System Pharmacists, among concerns expressed is how this requirement applies to discharge prescriptions when a Medicaid patient leaves an inpatient setting with prescriptions to be filled at an outside pharmacy.

There is also confusion in the industry as to what constitutes an "electronic" prescription, which would be exempt from the new requirements.

CMS spokesperson Mary Kahn tells MCN that the agency has no plans at this time to provide more guidance on the issue, and will follow whatever Congress advises.

Contact Kahn through CMS's Office of External Affairs at (202) 690-6145. For more information on the issue, go to www.aphsa.org. ♦

Medicaid Enforcement to Increase

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continue to face scrutiny from the HHS Office of Inspector General (OIG) through investigations and audits, and now face CMS audits through its new Medicaid Integrity Group (MIG) and Medicaid Integrity Program (MIP) auditors and via Payment Error Rate Measurement (PERM) auditors.

It's a Brave New World

The MIP, created by the Deficit Reduction Act (DRA), allows CMS to review "the actions of individuals or entities furnishing items or services" in return for Medicaid payment to determine whether fraud occurred; audit claims for items or services rendered or administrative services, including cost reports, consulting contracts and risk contracts; identify overpayments; and educate providers, managed care organizations and beneficiaries on payment integrity and quality.

Flood explained that MIP auditors will randomly select providers for sample audits. CMS is now the finder of fact. It can recommend to the Justice Department what action to take against providers and tell states to recoup any overpayments. None of these things has happened before, he said.

Add to that state regulation and enforcement, and providers have a lot to face, "at least for the next political cycle," Flood said. And he emphasized that providers must care about both aspects, federal and state.

Although the two sides of the chart (federal and state) "don't coordinate or talk with each other," he said, the programs do "run concurrently." Therefore, Flood warned that it is a "bad reaction" to say "I don't care about the state's error rate." Providers will be or have been contacted by PERM vendors to submit claims, and he stressed that if a provider doesn't respond, it is an "automatic error rate."

CMS implemented the PERM program to meet the requirements of the Improper Payments Information Act of 2002. Under that law, federal agencies must annually review and estimate the amount of improper payments identified for Medicaid and the State Children's Health Insurance Program.

The mail room has become a "high risk area," Flood said. He explained that when a provider receives a letter for PERM sampling, it won't know if it owes money for almost two years. At that point, if the provider does owe money, it will need to pay in 30 days. This is "fairly onerous," he said, and tracking what comes into the mail room, who gave it to you, and why becomes "pertinent."

Sheeder agreed, saying it is very important to know "who is opening your mail." Keep close tabs on requests

and "what is being asked," he added. If a provider is losing money and driving up a state's error rate, the state has nowhere to go except to "beat up on the provider."

There is no provision for providers to appeal or negotiate in error-rate analysis, Sheeder said. States must collect the money owed. Flood added that "if you are a nail sticking out of the floor, you will get pounded." This means that if a provider is causing the error rate in a state to spike, the state will come after that provider, he said. Thus, PERM is important to you, Flood explained.

Sheeder noted that states can appeal. But will they appeal or will they just recoup the money from the provider? he asked. And can the provider compel the state to appeal? These are all "open questions" leading to the confusion, Sheeder said.

And if a state appeals, it will take approximately 36 months to resolve that, Flood said, just in time for PERM audits to start again. He called it a "permanent audit cycle."

Providers also need to be concerned about Recovery Audit Contractors (RACs). According to Flood, when CMS was asked if RACs will apply to Medicaid, the agency said it was not taking any options off the table. To Flood, "that means yes."

Compliance Is Not an Option

So what can providers expect from their states? Both Flood and Sheeder contend that mandatory compliance programs are the wave of the future. Texas has already instituted them, and New York is modeling its program after Texas. The state has passed a law making mandatory compliance programs a condition of Medicaid participation. They "will take shape in other states," Sheeder said.

Now is the time for providers to see if they have compliance programs and if they "pass muster," he said. Flood warned that it "doesn't matter if you have the seven elements" of a compliance program. The "program must be effective." If a provider cannot show an effective compliance program, it loses, he added. Before, states hoped providers had compliance programs; now it's "presumed you have one."

Unfortunately, Sheeder said, he still doesn't "think some providers realize" that the education provisions in the DRA are a "prerequisite for reimbursement."

He advised providers to look at two documents — CMS's December 2006 letter to state Medicaid directors, explaining what states should require providers to do, and CMS's March 2007 guidance in Frequently Asked Questions format, explaining how providers should educate employees and outside contractors or vendors about false claims recovery.

Under Section 6032 of the DRA, any entity receiving or making at least \$5 million in Medicaid payments each year must create written compliance policies and educate staff and agents about false claims and whistleblower protection. The policies must include detailed information regarding the entity's policies and procedures for preventing and detecting fraud and waste in Medicaid programs, and must be communicated to all staff and agents.

"To say [CMS's] guidance is not crystal clear would be an understatement," Sheeder said, particularly with regard to educating vendors. In response to a question about whether providers must include the DRA provisions in their vendor contracts, he warned attendees to

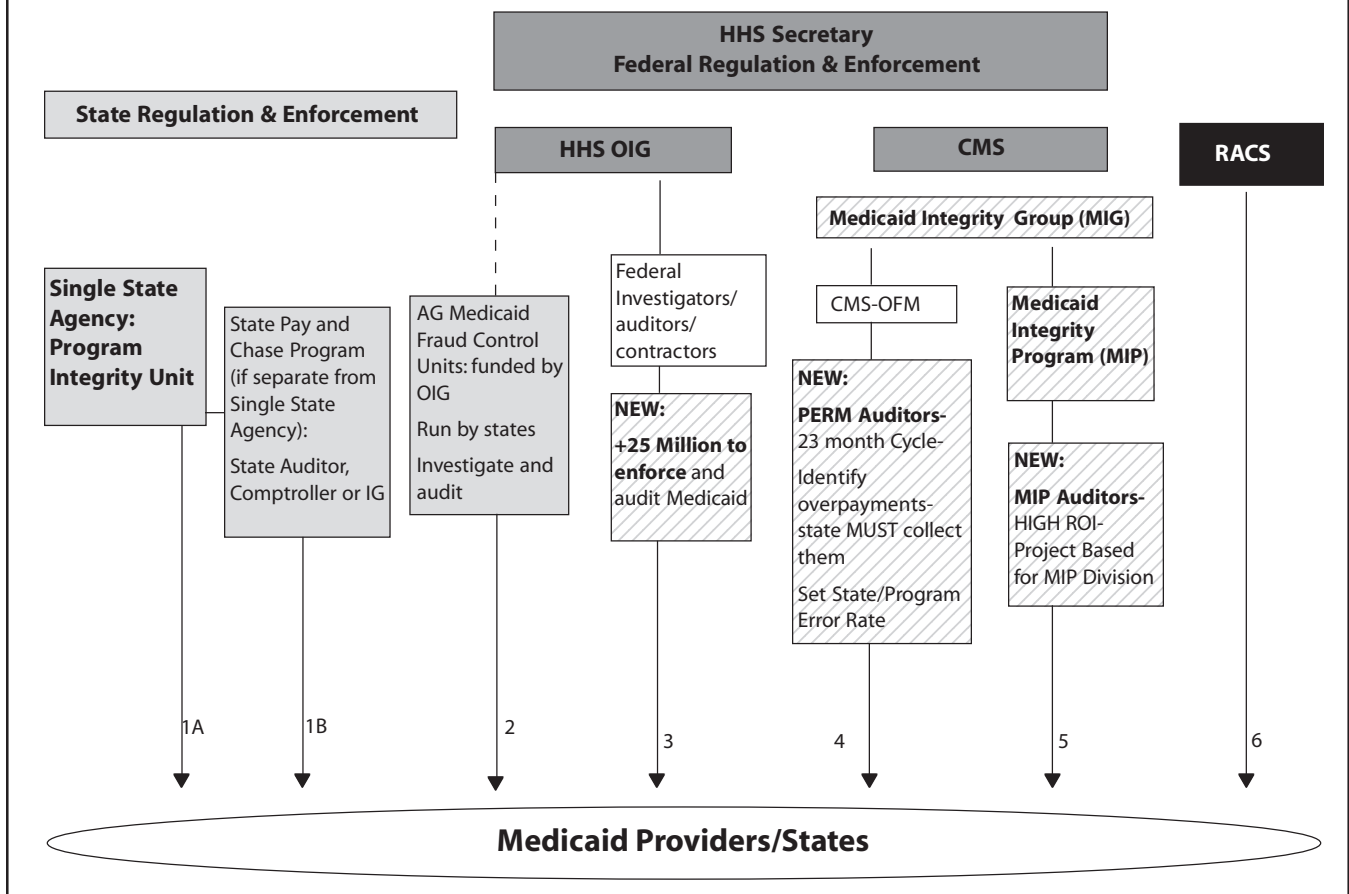
remember HIPAA. He suggested a few options providers have: (1) make adherence to the provisions a condition of doing business; (2) include the provisions in a company newsletter; (3) put the provisions on the company Web site; (4) provide vendor education; or (5) distribute vendor orientation packets that include the provisions.

One problem he identified is that CMS has said vendors must adopt the policies of providers. How? he asked. This requirement is in direct contrast to the fact that there is nothing in the law saying that a vendor must send something back to the provider indicating that the vendor received its policies. There is "no attestation required," said Sheeder.

continued

New World of Federal and State Medicaid Enforcement

This chart describes the powerful audit and enforcement forces emerging in the Medicaid world. Medicaid audits are on the rise because of several major events. They include the 2005 Deficit Reduction Act, which created and funded the CMS Medicaid Integrity Program and the separately funded OIG Medicaid oversight efforts, and the initiative to enforce the 2002 Improper Payments Information Act, which has unleashed auditors to perform Medicaid Payment Error Rate Measurement (and in turn will lead to recoupment). The chart was developed by former Texas Medicaid Inspector General Brian Flood, now a managing director at KPMG LLC. Contact him at bgflood@kpmg.com.



He advised providers to make the best effort they can. Have a written plan document for each vendor, even if you don't send it to a particular vendor, Sheeder recommended.

Flood's advice was to keep a low profile. It is "bad news" for a provider to be in the news, and the "system will navigate to the highest target," he said.

The DRA motivates states directly to recover overpayments, and while they may "start with low hanging fruit," as time goes on they will "need to dig deeper," said Sheeder.

Contact Flood at (512) 320-5214 and Sheeder at (214) 969-2900. ✧

NEWS BRIEFS

◆ **The U.S. Court of Appeals for the 8th Circuit upheld the HHS Office of Inspector General's (OIG) use of civil monetary penalties (CMPs) and exclusion authority against a corporate owner and executive for allegedly causing a home health agency (HHA) to submit fraudulent Medicaid and Medicare claims.** OIG imposed CMPs on Hawkeye Health Services, Inc., an Iowa HHA; its founder and former owner, president and CEO, Thomas Horras; and Christine Richards, its former director of finance. OIG found that "Horras 'submitted or caused to be submitted annual Medicare and Medicaid cost reports covering the periods of 1995 through 1997 that contained 192 items or services that were not related to patient care and/or were not reasonable and proper costs of operation.'" In 2002, OIG imposed a \$38,000 CMP against Horras, plus a \$784,072 assessment. Also, OIG found that Richards caused 124 fraudulent claims to be submitted, and imposed a \$20,000 CMP and a \$100,000 assessment against her, the decision says. In 2003, Hawkeye tried to settle with OIG. Two years later, an administrative law judge (ALJ) said OIG's original CMPs should stand, but took the settlement into account and reduced Horras' assessment to \$673,212. The ALJ reduced Richards' CMP to \$2,500, the assessment to \$2,146 and her exclusion to one year. Dean Stowers, an attorney representing Horras, says they disagree with the court's decision and are evaluating whether to ask it for further review. An attorney representing Richards says they will not be appealing the case further. Read the decision at www.ca8.uscourts.gov; click "All Opinions," click "Search Descriptions," and search the party names for "Horras."

◆ **The U.S. Department of Justice says that Southfield, Mich.-based Ciena Healthcare Management Inc., a company with 30 nursing homes in the Detroit area, will settle for \$1.2 million a civil lawsuit alleging it improperly billed Medicaid**

and Medicare for inadequate care. Under the terms of the settlement, Ciena will pay approximately \$708,000 to the federal government and approximately \$542,000 to the state of Michigan. The company has also entered into a five-year agreement with HHS to assure compliance with Medicaid and Medicare requirements, according to U.S. Attorney Stephen Murphy. The case was originally brought by the former acting director of nursing at St. James Nursing Center as a whistle-blower lawsuit.

◆ **Drug maker sanofi-aventis has agreed to pay the federal government and some states more than \$190 million to resolve allegations that one of its predecessor companies caused false claims to be filed to Medicaid and Medicare, the Department of Justice (DOJ) said on Sept. 10.**

The feds allege that Aventis Pharmaceuticals Inc. tried to "set and maintain fraudulent and inflated prices" for Anzemet, a drug used in oncology and radiation treatment to prevent nausea and vomiting. "Because reimbursement from federal programs was based on the fraudulent, inflated prices, the [feds] contended that Aventis caused false and fraudulent claims to be submitted to federal health care programs," DOJ says. The company's U.S. pharmaceutical subsidiary has also entered into a five-year corporate integrity agreement. In a statement, the company points out that the alleged activity occurred before sanofi-aventis was formed, and that the company did not admit any wrongdoing in the settlement. Visit www.usdoj.gov and www.sanofi-aventis.us.

◆ **PERSON ON THE MOVE: Brian Flood**, former Medicaid Inspector General for the state of Texas, was hired as managing director of the National Forensics Practice at consulting firm KPMG LLG in Austin, where he will advise clients on conducting internal investigations, handling regulatory and law enforcement investigations, and preventing and detecting fraud and abuse.

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