Provider Fraud from the Government's Perspective

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Who are we?

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Who Performs Health Care Fraud Investigations?

Medicaid Fraud Control Unit

- The MFCU investigates and prosecutes medical assistance provider fraud and patient abuse and neglect within the state Medicaid system.
- The MFCU is a self-contained unit located within the Office of Special Prosecutions in the Criminal Division of the Department of Law.

HHS, Office of Inspector General

- Among other responsibilities, OIG investigates allegations that health care providers have submitted claims to HHS-funded health care programs (e.g., Medicare, Medicaid, CHIP) which are false or for worthless services.
- OIG is independent from the rest of HHS.

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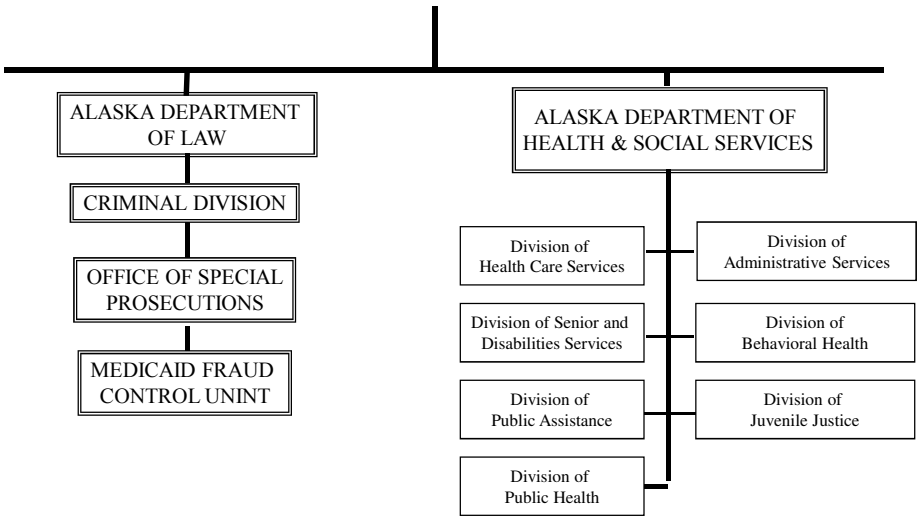
Medicaid Fraud Control Unit
Separate and Distinct from Department of Health and Social Services



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Federal Structure

- Similar to State structure and process, except more agencies and programs
- Also, must consider administrative sanctions and penalties

Department of Justice	U.S. Dept. of Health and Human Services, Office of Inspector General	Department of Defense, Office of Inspector General (Defense Criminal Investigative Service)	State
United States Attorney's Offices	U.S. Dept. of Health and Human Services, Centers for Medicare and Medicaid Services	Department of Defense, Defense Health Agency (TRICARE)	State
Federal Bureau of Investigations	U.S. Dept. of Health and Human Services, Indian Health Service	Office of Personnel Management, Federal Employee Health Benefits	

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Investigations and Litigation

What we do.

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Where do cases come from?

- Private citizens
  - Provider competitors
  - Provider employees
  - Beneficiaries
- Police and other governmental entities
  - Survey organizations
  - Including, from contractors who pay claims
- Data mining
- News reports

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Qui Tam Complaints

- Private persons, known as relators, may file lawsuits against individuals and entities that defraud the government by submitting false or fraudulent claims under State Medicaid programs.
- The government is required to investigate the relator's allegations and may intervene and take over the prosecution of the action.
- If government chooses not to intervene, the relator has the right to conduct the action.
- Relator is entitled to percentage of the proceeds of the action or settlement of the claim depending on the extent to which the relator substantially contributed to the case.

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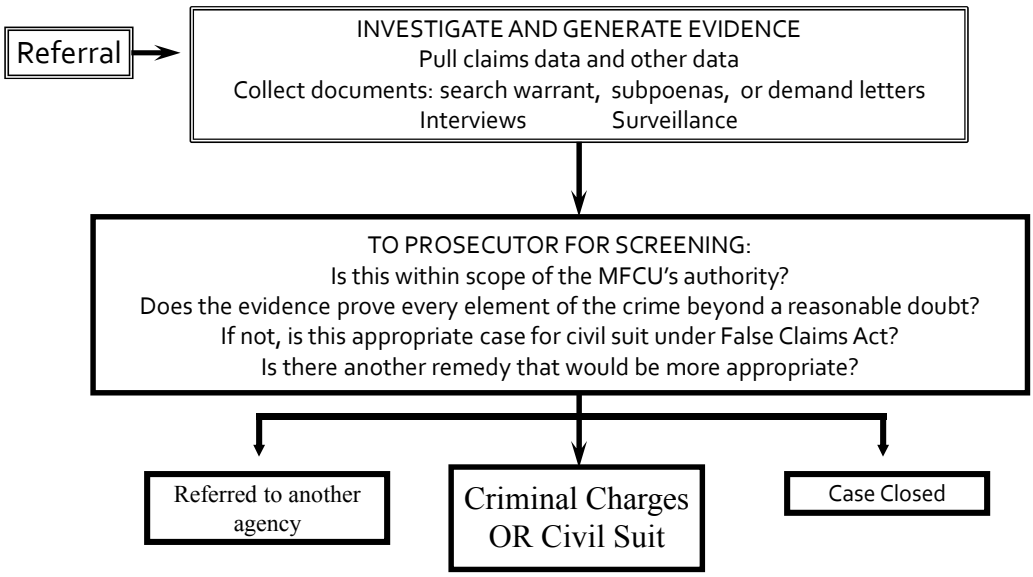

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Federal Investigations

- Federal agents investigate…
  - Criminal violations
  - Civil violations
  - Administrative violations
- Criminal and civil violations enforced by the United States Attorneys Offices and Department of Justice
- Administrative violations enforced by Health and Human Services (both Office of Inspector General and Centers for Medicare and Medicaid Services), and other agencies with health programs

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Joint Investigations

- Federal and state investigators may work together or share information, as permitted by law
- Resolutions may occur at the federal level, state level, or both

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Authorities

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Federal Criminal Laws

Includes

- Health Care Fraud, 18 U.S.C. § 1347
- Attempt or conspiracy to commit health care fraud, and conspiracy to defraud the United States, 18 U.S.C. § 1349 and 18 U.S.C. § 371
- Criminal False Claims, 18 U.S.C. § 287
- Theft or Embezzlement in Connection with Health Care, 18 U.S.C. § 669
- Unlawful Use of Health Information, 42 U.S.C. § 1320d-6
- False Statements Relating to Health Care Matters, 18 U.S.C. § 1035
- The Anti-kickback Statute, 42 U.S.C. § 1320a-7b(b)
- Aggravated Identity Theft, 18 U.S.C. § 1028A

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Alaska Criminal Laws: Medical Assistance Fraud

Violation				Statute
Preparation/Submission of Claim Reckless Disregard Not Entitled to Property **Illegal remunerations**				AS 47.05.210(a)(1)-(2) AS 47.05.210(a)(3)
	B Felony	Benefit/Claims ≥ $25,000	Up to 10 years jail; $100,000 fine ($2.5m for corp.)	
	C Felony	Benefit/Claims ≥ $500	Up to 5 years jail; $50,000 fine ($2.5m for corp.)	
	A Misdemeanor	Benefit/Claims < $500	Up to 1 year jail; $25,000 fine ($500,000 for corp.)	
Failure Produce Medical Records to Person Authorized (A Misdemeanors) **Knowingly Making False Entry in Medical Asst. Record** **Knowingly Tampers with Medical Asst. Record (destroy, conceal, remove)** **Violation of Provision of A.S. 47.07-.08 or Regulatoin (AAC)** (B Misdemeanor)				AS 47.05.210(a)(4)-(6) AS 47.05.210(a)(7)
	A Misdemeanor		Up to 1 year jail; $25,000 fine ($500,000 for corp.)	
	B Misdemeanor		Up to 10 days jail; $2,000 fine ($75,000 for corp.)	

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Alaska Criminal Laws: General Fraud

Violation				Statute
THEFT				AS 11.46.120 -11.46.150
	First Degree	B Felony	$25,000 OR MORE	
	Second Degree	C Felony	$750 TO $24,999.99	
	Third Degree	A Misdemeanor	$250 TO $749.99	
FORGERY				AS 11.46.500 - 11.46.510
	Second Degree	C Felony	Commercial Instrument/Public Record	
	Third Degree	A Misdemeanor	Any document	
OBTAINING A SIGNATURE BY DECEPTION (A Misdemeanor)				AS 11.46.540
SCHEME TO DEFRAUD		B Felony	$10,000 of 5 Persons	AS 11.46.600
FALSIFYING BUSINESS RECORDS (C Felony)			Intent to defraud	AS 11.46.630
COMMERCIAL BRIBERY/RECEIVING BRIBE				AS 11.46.660 - 670
		C Felony	VIOLATION OF DUTY *incl. physicians and corp. officers*	

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Alaska Criminal Laws
Patient Abuse and Neglect

Violation	Statute	Class
Assault and Reckless Endangerment	AS 11.41.200 - 250	Felony/Misd.
Sexual Assault and Abuse	AS 11.41.410 - 460	Felony/Misd.
Criminally Negligent Homicide	AS 11.41.130	C Felony
Endangering the Welfare of Vulnerable Adult First Degree Second Degree	AS 11.51.200 - 210	 C Felony A Misdemeanor
Harassment First Degree Second Degree	AS 11.61.110-120	A Misdemeanor B Misdemeanor

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Federal False Claims Act

- It is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent
  - Knowledge includes deliberate ignorance or reckless disregard of the truth or falsity of the information
- Claims may be "tainted" (false) by violation of the anti-kickback statute or physician self-referral law
- Treble damages plus penalties on a per-claim basis
  - each instance of an item or a service billed to Medicare or Medicaid, each line item counts as a claim
- 31 U.S.C. § § 3729-3733

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Illegal Arrangements

Anti-Kickback Statute

42 U.S.C. § 1320a-7b(b)

- Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal health care program business
- Remuneration = anything of value
- Up to five years in prison per violation; $50,000 CMP for each violation
- Voluntary safe harbors

Physician Self-Referral (Stark) Law

42 U.S.C. § 1395nn

- prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless exception applies
- Strict liability; CMPs and program exclusion for *knowing* violations
- Up to $15,000 CMP for each service
- Mandatory exceptions

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Alaska Medical Assistance False Claim and Reporting Act SB74 *(2016 SLA ch. 25, §§16, 18, 51)*

- **Passed in 2016**
- **Generally modeled after the Federal False Claims Act with some material differences.**
- **Creates a civil action that is enforceable by Attorney General and/or Private Party (relator)**

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False Claims Act Penalties

(currently)

State	Federal
$5,500 to $11,000	$11,181 to $22,363

(c) In addition to any criminal penalties under AS 47.05, a medical assistance provider or medical assistance recipient who violates (a) or (b) of this section shall be liable to the state in a civil action for

(1) a civil penalty of not less than $5,500 and not more than $11,000;

is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-410[1]), plus 3 times the amount of damages which the Government sustains because of the act of that person.

Claims Act (1986); violation, minimum from $10,957 to $11,181; maximum from $21,916 to $22,363.

(b) *Bureau of Industry and Security.*

Compare AS 09.58.010 to 31 U.S.C. § 3729 and adjustments in 83 Fed. Reg. 707 (Jan. 8, 2018) (codified at 15 C.F.R. § 6.3(a)(3))

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Overpayments

"Any funds a person has received or retained under title XVIII of the Act to which the person, after applicable reconciliation, is not entitled under such title."

60 Day Overpayment Rule

- Liability for knowing retention of an overpayment
- ACA Section 6402(a) (42 U.S.C. § 1320a-7k(d))
- Tolling: OIG & CMS Self Disclosure Protocols

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Civil Monetary Penalties

- Under the CMPL, 42 U.S.C. § 1320a-7a(a), penalties and damages for:
  - Submission of false claims; creating false record to support false claim
  - Claims submitted with a false certification of physician license
  - Presentation of claims by an excluded party; ownership or control of a participating entity by an excluded party; employing or contracting with excluded party; ordering or prescribing while excluded
  - Remuneration offered to induce program beneficiaries to influence choice
  - Pattern of claims for medically unnecessary services and supplies
  - Knowing provision of false or misleading information to influence hospital discharge
  - Violation of the anti-kickback statute
  - False statements or omissions in an enrollment application
  - Knowing retention of an overpayment
- Violation of the physician self referral law, 42 U.S.C. § 1395nn(g)(3)
- Misuse of Departmental symbols or emblems, 42 U.S.C. § 1320b-10(b)

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Exclusion from Federal programs

- Mandatory Exclusion: minimum 5-year exclusion for conviction of certain offenses (*e.g., program-related crimes, patient abuse, felony health care fraud, or felony convictions relating to controlled substances*).
- Permissive Exclusion: OIG may exclude under 16 additional authorities (*e.g., losing a state license to practice, failing to repay student loans*).
- Effect: Federal health care programs will not pay for items or services furnished, ordered, prescribed, or supplied by an excluded individual or entity.
  - The list of excluded individuals and entities (LEIE) is updated monthly, and provides constructive knowledge of excluded status.
- Violation of Exclusion: OIG may impose civil monetary penalties of up to $10,000 per item or service claimed while excluded and an assessment of three times the amount claimed.

42 U.S.C. § 1320a-7

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Corporate Integrity Agreements

- OIG negotiates corporate integrity agreements (CIA) with health care providers and other entities as part of the settlement of Federal health care program investigations in exchange for a release of OIG's permissive exclusion authority.

What's in a CIA?

- Based on the seven elements of a compliance program
- Each one addresses the specific facts at issue in the investigation
- Requires review by independent organization or monitor

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Case Example

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Arc of Anchorage

THE GREAT STATE of ALASKA myAlaska Departments State Employees

State of Alaska
DEPARTMENT OF LAW

This settlement was the result of a coordinated effort by the Alaska Medicaid Fraud Control Unit (MFCU), the Office of Inspector General (OIG), the Alaska Medicaid Program, and the cooperation of the Arc of Anchorage.

The State contends the Arc submitted or authorized the submission of false claims to the Alaska Medicaid Program. Specifically, the State contends the Arc billed for services not provided, and billed for overlapping services with the same provider. The State further contends that the Arc failed to repay money owed to the Medicaid Program identified in audits performed by the Arc.

The settlement requires the Arc to enter into a five year Corporate Integrity Agreement with OIG, which calls for the Arc to comply with specific terms set by OIG that guarantee there will be no waste, fraud, and abuse in the future.

ANCHORAGE DAILY NEWS

Business/Economy

Arc of Anchorage to pay nearly $2.3 million in settlement over Medicaid billing

Author: Annie Zak Updated: April 25, 2018 Published April 24, 2018

An Anchorage nonprofit that serves people with developmental or intellectual disabilities has agreed to settle allegations about false Medicaid claims.

The Arc of Anchorage will pay the Alaska Medicaid Program nearly $2.3 million, according to a statement the Alaska Department of Law released Tuesday.

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Arc of Anchorage

- Alaska investigated Arc of Anchorage for knowingly submitting false or fraudulent claims to the Alaska Medicaid program and for knowingly retaining an overpayment.
- OIG and Alaska allege that, during the period January 1, 2012 through December 31, 2016, Arc of Anchorage knowingly submitted or authorized the submission of claims to the Alaska Medicaid program claims for items or services that Arc of Anchorage knew or should have known were not provided as claimed and were false or fraudulent.
- OIG and Alaska also allege that, as of November 2015, Arc of Anchorage knowingly retained an overpayment owed to the Alaska Medicaid program which was identified in audits performed by or at the direction of Arc of Anchorage.

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Arc of Anchorage

- Alaska releases Respondent from any claims or causes of action it may have against Respondent under Alaska Statute 09.58.010 and Alaska Statute 47.05.210.
- OIG releases Respondent from any claims or causes of action it may have against Respondent under 42 U.S.C. §§ 1320a-7a and 1320a-7(b)(7).

CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
ARC OF ANCHORAGE

I. PREAMBLE

Arc of Anchorage (Arc) hereby enters into this Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) (Federal health care program requirements). Contemporaneously with this CIA, Arc is entering into a Settlement Agreement with the OIG and the State of Alaska.

II. TERM AND SCOPE OF THE CIA

A. The period of the compliance obligations assumed by Arc under this CIA shall be five years from the effective date of this CIA. The "Effective Date" shall be the date on which the final signatory of this CIA executes this CIA. Each one-year period, beginning with the one-year period following the Effective Date, shall be referred to as a "Reporting Period."

B. Sections VII, X, and XI shall expire no later than 120 days after OIG's receipt of: (1) Arc's final Annual Report or (2) any additional materials submitted by Arc pursuant to OIG's request, whichever is later.

C. For purposes of this CIA, the term "Covered Persons" includes: (1) all owners who are natural persons, officers, directors, and employees of Arc; and (2) all contractors, subcontractors, agents, and other persons who furnish patient care items or services or who perform billing or coding functions on behalf of Arc, excluding vendors whose sole connection with Arc is selling or otherwise providing medical supplies or equipment to Arc.

III. CORPORATE INTEGRITY OBLIGATIONS

Arc shall establish and maintain a Compliance Program that includes the following elements:

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Compliance Generally

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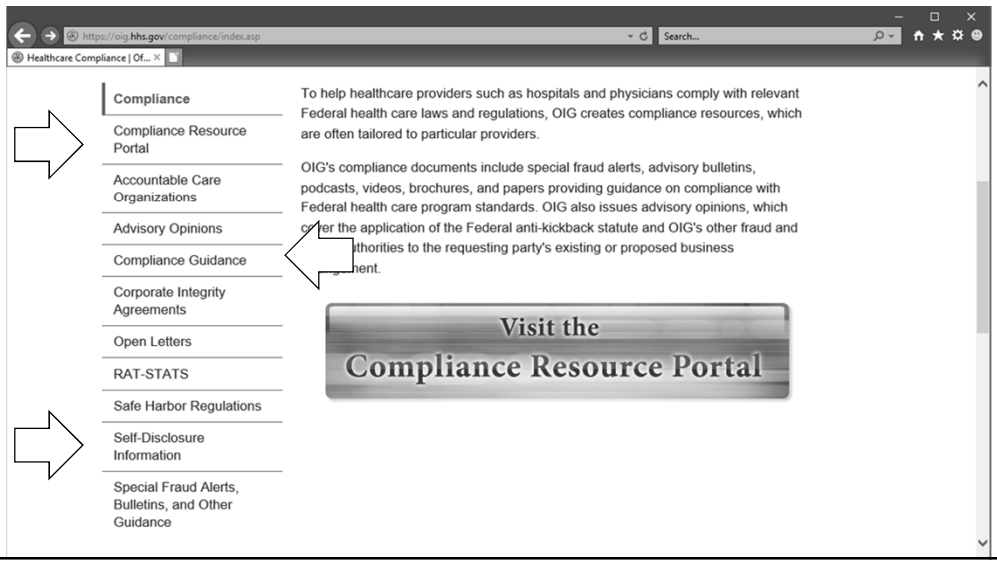
Compliance Resources



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Compliance Resources

Compliance Resource Portal

- Toolkits +
- Provider Compliance Resources and Training +
- Advisory Opinions +
- Voluntary Compliance and Exclusions Resources +
- Special Fraud Alerts, Other Guidance, and Safe Harbor Regulations +
- Resources for Health Care Boards +
- Resources for Physicians +
- Accountable Care Organizations +

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Compliance Resources: CPGs

Seven Fundamental Elements

1. Written policies and procedures
2. Compliance professionals
3. Effective training
4. Effective communication
5. Enforcement of standards
6. Internal monitoring
7. Prompt response

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Self-Disclosure to OIG

- Benchmark 1.5 multiplier
  - Claims Calculation
    - All claims or statistical sample of 100 claims minimum
    - Use point estimate (not lower bound)
  - Excluded persons – salary and benefits-based
  - AKS – remuneration-based
- Presumption of no CIA
- Six-year statute of limitations
- Tolling of the 60-day period after submission

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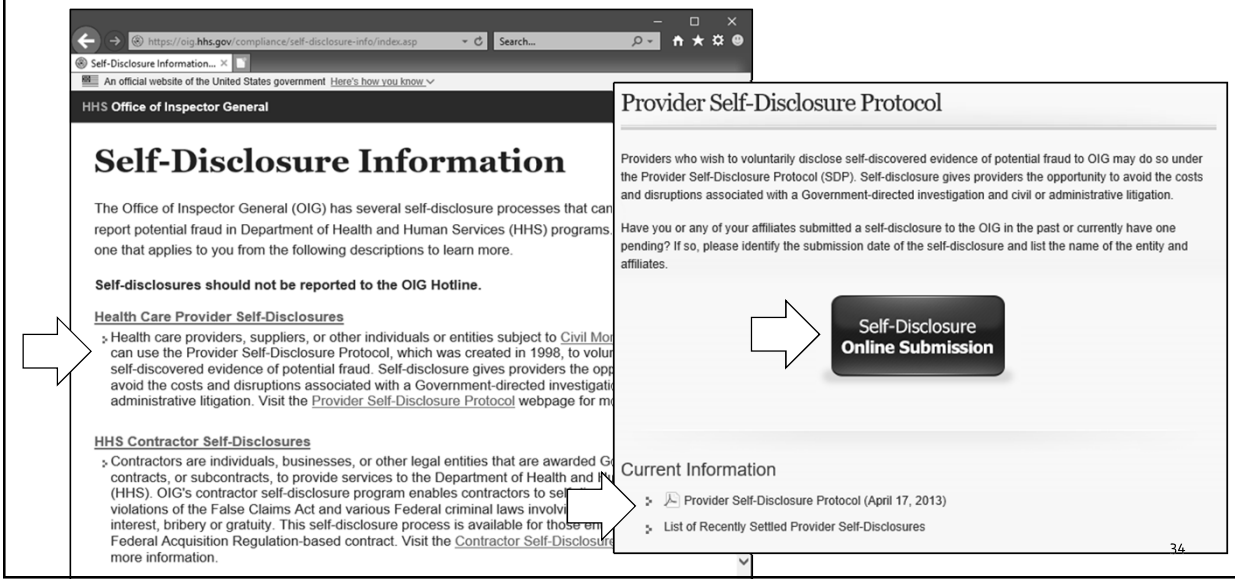
Self-Disclosure to OIG



Tribal Health

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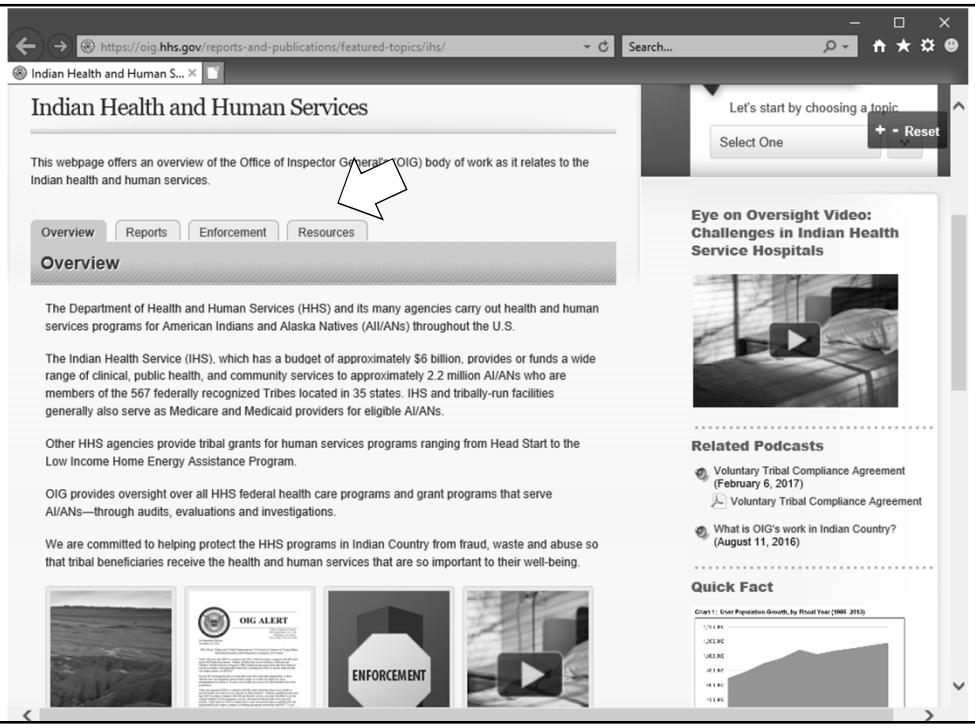

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Compliance Resources

- On April 27, 2017, OIG held a conference *Protecting Indian Health and Human Services Programs and their Beneficiaries: The Basics of Health Care and Grants Management Compliance* for Indian Health Services and tribal employees in Crazy Horse, South Dakota.
- Our website has audit reports, information regarding enforcement actions, and compliance resources.
  - https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/
- More conferences and materials are forthcoming.

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Compliance Resou

Related Reports

Report	Date
The Fort Peck Assiniboine and Sioux Tribes Improperly Administered Some Low-Income Home Energy Assistance Program Funds for Fiscal Years 2011 Through 2015 (A-07-18-04106)	08/21/2018
The Passamaquoddy Tribe's Pleasant Point Health Center Did Not Always Meet Federal and Tribal Health and Safety Requirements (A-01-17-01500)	07/30/2018
The Turtle Mountain Band of Chippewa Indians Improperly Administered Some Low-Income Home Energy Assistance Program Funds for Fiscal Years 2010 Through 2013 (A-07-16-04233)	09/27/2017
The Administration for Children and Families Did Not Always Resolve American Indian and Alaska Native Head Start Grantees' Single Audit Findings in Accordance With Federal Requirements (A-06-17-07003)	12/14/2017
Two Indian Health Service Hospitals Had System Security and Physical Controls for Prescription Drug and Opioid Dispensing but Could Still Improve Controls (A-18-16-30540)	11/28/2017
The Three Affiliated Tribes Improperly Administered Low-Income Home Energy Assistance Program Funds for Fiscal Years 2010 Through 2014 (A-07-16-04230)	07/13/2017
Indian Health Service Hospitals: More Monitoring Needed to Ensure Quality Care (OEI-06-14-00010)	10/6/2016
Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care (OEI-06-14-00011)	10/6/2016
Expenses Incurred by the Rocky Boy Health Board Were Not Always Allowable or Adequately Supported (A-07-15-04221)	3/22/2016

Compliance Training Conference

On April 27, 2017, OIG held a conference *Protecting Indian Health and Human Services Programs and their Beneficiaries: The Basics of Health Care and Grants Management Compliance* for Indian Health Services and tribal employees in Crazy Horse, South Dakota. Below are the materials handed out to attendees:

- Full Conference Packet
- General Overview and Compliance Programs: Amitava (Jay) Mazumdar, Deputy Branch Chief, Office of Counsel to the Inspector General and Andrea Treese Berlin, Senior Counsel, Office of Counsel to the Inspector General
- Internal Controls - Case Studies: Patrick Cogley, Regional Inspector General for Audit Services, Kansas City, Office of Audit Services Amitava (Jay) Mazumdar, Deputy Branch Chief, Office of Counsel to the Inspector General and Andrea Treese Berlin, Senior Counsel, Office of Counsel to the Inspector General and Debra Keasling, Assistant Regional Inspector General for Audit Services, Denver, Office of Audit Services. Moderated By: Maritza Hawrey, Assistant Director for Grants and Internal Audits Division, Office of Audit Services

Joanne Chiedi, HHS OIG's Principal Deputy Inspector General, gives opening remarks at the conference.

- Documentation: Lucia Fort, Senior Advisor to the Chief of Staff and Lisa Re, Assistant Inspector General for Legal Affairs, Office of Counsel to the Inspector General
- Single Audits - Quality Matters: Tammie Brown, NEAR Audit Manager, National Single Audit Coordinator, Office of Audit Services
- The Office of Investigations: Charles Hackney, Assistant Special Agent in Charge, Kansas City Regional Office, Office of Investigations and Curt Muller,

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