MFCU

Your fraud fighting partner

What is a MFCU?

- Established in 1978, a MFCU is typically the only statewide unit with both criminal and civil powers and is the enforcement arm for Washington's $12.8 billion Medicaid program.
- MFCU investigates and prosecutes:
  - ***criminal and civil Medicaid and Medicare provider fraud***
  - ***abuse and neglect in long term care residential facilities.***
- Partners directly with our state agencies, Managed Care Organizations, federal agencies and you in combating fraud, abuse and neglect

Types of Cases

- Our investigations can be criminal/civil or both. Typical cases include:
  - pharmacy
  - pill mills
  - doc in the box
  - durable medical equipment
  - behavioral health
  - day hab facilities
  - money laundering
  - complex conspiracies
  - residential long term care institutional
  - caregiver abuse/neglect

Essence of a Fraud Case:

- Was the claim submitted or caused to be submitted knowingly false and was the falsity material to the decision to pay?
  - i.e. had Medicaid known of the misrepresentation would it have paid the claim

Abuse/Neglect Case

- Abuse/ neglect:
  - Duty of care
  - Standard of care
  - Neglect examples: Non provision of services- billing for rendering care, yet residents not receiving basic care, decent food, etc.
  - Abuse examples:
    - Serious bodily injury, example: fractures, bed sores
    - Sexual Assault
    - Deaths

Things we look for…

- Medicaid Impact
- Medicare Impact
- Deterrent effect
- Nature and grievousness of the allegation

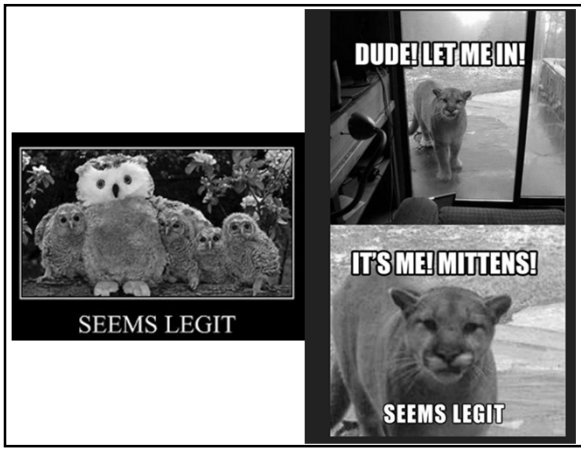
- What Does Medicaid Fraud have to do with Compliance?

Fraud is non compliant behavior

- Strawmen, kickbacks and SOX
  - Why who is really in charge matters
  - Why paying for a "deal" matters
  - Why ensuring your internal controls matters

Strawmen:

Things that may appear to be legitimate, but are really a front to hide true ownership or control



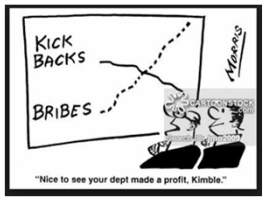
Medicaid Fraud Strawmen Examples

- Excluded provider
  - Have another act as owner to hide that they are in control
- Unlicensed owner
  - Hide that non professional exerting control / ownership over professionals
- Money laundering scheme
  - Fake companies to hide funds source, ownership

How do you find the straw/ shell?

- Financial records
- Required filings
- Corporate documents
- Addresses
- "Consulting" "advertising" or "marketing"
  - What did they actually provide?

Kickbacks

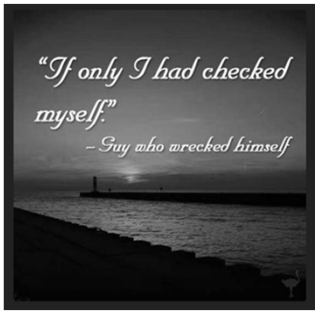


How can it arise in Medicaid?

- Labs
- DME
- Pharmacies
- Scans
- Housing

SOX and Fraud

– check yourself before you wreck yourself



The board has oversight and review responsibilities to ensure compliance programs function properly.

This includes:
(1) roles of, and relationships between, the organization's audit, compliance, and legal
departments;
(2) mechanism and process for issue-reporting within an organization;
(3) approach to identifying regulatory risk; and
(4) methods of encouraging enterprise-wide accountability for achievement of compliance goals
and objectives.

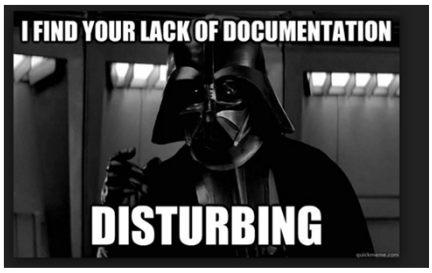
OK what does that mean….

There is no one size fits all solution.

What happens in fraud investigations when we find entities:

- lacking internal controls, with little /no documentation or tracking of:
  - privacy protections
  - fraud referrals
  - compliance reports to board
  - ethics training

First, we think along these lines…..



Even worse, don't make it up

- Falsifying documentation to make it look like there were reports, records or whatever is so much worse.
- Several cases are based upon the cover-up rather than the initial allegation.
- Cookie jar analogy
  - We know most of the answers before we ask…

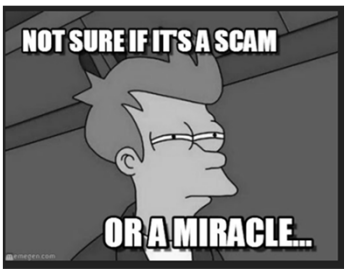
Reporting:

1. A reporting system exists
2. That reporting system ensures that relevant and appropriate information reaches the board relating to compliance matters
3. What can I use as a resource?
   1. OIG, *Compliance Guidance*, Http://oig.hhs.gov/compliance/compliance-guidance/index.asp.
   2. U.S. Sentencing Commission, *Guidelines Manual* (Nov. 2013) (USSG), http://www.ussc.gov/sites/default/files/pdf/guidelines-manual/2013/manual-pdf/2013_Guidelines_Manual_Full.pdf

Take Aways

And some extra stuff

Looks too good to be true?



Sharing knowledge is caring. Engaging in kickbacks is not.

Internal controls – no one size fits all solution

Medicaid Providers

- Requirements under their provider enrollment and keeping up on the rules and regulations
- Remember that ignorance is no excuse and not a good defense
- Certify that each claim submitted or cause to be submitted is true and accurate

Deficit Reduction Act Section 6032

- an entity includes organizational units (a governmental agency, organization, unit, corporation, partnership, or other business arrangement) and individuals, as long as the organizational unit or individual receives or makes payments totaling at least $5 million annually under a Title XIX State Plan, State Plan waiver, or Title XIX demonstration.
- It is the responsibility of each entity to establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. For purposes of determining whether an individual or organization must comply with section 6032 as an entity or as a contractor:

- if a provider is directly paid $5 million in a Federal fiscal year from the State Medicaid Agency, the provider would qualify as an entity, and must comply as such, regardless of whether the provider also contracts with a Medicaid Managed Care Organization (MCO); or
- if a provider contracts with a Medicaid MCO that has met the $5 million threshold, but the provider itself receives less than $5 million annually directly from the State Medicaid Agency, then the provider must comply as a contractor of the Medicaid MCO, regardless of the amount it is paid by the Medicaid MCO for Medicaid patients."
- any entity making or receiving payments to Medicaid of at least 5 million per year must provide False Claims Act education to their employees

False Claims Act

- FCA case, RCW 74.66: if the person:
- Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; or
- Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

- Liable for 3x times the government's damages
  - 2x if defendant provides all information known to him/her within 30 days, cooperates and didn't otherwise know about the criminal/civil investigation or an administrative investigation
- Penalties of $10,95 to $21,916 per false claim, [Note that FCA penalties have been adjusted for inflation at the state and federal level]
- Attorney fees & costs-RCW 74.66.020(1);
- Interest

Questions?