

FOLEY EXECUTIVE BRIEFING SERIES



**Medicaid Enforcement Priorities –  
Insights from the Illinois Inspector  
General**

October 14, 2008



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**State of Illinois Healthcare and  
Family Services  
Office of Inspector General**

**John C. Allen, IV – Inspector General**



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## Agenda

- OIG Overview
- Inpatient DRG Audits
- Preliminary Call
- Questions



## Office of Inspector General (OIG)

- Created as a result of Public Act 88-554
- Focus on Prevention, Detection, and Enforcement
- Work with Providers to Ensure Compliance with the Department's Policies



## Audits

- As part of its enforcement efforts, OIG conducts audits of providers
- Providers that OIG currently audits include individual practitioners, pharmacies, transportation companies, DMEs, home health care companies, nursing homes, hospitals, labs, clinics, and others



## Hospital Audits

For Hospitals, OIG currently examines:

- Ongoing Outpatient hospital services
- Selected DRG records through targeted self audit process
- Piloted Inpatient DRG Review



## Hospital DRG Audit Program Going Forward

- Comprehensive review of inpatient DRG claims
- Selection of up to 50 hospitals annually for review
- Review of three years of services
- Use of sampling and extrapolation



## Hospital DRG Audit Program Going Forward (cont'd)

- The OIG will contract the Medical DRG Review
- Plan to contract vendor beginning January 2009
- Vendor will use certified coders



## Claims Universe

Current plans are to

- Include:
  - Paid, non-voided services
  
- Exclude:
  - Zero-paid and Medicare Crossover services
  - Services reviewed by the Department utilization review vendor (HSI) in their prepayment reviews
  - Children's hospitals



## Record Selection

*Which records will we review for each selected hospital?*

- All records with very large payments
  
- A statistically valid random sample of all remaining records in the hospital's universe



## Audit Process – Initial Contact

- Conduct initial interview
  
- Provide Record Request List, which will identify the claims being reviewed. Includes:
  - Patient Name
  - Patient DOB
  - Recipient ID
  - Admission Date
  - Discharge Date
  - Medical Record Number (if available)
  - Provider Reference Number (if available)
  - Voucher



## Audit Process – Record Review

- Conduct the record review on site at the hospital
  
- Contract out the medical record review
  
- Notify the hospital of missing records
  
- Scan copies of potential discrepant records



## Audit Process – Findings

- Identify discrepant claims
- Re-code and re-price these discrepant claims
- Determine overpayments
  - Actual overpayments for the universe of very large payments
  - Estimated overpayments by extrapolating from the sample



## Audit Process – Findings (cont'd)

- Conduct exit conference
  - Review initial findings
  - Provide hospital with an opportunity to discuss findings
  - Advise hospital if they are compliant with the Federal False Claims Act
- OIG will distribute audit report



## Hospital Options

- Agree with findings
  
- Disagree with findings
  - Discuss concerns with OIG and Vendor
  - Request a re-audit (only 1 re-audit is permitted)
  - If no resolution, an administrative hearing will be scheduled to ensure due process



## Administrative Hearing Process

- Notice of Department Action to Recover
  
- Formal Conference
  
- Administrative Hearing
  
- Administrative Law Judge Recommended Decision





## Administrative Hearing Process (cont'd)

- Director's Final Decision
- Appeal Process



## Recoupment Method

- Hospital can repay via check
- Recoupment can also occur via offsets from future HFS payments
- Offsets – HFS will recoup a fixed dollar amount each month and any remaining payments will be paid



## Recoupment Schedule

- Hospital can repay in one lump sum or monthly installments
- Installments can be either 6 months or 12 months
- If hospital chooses to repay via installment, it must sign an installment withholding note



## Recommendations to Avoid Audit Findings

- Review the Department's policies
- Review ICD 9 coding practices and provide guidance to coders
- Maintain well documented and complete medical records



## Recommendations to Avoid Audit Findings (cont'd)

- Review medical record retention and storage practices
- When you receive the record request list, consider placing a priority on obtaining all records as soon as practical



## Hospital DRG Audits

Questions?



## Administrative Hearings

The purpose of the **Preliminary Call** is to hear single issues cases in an expeditious manner.



## Preliminary Calls

- Monthly calls (70 – 80 cases)
- In most instances, cases are resolved in one hearing



## Types of Cases

- Child support non-compliance
- Termination cases of providers licensing issues
- Convictions
- Non-cooperation of provider overpayment
- Nursing home decertification



## Child Support Cases

- Non-custodial parent delinquent in compliance with child support order
- The Department certifies delinquency enabling the licensing agency to suspend providers
- The Department may terminate the non-custodial parent



## Termination/Suspension Cases

- Not properly licensed
- Provider has professional license or certification revoked, suspended, or terminated



## All Conviction Cases

- A conviction of a felony offense based on fraud or willful misrepresentation related to Medical Assistance Program (MAP)
- Conviction of application federal or State laws or regulation relating to MAP
- Murder or Class X Felony and or conviction of a prohibited offense



## Recoupment Cases

- The providers who fail to appear at formal conference
- The providers who fail to request a hearing
- The Department files a motion for default



## Decertification Cases

The Federal Centers of Medicare and Medicaid Services takes action to decertify providers.



## Preliminary Calls

Questions?



## Contact Information

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## Criminal Liability for Failure to Disclosure of Overpayments

- Federal Criminal Statute Mandating Disclosure of Medicaid Overpayments
  - 42 U.S.C. § 1320a-7b(a)(3)
    - Felony for failure to disclose a known overpayment
    - Even if initially obtained innocently
    - Applies to Medicaid Overpayments because Medicaid is a “Federal Health Care Program”
    - Continuing offense



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## Civil Liability for Failure to Disclose Overpayments

- Illinois Whistleblower and Reward Act (740 ILCS 175/1 et seq.)
  - Contains a “reverse false claims” provision prohibiting the making of a false statement to conceal or avoid paying money owed to the State
  - Penalties include treble damages, fines of not less than \$5,500 nor more than \$11,000 per claim, plus attorneys fees and costs
  - “Knowingly” includes acting in deliberate ignorance or reckless disregard of the truth



## Potential Risks and Benefits of Self Disclosure

- Potential Advantages
  - May result in reduced fines and penalties
  - May avoid criminal prosecution
  - May avoid suspension or termination from Medicaid Program
  - Minimize disruption and cost by conducting investigation internally
  - IG will work with providers in a forthright and fair manner
  - Potential protection against qui tam suits
- Potential Disadvantages
  - No guarantee of leniency
  - Providing a roadmap of wrongdoing
  - Negative PR



## Making the Voluntary Disclosure

- To whom should you disclose Medicaid Overpayments?
  - DHFS
  - MFCU
  - Inspector General's Office
  - Attorney General's Office
  - DHHS OIG Self Disclosure Protocol
  - U.S. Attorney's Office



## Components of Voluntary Disclosure

- Process Review (Should know before disclosure)
  - Who knew
  - When did they know
  - Who should have known
  - How was the issue discovered
  - Was there fraud involved
  - Has corrective action been taken
- Sampling (Don't have to audit before disclosure)
  - Probe samples
  - Full samples
  - Agreement with IG re: methodology prior to sampling
  - Time period for audit



## Practical Tips

### Improve Board Education and Oversight

- Board must recognize quality/safety as a core fiduciary obligation
- On September 13, 2007, OIG and AHCA issued a joint publication, *Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors*
  - Health care quality is a key component of corporate mission and a core fiduciary obligation for the board
  - Elevate quality to the same level of fiduciary obligation that financial viability and regulatory compliance currently constitute



## Practical Tips (cont'd)

- Board and medical staff need to frame an agenda for quality – IHI campaign, Joint Commission, quality measures
- Governance responsibility for quality – measures and goals
- Board needs to receive regular reports (errors, outcomes)
- Increasing board education on quality – part of orientation
- Recruiting one or more board members with expertise on quality
- Government/Industry Roundtable to be held on November 10, 2008



## Practical Tips (cont'd)

### Assessment to Enhance Quality and Compliance

- Subject quality processes to same compliance scrutiny as billing/coding or physician financial relationship
- Close gaps in processes
- Know fraud and abuse risks
- Assess for 2009 OIG Work Plan risks
- Is there an auditable trail for quality data?



## Practical Tips (cont'd)

### Mine Your Own Data

- Need to know the data mining techniques used by federal government and your state
- Can you replicate reports?

*“We are reviewing assorted sources of quality information on your facility to see what it says and if it is consistent. You should be doing the same.”*

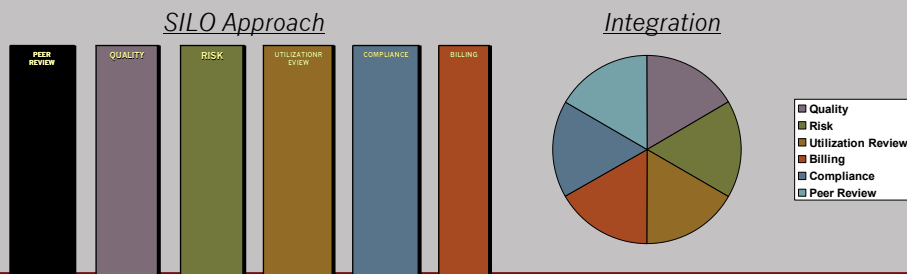
James G. Sheehan  
Medicaid Inspector General, New York  
February 6, 2007



## Practical Tips (cont'd)

### Integrate Quality and Compliance

- Policies and education to address compliance risks associated with quality
- Need to investigate compliance implications of quality failures. Reporting procedures need to be established. Be careful to maintain the privilege



## Practical Tips (cont'd)

### Revamp Medical Staff

- Standardization of care drives Quality and Safety under the new Paradigm
- Only Qualified and Aligned Physicians on Staff (voting vs. non-voting status)
- Consider
  - Multi-disciplinary Peer Review
  - Cross-discipline departments
  - Competency based credentialing
    - Appoint only excellent physicians
    - Set and communicate expectations
    - Measure performance (case review, outcomes data (rate indicators), compliance with quality targets (rule indicators))
    - Proctoring
    - Manage poor performance



## Practical Tips (cont'd)

### Improve Hospital/Physician Collaboration

- Existing structures that meet current legal requirements:
  - Employment (different from employment wave of 1990s)
  - Co-management
  - Provision of mid-level support to physicians
  - Ancillary/whole hospital joint ventures
  
- Limitations of existing structures



## Practical Tips (cont'd)

- Advisory Opinion (to be released soon) addresses new legal structure to align physicians around quality
  
- New legal entity created to allow sharing of payments received from a payor or payors
  
- Make the program specific:
  - Achievements of quality targets
  - How much are they worth?
    - Fixed payments?
    - Percentage of hospital's bonus?
    - Hybrid?
  - Determine fair market value
  
- Allows hospital to perform well under P4P



## Practical Tips (cont'd)

### Build in Safeguards:

- Consider requirements of new proposed Stark exception
  - Limiting payments that can be earned to the number of patients that matches the prior year's patient base for that physician or group, to prevent incentivizing additional referrals (but can inflation adjust payments)
  - Limiting physician participation to existing medical staff members, to limit the risk of luring new physicians to the hospital
  - Disclosure to patients
  - Quality targets limited to those included in Specifications Manual for National Hospital Quality Measures



## Contact Us

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