The HCCA-AIS

Volume 2, Number 10 • October 2008

MEDICAID COMPLIANCE NEWS

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

Contents

OIG Targets About 70 Medicaid Items on Work Plan; Some Echo Medicare Concerns

Medicaid is again a big star of the HHS Office of Inspector General's (OIG's) Work Plan, this time for fiscal year 2009. The Work Plan was released Oct. 1, the first day of the federal fiscal year. It contains roughly 70 Medicaid items, and they tackle numerous risks including poterntial provider overpayments, state controls of provider coding and billing and the integrity and privacy of Medicaid data.

The fact that Medicaid items will clearly be where OIG watchdogs spend a lot of their energy this coming year may be a reflection of the big boost in funding OIG got from the 2005 Deficit Reduction Act (DRA). After a series of Goverment Accountability Office reports (and other sources) raised awareness about the inadequate federal oversight of Medicaid, Congress allocated hundreds of millions of dollars in Medicaid fraud-and-abuse-fighting dollars to CMS and OIG. There are about 25% more Medicaid targets on the 2009 Work Plan, for example, than on the pre-DRA 2003 OIG Work Plan.

"It's hard not to be struck by the number of audits and evaluations they are doing or plan to do [involving] state Medicaid programs," says Boston attorney Larry Vernaglia, with law firm Foley & Lardner, LLP. "It doesn't surprise me because we saw the feds' interest in Medicaid really growing." And, he says, when it comes to fraud-and-abuse enforcement, the government looks as "holistically" as possible — not just Medicare but Medicaid as well — anywhere the dollars are sucked away.

The OIG Work Plan is a "comprehensive" list of the projects OIG plans to work on during the year because they've been deemed "most worthy of attention," OIG says. HHS and the Office of Management and Budget help refine it before publication.

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Sheehan Lists Medicaid Integrity Initiatives; New York Office Issues Recovery Data

Thinking outside the box can generate surprising gains for auditors and enforcers, and it's paying off for the New York Office of Medicaid Inspector General (OMIG). According to its new annual report, released Oct. 3, OMIG led the nation in Medicaid recoveries in fiscal year (FY) 2007. OMIG is holding off on revealing the specific dollar amount recovered during FY 2007, the most recent year for which complete data exists, but the stakes are very high for Medicaid overpayment recovery in New York. That means providers should expect auditors to try to leave no stone unturned in their quest for improper payments.

Under the Federal-State Health Reform Partnership (F-SHRP) agreement between New York and CMS, CMS invested a lot of money in OMIG in return for a pledge that the state would get a healthy return on investment. The state must recover $215 million by Sept. 30, 2008; $322 million by Sept. 30, 2009; $429 million by Sept. 30, 2010; and $644 million by Sept. 30, 2011. CMS invested $1.5 billion total for reform initiatives. New York Medicaid Inspector General Jim Sheehan has said that the 2011 goal would

be difficult to meet, and that hospitals and nursing homes would be targeted for audits *(MCN 3/08, p. 3)*.

The annual report describes the audits, investigations, administrative actions, referrals and civil actions initiated and completed that year. One interesting approach is the "undercover shopper program," which "has grown exponentially," OMIG says, and was expanded and improved last year. Shoppers are undercover investigators who pretend to be Medicaid enrollees, using Medicaid cards to seek and/or get medical care from various provider types, the report explains.

In an interview, Sheehan tells *MCN* that shoppers are looking for indicators that all is not kosher at the places they visit (e.g., clinics, pharmacies). For example, if there is always a line of 10 patients waiting outside a particular clinic by 9 a.m., there's a risk that it is a "pill mill." Shoppers chat with other patients, who may unknowingly provide more clues by saying things like "This doctor is great. You can rent your Medicaid card to him or if you bring in three other patients, he pays you $10." Shoppers can't solicit conversations, but they can pick up the chatter among the real patients or respond if someone talks to them. Or shoppers may be able to report back that they never had physical therapy by Dr. Smith at XYZ Clinic, so when Medicaid receives a bill for it, there is proof of fraud.

Sheehan explains that providers aren't targeted randomly by shoppers. "We do a predication" — which means OMIG has been pointed in the direction of the provider by, for example, multiple hotline tips or statistical analyses.

Shoppers write up their findings, and information is entered into a tracking system. In fact, OMIG has a computer system to track every relevant document relating to providers, Sheehan says. This includes credentials verification, audits, investigations, hotline tips and voluntary disclosures.

Anomalies identified by shoppers are investigated and cases referred to other law enforcement agencies, as appropriate. As a result of the shopper program, some providers and suppliers have been excluded or terminated from Medicaid, paid penalties or have been referred to the state attorney general's Medicaid Fraud Control Unit, Bureau of Narcotic Enforcement, Office of Professional Medical Conduct and OMIG's Bureau of Medicaid Audit, the report notes.

"The shopper program has identified physicians who billed Medicaid for services not rendered as well as those who provided substandard care to Medicaid patients. Part-time clinics are also identified for billing outside of clinic hours. Optical providers have billed Medicaid for glasses when none have been ordered or billed for extra services that were not provided. Pharmacies billed Medicaid for refills without providing the service," the report states.

Shopping Leads to Termination

To get a sense of the monetary impact, OMIG notes that two inquiries involving shoppers led to two providers' Medicaid termination. OMIG puts the cost-avoidance total for these two providers at $854,093. (Terminated providers cannot bill Medicaid directly, but, for example, when a hospital employs a terminated physician, the hospital can bill Medicaid on the physician's behalf. Exclusion bars direct and indirect relationships between the excluded provider and Medicaid.)

As OMIG continues to staff up — it's at 520 employees now but is working its way toward the 750 positions it's funded for — the number of targeted "shops" will also rise.

The shopper program is one of the many types of audits and investigations described in the report. A theme that runs through it, says attorney Judy Waltz, is the "degree of integration and coordination" of the different

The HCCA-AIS Medicaid Compliance News (ISSN: 1937-6669) is co-published 12 times a year by the Health Care Compliance Association and Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, www.AISHealth.com.

Editors, Barbra Golub, Nina Youngstrom; Associate Editor, Eve Collins; Executive Editor, James Gutman; Co-Publishers, Roy Snell, Richard Biehl; Marketing Director, Donna Lawton; Fulfillment Manager, Gwen Arnold; Production Director, Andrea Gudeon.

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programs. "I was a government lawyer for more than 20 years. It's not that easy to get people working together," says Waltz, who is with law firm Foley & Lardner LLP. This matters because "it extrapolates the impact" of the work being accomplished, Waltz says.

In fact, she says, reading the report conveys a "complete picture" of the health care scene in New York since Medicaid is such a big part. That means OMIG's findings can be applied to other health care goals, Waltz says.

OMIG itself notes that its work has the potential to apply to other realms. In a section describing the use of its data tools — which includes the largest Medicaid claims data warehouse run by any state integrity program — OMIG says "these opportunities extend beyond control of fraud and waste to disease management, medical error and unanticipated outcome detection, and assistance to patients in managing their medical conditions."

Medicaid Is the Payer of Last Resort

Sheehan says another important part of program integrity is the third-party payments issue. OMIG uses a contractor to identify when other payers should pick up the tab for a health care service, since Medicaid is always the payer of last resort. "A lot of Medicaid enrollees have other insurance that would be primary," but Medicaid winds up paying unless the state can identify and rectify these situations. OMIG also works with a pharmacy benefit manager to identify when drugs should have been reimbursed by another payer. "A lot of people on Medicaid have private insurance because they work or they are dependent on someone and gets their insurance," Sheehan says. "A lot of [Medicaid] money gets wasted."

Here are some other results from the OMIG report:

◆ ***The Provider Surveillance Utilization Review System (SURS)*** conducted 871 reviews, 764 of which were closed. Of the rest, 39 were referred to the state Medicaid Fraud Control Unit, two were referred to the MIG division of audit, and one resulted in a joint inquiry with HHS, among others.

◆ ***Two cases resulted in FBI enforcement and prosecutions.*** "Our office has provided investigative and covert undercover support in the course of Medicaid fraud investigations," the annual report says.

◆ ***71 providers were terminated from Medicaid, and 802 were excluded***.

◆ ***286 providers were issued monetary penalties totaling $1.1 million.***

◆ ***The MIG received 74 cases of provider self-disclosure of fraud, waste or abuse, resulting in $10.2 million in identified overpayments.*** Occurrences providing reasons for self-disclosure can include improper credentialing of professional staff, billing for services not included on the facility's operating certificate, incorrect rate codes billed and unbundling of physician services from the facility's rate.

◆ ***Provider audits resulted in overpayments*** of $1.4 million from 22 diagnostic treatment centers, $3.8 million from 24 hospital outpatient departments, and more than $1 million from 10 durable medical equipment providers.

Visit www.omig.state.ny.us/data/. Contact Waltz at jwaltz@foley.com. ✧

Despite Favorable Ruling in Case, Conn. Medicaid Faces Audit Calls

The Connecticut Supreme Court has upheld a ruling made by the state's Department of Social Services (DSS) against an oxygen supply company for defrauding the state's Medicaid program. But it might be a case of too little, too late in terms of growing criticism about DSS's Medicaid performance.

In 1997, DSS audited Goldstar Medical, Inc., a Farmington, Conn.-based provider of oxygen to nursing homes and other health care facilities. Based on the audit, DSS terminated its provider agreement with Goldstar in 1999, and in 2005 it ordered Goldstar to pay approximately $198,193 in restitution. It also suspended Goldstar owner Donald Bouchard from the state Medicaid program for five years.

According to the attorney general's office, the audit found that Goldstar submitted claims for uncovered services and services not ordered by a physician, double billed some patients and illegally altered documents.

For Medicaid patients needing oxygen, the state requires nursing homes and other long-term care facilities to use devices called concentrators that remove oxygen from the air instead of bottled oxygen. The state found evidence showing that Goldstar altered documents to make it appear that patients needing just small amounts of oxygen needed more. Thus, patients who received oxygen from concentrators, which is already included in a patient's nursing-home rate, received bottled oxygen at an additional charge billed to Medicaid.

Now, in *Goldstar Medical Services, Inc. et al. v. Department of Social Services, SC* 18111 (Sept. 23, 2008), the Connecticut Supreme Court upheld DSS's audit findings. "We agree with the commissioner that the record in the present case reveals overwhelming evidence that the plaintiffs committed Medicaid fraud. Accordingly, we conclude that the trial court properly determined that the evidence in the administrative record

was sufficient to support the commissioner's findings and decision," the court said.

Specifically, the court disagreed with Goldstar that DSS lacked jurisdiction to sanction the company because it was no longer a "provider" at the time of the sanctions and to suspend Bouchard personally from the state Medicaid program.

The court also disagreed with Goldstar's argument that the trial court improperly concluded that DSS was allowed to extrapolate from a sample of paid claims the total amount of excess reimbursement Goldstar received. Goldstar contended that state regulations do not authorize this process. However, the court agreed with DSS that the method "is appropriate, legal and sanctioned by federal regulations."

In announcing the court's decision, Attorney General Richard Blumenthal (D) said that the Supreme Court "has roundly rejected efforts to avoid refunds and other remedies. This case should send a stark message that Medicaid fraud will be vigorously pursued, and wrongdoers will be held to their penalties."

DSS Commissioner Michael Starkowski said that DSS "would closely scrutinize any request [by Goldstar or Bouchard] to re-enter the program after the suspension period."

Goldstar's attorney did not respond to requests for comment by *MCN* press time.

State Comptroller to Audit DSS

Despite some success in fighting Medicaid fraud, DSS has still come under fire for not doing enough. Based on the state's Medicaid budget for the current fiscal year, Democrats have called for an audit of the entire budget overseen by DSS. The current Medicaid budget accounts for $3.7 billion of the $5.3 billion budget under DSS jurisdiction.

Democratic leaders, including Senate President *Pro Tem* Donald Williams, Senate Majority Leader Martin Looney, House Speaker James Amann, and House Majority Leader Chris Donovan, last month called on state Comptroller Nancy Wyman (D) to immediately audit DSS in an effort to "eliminate waste and overbudgeting." Wyman's office has agreed to the audit.

With the current economic situation, Connecticut Democrats suggested focusing on "eliminating waste and inefficiency in state government before vital programs are slashed." And with the largest budget, DSS's finances are "the most complex and least transparent area of our budget," said Looney.

Wyman said the DSS audit "really should have been done probably years ago. It's a hard department to get your hands around."

Areas Democratic leaders want Wyman to focus on include the following:

◆ ***Carryforwards***— In 2008 DSS asked to carry forward more than $100 million, the vast majority in retroactive Medicaid payments and rate increases that DSS owes providers. The leaders are requesting "better answers as to why this large amount of money is carried forward."

◆ ***Multiple changes in HUSKY*** — There have been recent changes to the Healthcare for UninSured Kids and Youth (HUSKY) program that have resulted in unknown costs to the program and the state, said the

leaders. These include contracts with managed care organizations which were "abruptly terminated" by Gov. Jodi Rell (R) in November 2007; the move to a fee-for-service model; and moving HUSKY clients back to managed care.

◆ ***COHP/HUSKY start-up*** — The undertaking of Charter Oak Health Plan (COHP), which is linked to HUSKY, is seen by Democratic leaders as a "major new undertaking for DSS." They have requested that Wyman assess the costs associated with the startup of the program.

◆ ***Dollars appropriated for programs that are not or partially implemented*** — Democratic leaders contended that DSS does not consistently start important programs in a timely manner or fund community programs as directed. Areas cited include disease management, primary care case management and medical interpreting services.

DSS Has Issues With UHY

Wyman said that Urban Hacker Young International Ltd. (UHY) will perform the audit.

According to Starkowski, UHY Advisors, affiliated with UHY, represents two service providers who have rate appeals before DSS and is on record as representing 41 other private providers at DSS. In a letter to Wyman, he called this an "obvious and blatant conflict of interest." Since UHY would be looking at DSS records, logs, financial statements and other documents, Starkowski said it is "highly inappropriate" and a "gross conflict of interest" for UHY to have access to this information while representing private clients.

Starkowski told Wyman that DSS "will fully cooperate" with the auditor, but stressed that it "should be a fair and objective review, with no financial or other interest on the part of the auditor."

Specific reasons given by DSS as to why it says UHY should not conduct the audit include:

◆ Professional audit firms should have a single purpose when auditing an entity, not multiple interests.

◆ Nursing-home expenses and rate setting have a major effect on DSS's budget and would likely be a major area that is reviewed by any outside audit firm.

◆ UHY would have a perceived ability to leverage DSS on rate-setting appeals involving taxpayer dollars, and there is a potential for attempted undue influence on DSS decisions because of the powerful position of an auditor.

◆ Use of UHY would "open the door" for complaints by other health care providers that UHY clients have an unfair advantage.

◆ There is a potential for business gain by UHY if additional health care providers retain the organization because of an audit relationship with DSS.

◆ This would put DSS in an "untenable position" because its rate-setting decisions regarding UHY clients could be questioned.

DSS spokesperson David Dearborn tells *MCN* that the state comptroller's office has not responded to DSS as of yet.

Visit www.ct.gov/ag. Contact Dearborn at david.dearborn@ct.gov. ✧

Whistle-blower Suits Result in Big Recoveries for States, Plaintiffs

Cephalon, Inc. and Walgreen Co. have both entered into settlements stemming from whistle-blower lawsuits alleging health care fraud. Not only do the whistle-blowers stand to receive large amounts of money, but the states involved in the suits also are in line to recoup millions of dollars.

Walgreen Co. entered into a settlement last month to resolve Medicaid billing issues and allegations involving Medicaid claims. The company has agreed to pay $9.9 million to the feds and four states — Florida, Massachusetts, Michigan and Minnesota to settle allegations that it improperly billed Medicaid for medications dispensed to beneficiaries who also had private health insurance.

The settlement stems from a whistle-blower suit brought by two pharmacists in Minneapolis. Under the settlement, the two will receive a combined $1.44 million. Under the federal False Claims Act (FCA), private individuals can bring *qui tam* actions for fraud on behalf of the United States and collect a share of any proceeds recovered. Moreover, under many state FCAs, private individuals can also bring actions for fraud on behalf of those states and receive a share of the proceeds. Under 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. In this particular case, Pennsylvania does not have a state FCA.

According to the Department of Justice (DOJ), Walgreen charged the Medicaid programs in the four states the difference between the amount that private insurers paid for the medications and the amount that the programs would have paid for beneficiaries who did not have private health insurance. However, Walgreen can bill Medicaid programs only for the amount of copayments for medications dispensed to beneficiaries who also have private health insurance, DOJ said.

Walgreen spokesperson Michael Polzin, tells *MCN* that the billing errors were "inadvertent" and stemmed from the "unique requirements when Medicaid is billed as a secondary insurer." This "resulted in both underbillng and overbilling," he says.

Walgreen has "already changed our system to comply with these…billing procedures, and we've also added training in these states to ensure those procedures are followed," Polzin says.

Cephalon Resolves Improper Sales Issues

Cephalon also completed a $443.9 million settlement last month with federal and state agencies relating to allegations of improper sales and marketing practices for the medications Actiq, Provigil and Gabitril. The allegations against Cephalon resulted from whistle-blower lawsuits filed by four former employees. These employees alleged that Cephalon promoted the drugs for uses that the FDA had not approved.

Under the settlement, which was first disclosed in November 2007, Cephalon agreed to plead guilty to one misdemeanor count of violating the U.S. Food, Drug and Cosmetic Act, pay $40 million in criminal fines and $10 million to be applied as "substitute assets to satisfy forfeiture obligation," according to DOJ.

Cephalon also agreed to pay $375 million to settle False Claims Act (FCA) allegations, with the majority of the money going to Medicaid, which covered the cost of many of the prescriptions. The company also will pay $6.15 million to Connecticut and $700,000 to Massachusetts. Other state Medicaid programs receiving money are California, Delaware, Florida, Hawaii, Illinois, Louisiana, Nevada, New Hampshire, New Mexico, Texas, Tennessee, Virginia and the District of Columbia.

The whistle-blowers who brought the suit in federal court for the Eastern District of Pennsylvania will share $46 million of the settlement.

The company also agreed to enter into a five-year corporate integrity agreement (CIA) with OIG that requires the company to report payments to physicians on its Web site, among other things.

In a prepared statement, Valli Baldassano, executive vice president and chief compliance officer, said the company cooperated with the government throughout the investigation. And the statement says it believes that its "existing compliance policies and procedures already address the majority of the requirements outlined in the CIA and that the strong compliance infrastructure now in place has improved the accountability of our employees and the transparency of our actions."

Maryland Nutritionist Is Given Three Years for Improper Coding

The owner and operator of a nutrition business was given a prison sentence and probation for improperly coding services on Medicaid claims, the Maryland Attorney General's Office said on Sept. 26.

Olusola Idowu was the owner of Healthy You Nutrition Services, LLC and was the entity's only nutritionist, state officials say. She is not a physician, but allegedly submitted bills to Medicaid managed care organization AMERIGROUP and private insurers using the billing code reserved for medical doctors who perform consultations, the state says. This is the highest-paying billing code, Maryland officials add. Idowu used the code for initial consultations for patients coming in for follow-up visits, the state says.

Idowu allegedly used the code "hundreds of times" between 2002 and 2006 to bill for services that she rendered. She allegedly submitted claims for 80-minute visits for patients, when she really saw them for 30 minutes or less, the state says. "The proper code for nutritional services performed by a nutritionist paid about $15 for a 15-minute session," says a prepared statement from the attorney general's office. "By billing fraudulently, Idowu received between $177 and $186 for as little as 15 minutes of services."

Idowu was charged with defrauding a state health care program, theft and submitting false/misleading information on Nov. 6, 2007. She was found guilty of all the charges by a jury in July and was sentenced to three years in prison and five years of probation on Sept. 16. She also was ordered to pay $178,000 in restitution, $107,000 of which goes to the Department of Health and Mental Hygiene, court records show. The remainder will go to private health insurers. Idowu also will not be permitted to own her own nutritionist business or work as a nutritionist unless she is employed by someone else, the state says.

An attorney representing Idowu could not be reached for comment. Idowu told a local newspaper that she is not guilty, but was working under a contract and followed that contract.

The CIA "generally reflects our current enhanced compliance program and adds additional requirements for monitoring, auditing and reporting related to our sales and promotional activities," said the company.

According to Cephalon, the company agreed to plead guilty to "a single misdemeanor count…[because] settling the federal investigation was in the best interest of our company and our shareholders."

Cephalon said it believes that its current compliance program "includes all of the elements of compliance guidance issued by [OIG]" and has "all of the salient components required by the CIA." Specifically, it noted that the company has a chief compliance officer, a compliance committee, a code of conduct, policies and procedures "specific to promotion and marketing, extensive training, monitoring and reporting programs, including a compliance hotline and disciplinary and corrective action processes." Moreover, Cephalon said it "elevated" the position of chief compliance officer to one reporting directly to the CEO.

In agreeing to send letters to physicians and publish the information on its Web site, Cephalon said it "supports transparency in financial relationships with physicians [and] has agreed to be among the first pharmaceutical companies to make the financial nature of those relationships available to the public."

Contact Polzin at Michael.polzin@walgreens.com. To access Cephalon's CIA, go to www.oig.hhs.gov/fraud/cia/index.html. ✧

N.Y. Hospital Settles Health Care Fraud Suit, Denies Liability

For the third time in nine years, Staten Island University Hospital (SIUH) has settled a billing fraud case with the government. The U.S. Attorney's Office for the Eastern District of New York said last month that SIUH— the largest hospital on Staten Island in New York City — agreed to pay $88.9 million to settle Medicaid, Medicare and TRICARE false claims allegations.

The settlement wraps up several different investigations of the hospital's billing practices, two of them launched by separate whistle-blowers. A 45-page, five-year corporate integrity agreement was also imposed on the hospital.

The hospital already had replaced its board once at the behest of the state attorney general. That may be the kind of crackdown boards will face more in the future as the government expects them to take a bigger role in compliance oversight, one expert says.

The hospital has agreed to pay New York state $14.8 million to settle the Medicaid false claims allegations, and to pay the federal government $74,032,565 to resolve the Medicare and TRICARE allegations.

In a prepared statement, SIUH says "these settlements do not reflect an admission of liability." In fact, the hospital says it "has already established and implemented a strong program for compliance and corporate integrity that were [sic] put into place while the investigations were ongoing."

Whistle-blower Alleged Fraudulent Billing

One part of the case began with a whistle-blower, Miguel Tirado, M.D., a former director of chemical dependency services at SIUH. His lawsuit alleged that the hospital had fraudulently billed Medicare and Medicaid for inpatient alcohol and substance-abuse detoxification. According to the U.S. attorney, between July 1, 1994, and June 30, 2000, the hospital billed Medicaid and Medicare for detox provided to patients in 12 beds that had no certificate of operation from the New York State Office of Alcoholism and Substance Abuse Services (OASAS). The hospital, however, had a license to operate 56 inpatient detox beds. New York state has a False Claims Act, so the hospital was liable under both federal and state laws for this alleged violation.

Another part of the settlement also allegedly triggered both Medicaid and Medicare false claims submissions. SIUH kept certain detox patients "in a locked, separate wing and concealed the existence of the wing from OASAS," the U.S. attorney contends. But the hospital still submitted claims for their care, the feds say.

At one point during this whole case, the New York Court of Appeals determined that one whistle-blower lacked standing to file a claim. According to the court, Carmel Reddington, a former employee of SIUH who coordinated medical services for international cancer patients, did not qualify as a health care services employee and could not bring suit under the state whistle-blower law. The judge held that "to be subject to the special protections of [the health care whistle-blower law] an employee of a health-care provider must 'perform health care services,' which means to actually supply health-care services, not merely to coordinate with those who do."

Reddington filed a lawsuit against the hospital in March 2004, alleging that she was fired for calling attention to questionable international patient recruitment practices.

It's *déjà vu* all over again for SIUH. In 2005, the hospital agreed to pay New York state $76.5 million to resolve allegations that it fraudulently overbilled Medicaid through inflated clinic charges. This began around the time that the hospital was wrapping up its 1999 settlement with the state attorney general (AG) for $45 million. The AG alleged in the first case that the hospital had

billed Medicaid for undelivered primary care services. "Rather than cutting excessive expenses and reforming managerial inefficiencies, the hospital embarked on additional billing and rate fraud," the complaint alleged.

So SIUH bought a network of 10 part-time clinics from a company called CHAPS Community Health Services Inc. As part-time clinics in underserved neighborhoods, they were eligible for two perks: much higher reimbursement under a special Medicaid program created to increase access to medical care in certain neighborhoods, and freedom from strict health and safety regulations imposed on regular, full-time clinics. Medicaid limited the operating hours to 60 a month, but reimbursement could be as much as eight times higher than regular Medicaid reimbursement.

The state AG sued the hospital for fraudulent business practice, fraud and intentional misrepresentation, unjust enrichment and overpayment of public funds.

Compliance Issues May Reflect on Board

Mark Pastin, president of the Council of Ethical Organizations in Alexandria, Va., says compliance officers and boards should take notice of the fact that at one point the state AG apparently forced SIUH to discharge its board and assemble a new one. "Wholesale replacement of a board is unprecedented," he says. Whenever there is a massive compliance failure, he asserts, "the logical conclusion is that the board did not delegate adequately responsibility for compliance" to someone in the organization, or it simply didn't address the issue of providing compliance oversight at all.

To avoid internal debacles, "boards need to understand the compliance officer is not like the truant officer. The compliance officer is actually them [i.e., their surrogate] — acting in the name of the board and acting on the delegated power to help the board exercise its responsibility for oversight of the entity."

Contact SIUH through spokesperson Arleen Ryback at (718) 226-2483 and Pastin at councile@aol.com. ✧

Medicaid Is Big Focus of Work Plan

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The Work Plan also serves as a blueprint for compliance monitoring because it's a litany of the government's perceptions of Medicaid and Medicare vulnerabilities. But OIG notes development of the document is a dynamic process, which means during the year OIG may add items or "delay or cancel lower-priority work."

There are some themes to the Medicaid items on the Work Plan. For one thing, OIG is applying the program-integrity savvy it has in certain classic Medicare problem areas to Medicaid. Here are the Medicaid Work Plan items that show OIG appears concerned about certain issues in Medicaid the same way it is in Medicare:

◆ ***Hospital outlier payments:*** OIG is reviewing Medicaid payments for hospital outliers, which are cases that generate extra payments because they cost so much to treat. The methodology some states use to calculate Medicaid outliers is similar to Medicare's methodologies. There's a history of Medicare vulnerabilities in claims for hospital outliers, so "we will determine whether similar vulnerabilities exist in Medicaid state agencies' methods of computing inpatient hospital cost outlier payments." Medicare outlier payments have been a major risk area. A number of hospitals have settled false claims cases for allegedly inflating charges to trigger outlier payments.

◆ ***Disproportionate share payments (DSH):*** OIG plans to review the Medicaid inpatient utilization rate used to decide eligibility for Medicaid DSH payments. The Social Security Act (SSA) requires hospitals to have a Medicaid inpatient utilization rate of not less than 1% before being declared eligible to collect Medicaid DSH payments. "We will examine the appropriateness of this threshold and, if appropriate, recommend changes to the program," OIG states. In another Medicaid DSH review, OIG will determine "the magnitude of federal DSH funding being used to pay for the cost of uncompensated care provided to individuals aged 21 to 65 residing in institutions for mental diseases."

◆ ***Credit balances*** (Medicaid and Medicare): OIG will review hospitals, labs and other providers for overpayments in the form of credit balances. Providers have to determine when they have received more money from Medicaid or Medicare than they are entitled to, and then return it (according to the SSA and other laws). "Prior OIG work has identified Medicare/Medicaid overpayments in patient accounts with credit balances," OIG states.

◆ ***Potentially excess Medicaid payments for inpatient and outpatient services:*** OIG will review state controls to detect potentially over-the-top payments to institutional providers. The SSA lets CMS adjust payments to states based on states' overpayments and underpayments to providers. OIG is concerned because its work in the Medicare arena has found that many overpayments to hospitals for inpatient and outpatient services resulted from incorrect diagnosis, admission, discharge, HCPCS and procedure codes, as well as inaccurate charges and number of units billed. Now it's turning to Medicaid. " We will determine

whether similar vulnerabilities exist in state agencies' controls for detecting potentially excessive Medicaid payments," OIG notes.

Vernaglia says this item represents the OIG stepping in to see if the states are doing adequate oversight, or whether "they are so overwhelmed and so underfunded that they aren't doing enough fraud prevention and detection. States don't have the resources of the federal government. By OIG's own admission, the feds catch a small percentage of fraud and abuse. If the feds can't do it with all their resources, how are the states going to successfully manage their programs?"

Quality of care is another concern underlying some items in the 2009 Work Plan, Vernaglia says. He notes it was interesting that OIG released the Work Plan — which has a number of quality-related items — a day after it unveiled its supplemental compliance-program guidance for nursing facilities, which emphasizes quality of care in its risk areas.

For example, one Work Plan target is ownership structures at investor-owned nursing homes. Private equity or other for-profit investors are buying more and more nursing facilities. OIG says its prior reviews have shown this triggers a "complex web of ownership that essentially left the operators of the nursing facility with no assets. Determination of which entity is legally liable for patient care can be made difficult because of the ownership structure," OIG says. On top of that, sometimes new owners have cut back staff "and take other cost-cutting measures that increase profit at the expense of quality of care."

Another quality-related item focuses on plans of care in nursing homes and whether they are using the minimum data set and resident assessment protocols required by the federal government. These tools are designed to ensure nursing home residents receive proper care. Previous OIG reports found that about 25% of residents' needs were not reflected in their care plans.

Providers Should Prioritize Items

When looking through the Work Plan, one compliance officer interviewed advises looking at the bottom of each item to get a sense of where it fits in the scheme of OIG things. Is it a work in progress? A "new start"? Which office is in charge of the review — audit services or evaluations and inspections? "Compare what's new and what are ongoing projects," says the compliance officer, who asked not to be identified. "We look at the status of the coding at the bottom of the [item], which group got it, when the project was assigned or started and when the issue date is because these are prioritized, and some things never get done vs. some things about to be released."

Another compliance officer says he too studies the numbers at the bottom of the Work Plan items to see the status of the item and which arm of OIG will work on it. Then the compliance officer, who also asked not to be named, determines if the issue is applicable to his organization. If so, he develops a Work Plan assessment, which means pulling the regulations that reference the policy and getting feedback from relevant people in his organization on whether it's a high risk, moderate risk or low risk. If it's a high risk, the Work Plan item will get a special spot on the organization's risk assessment.

Medicaid Security Is One Focus

Here are some other items, and comments on their inclusion in the Work Plan:

◆ ***Information systems and data security:*** There are 11 items that tackle Medicaid or Medicare security or Medicaid/Medicare security jointly. Most are new starts. These include the ongoing review of CMS's oversight and enforcement of the HIPAA security rule, a new review of security of portable devices containing personal health information at hospitals and contractors, a new review of CMS's oversight of business associates of Medicaid claims-processing contractors and a new review of state controls of Web-based applications that let Medicaid providers submit claims electronically. "This is a good sign" given the extent of security and privacy breaches in the privacy sector, Vernaglia says.

◆ ***Managed care waivers:*** A number of Work Plan items address waivers, which allow states to skip certain Medicaid requirements as part of an overall plan to expand services, sometimes to a specific segment of enrollees. Vernaglia says OIG is chasing managed care plans through waivers. OIG wants to see if states that filed for waivers kept their promises," he says. "Providers have an odd alliance with OIG when the state Medicaid plan makes promises to the government through the waiver submission but then doesn't follow through, Vernaglia says. Sometimes providers take the state to court, such as in *Health Care for All v. Romney*, No. 00-CV-10833-RWZ (Feb. 3, 2006). In that case, advocates sued the state of Massachusetts because Medicaid paid so little to dentists under a waiver that children couldn't get services, he says. A federal judge agreed that the state violated federal requirements and risked federal financial participation.

Contact Vernaglia at lvernaglia@foley.com. Visit Government Resources at the Compliance Channel at www.AISHealth.com; click on OIG Work Plan. ✧

Self-Assessment Worksheet May Help Providers With Medicaid Audits

The New York state Office of Alcoholism and Substance Abuse Services (OASAS) provides clinical supervisors and program directors of chemical dependence outpatient services and outpatient rehabilitation services with a Medicaid Billing Self-Assessment tool — a voluntary risk management tool designed to assist them in a periodic assessment of their Medicaid patients' case record documentation. Use of this tool should improve case record documentation procedures and practices and minimize potential Medicaid audit disallowances, OASAS says. Following is an excerpt of the assessment tool instructions. These worksheets do not need to be submitted to OASAS and may be helpful for other types of providers to adapt.

Sample Selection — provided as a guide for selecting the records sample to undergo a self-assessment.		
Step #1	**Medicaid Billing Frequency**	**Sample Sources**
	Monthly	Medicaid remittance statement for the last month billed
	Semi-Monthly	Two remittance statements for the last month billed
	Weekly	Four remittance statements for the last month billed
Step #2	**Using the Medicaid remittance statements selected in Step #1**	
	Total number of paid dates of service from the remittance service multiplied by 10% equals paid dates of services sample size.	
Step #3	**Using the following criteria, select a sufficient number of specific paid dates of service from the remittance statements selected in Step #1, totaling the sample size determined in Step #1.**	
	Pick paid dates of service from as many different patients as possible.	
	Pick paid dates of service from as many different primary counselors as possible.	
Worksheet Instructions — For each of the paid dates of service in the selected sample, complete the following information on the Self-Assessment Worksheet.		
Medicaid recipient I.D. and patient I.D.		
Paid service date		
Level of care determination		
Date of admission		
Evaluation/assessment —Was a comprehensive evaluation or assessment done within appropriate regulatory time frames?		
Admission criteria — Does patient meet applicable admission criteria, including having a qualifying diagnosis?		
Individual treatment plan — Was an individual treatment plan developed for the patient by the primary counselor or therapist and reviewed and approved by a multidisciplinary team?		
Date of treatment plan		
Within required time — Was the individual treatment plan signed by all members of the multidisciplinary team within 30 days of the patient's admission?		
Physician signature		
Within required time — Was the individual treatment plan signed by the physician within seven days of the multidisciplinary team's review and approval?		
Treatment plan review —Was treatment plan reviewed and updated at least every 90 calendar days from the date of development?		
Attendance notes — Do attendance notes document date of service, type of service and duration of service?		
Progress notes for all visits		
Adequacy of notes — notes must be written, signed and dated; provide a chronology of the patient's progress; delineate the course and results of treatment; indicate patient's participation in all significant services; and fully document the content and/or outcome of all visits.		
Type of visit		
Sufficient individual visits		
Group counseling session of 15 or fewer people		
Duration of visit indicated		
Duration of visit adequate		
Treatment according to plan		
Score — Enter a "1" in the score column if an "N" is indicated in one or more columns for the reviewed paid service date; enter a "0" in the score column if a "Y" is indicated in all of the columns for the reviewed paid service date.		
Deficiency rate — Divide the total score by the total number of paid service dates reviewed in the sample to determine the deficiency rate.		
Corrective action on self-assessment results — providers should take corrective action as soon as possible in regard to all deficiencies uncovered. This may include implementing improved case record documentation procedures and practices to address systematic problems and/or provision of additional training to clinical staff on case record documentation requirements.		
SOURCE: Medicaid Billing Self-Assessment tool, New York Office of Alcoholism and Substance Abuse Services, June 2007		

STATE MEDICAID COMPLIANCE NEWS

◆ **A St. Lucie, Fla.-based home health care provider was arrested Oct. 2 on charges of stealing more than $4,000 from the state's Medicaid program,** said the Florida attorney general's office. Johnny Thomas allegedly billed the state for treatments that juvenile Medicaid recipients never received, according to state Attorney General Bill McCollum (R). Investigators said they received information from a parent of one of the Medicaid recipients alleging that Thomas offered money to parents in exchange for allowing him to bill Medicaid on their behalf, but specifically informed them that once he began paying them, he would no longer treat their children. Thomas was charged with grand theft. If convicted, he faces up to five years in prison and a fine of $5,000. No attorney for Thomas could be ascertained. Visit www.myfloridalegal.com/.

◆ **In response to an article appearing in last month's issue *(MCN 9/08, p. 4)* regarding accusations of fraud against Florida's Medicaid Fraud Control Unit, Sandi Copes, spokesperson for the Florida attorney general's office, tells *MCN*** that "the issue referenced in this article occurred several years ago." Since that time, she says, OIG "has reviewed the Medicaid Fraud Control Unit's policies and has approved them with no further issues having been found." Moreover, "the auditor general's review from last year did not find any hint of falsifications [or] improper activity," Copes says. Contact Copes at (850) 245-0150.

◆ **The owner of a Florence, S.C.-based medical transport services company was recently sentenced to 30 months in prison for health care fraud,** according to South Carolina U.S. Attorney Walter Wilkins. Nathaniel Wilson, the owner of Wilson Transport Services, pleaded guilty to inflating the mileage the company charged for ambulance and wheelchair van transportation and billing Medicaid and Medicare for the same transportation of the same patient. In addition to the prison sentence, Wilson was also ordered to pay $637,669.77 in restitution, according to the U.S. attorney's office. Go to www.usdoj.gov/usao/sc/LivePressReleases/wilson%20transport%20press.pdf.

◆ **South Dakota awarded a contract to CNSI Inc., a Rockville, Md.-based company, to replace the state's 30-year old legacy Medicaid Management Information System** with a Web-based platform. CNSI has developed an eCAMs solution, which features Web-based architecture and rules engine-based processing and is aligned with the Medicaid Information Technology Architecture framework. Visit www.cnsi-inc.com.

◆**A manager of a massage therapy business was arrested for allegedly attempting to scam Medicaid by submitting hundreds of dollars in false insurance claims,** according to the Louisiana attorney general's office. Elecia Crain, manager of Folsom, La.-based Natural Touch, was arrested on three counts of Medicaid fraud and three counts of filing or maintaining false public records. "The suspect allegedly submitted false claims for payment to the Medicaid program," the attorney general's office said in a prepared statement. She faces up to 15 years in prison and $60,000 in fines if convicted on the fraud charges. A spokesperson for Natural Touch declined to comment. Go to www.ag.louisiana.gov/.

◆ **The owner of a home health agency allegedly submitted 1,069 false claims for more than $1.2 million in reimbursement to the Virginia Department of Medical Assistance Services from October 2006 through March 2008,** according to the Virginia attorney general's office. After pleading guilty, Hawa Weller-Pace, owner of Alexandria, Va.-based Charity Home Care, was sentenced to 25 months in prison and three years supervised release and ordered to pay $877,342 in restitution. According to court documents, Weller-Pace forged the signatures of registered nurses on patient records and falsely claimed payment for services that were not properly rendered or never rendered. Visit www.usdoj.gov/usao/vae/press.html.

◆ **The Florida attorney general's office sued Merck & Company, Inc. on behalf of Florida state agencies damaged by the company's alleged deceptive marketing and promotion of the drug Vioxx.** According to the lawsuit, the company's repeated failure to disclose the adverse effects of Vioxx while offering it to the state's Medicaid program as a safe painkiller directly violates Florida's Deceptive and Unfair Trade Practices Act. The lawsuit demands restitution to Florida, plus interest, for all payments — including Medicaid reimbursements — made for Vioxx prescriptions. It also seeks civil penalties of up to $10,000 per violation of the law. Go to www.myfloridalegal.com/.

NEWS BRIEFS

◆ **CMS has awarded a Medicaid Integrity Program (MIP) task order to Health Management Systems (HMS)** under which it will examine payments to providers in an effort to identify overpayments made as result of fraud, waste and abuse. HMS will perform this task in the Dallas Jurisdiction, which consists of Arkansas, Colorado, Louisiana, Montana, New Mexico, North Dakota, Oklahoma, South Dakota, Texas, Utah and Wyoming. Go to www.hmsy.com.

◆ **CMS issued a final rule providing guidance to states that want to administer self-directed personal assistance services (PAS) through their state plans (73 Fed. Reg. 57854).** Under the Deficit Reduction Act, states may allow beneficiaries, through an approved self-directed services plan and budget, to purchase PAS. States may provide, as medical assistance, payment for part or all of the cost of the self-directed PAS if they have determined that if not for the assistance, a beneficiary would require and receive personal care services under the state plan or home and community-based waiver services. Medicaid payments for room and board are expressly prohibited. Visit http://edocket.access.gpo.gov/2008/pdf/E8-23102.pdf.

◆ **The HHS Office of Inspector General (OIG) issued a follow-up audit (A-02-07-01055) of New York's Medicaid drug rebate program, finding that the state implemented all recommendations from a previous audit** and has established controls that greatly improved the overall operation of the program. "The state agency is developing improvements to its system to address outstanding or disputed rebates for the period Jan. 1, 1991, through March 31, 1999," OIG said. Go to www.oig.hhs.gov/oas/reports/region2/20701055.asp.

◆ **OIG issued a follow-up audit (A-07-08-03108) of Colorado's Medicaid drug rebate program, finding that the state agency partially corrected weaknesses reported in the prior audit.** The follow-up audit found that the state reported $1.8 million in federal drug rebates for family planning and a state-funded program based on estimated, not actual, expenditures, the state agency did not report $45,000 in interest, the agency had $862,000 in outstanding disputes that were more than three years past due for resolution with manufacturers, it did not report all necessary data relating to its Medicaid drug rebate program, and it had not collected rebates for single-source drugs administered by physicians since June 30, 2007. OIG recommended that the state continue to work with CMS to finalize a refund to the feds; work with CMS to determine the actual amount in drug rebates from the current audit period that related to the Medicaid program, family planning, and the Old Age Pension program; refund to the feds the share of interest that was received but not reported; develop policies and procedures to actively report Medicaid drug rebate activity including reporting beginning balances, adjustments, and ending balances on Form CMS-64.9R; and develop policies and procedures for invoicing single-source physician-administered drug rebates and resume invoicing drug rebates on single-source drugs administered by physicians. Colorado concurred with all of OIG's recommendations and discussed implementation of those recommendations and corrective actions proposed. Visit www.oig.hhs.gov/oas/reports/region7/70803108.htm.

◆ **CMS granted Massachusetts a three-year, $10.6 billion Medicaid waiver to allow the state to continue its health insurance law.** The previous waiver expired June 30. The new waiver allows the state to maintain income eligibility for subsidized health coverage to residents with annual incomes up to 300% of the federal poverty level and spend $5 billion over the next three years on new programs. Go to www.cms.hhs.gov/medicaidstwaivprogdemopgi/mwdl/ItemDetail.asp?ItemID=CMS042959.

◆ **OIG recently issued supplemental compliance program guidelines for nursing facilities to address Medicaid and Medicare fraud and abuse problems related to poor quality of care, billing and kickbacks.** The updated guidance includes new risk areas for such facilities, including comprehensive care plans, sufficient staffing, appropriate medication management and resident safety. According to OIG, the guidance emphasizes the importance of submitting accurate claims and urges nursing facilities to consider the risks of improper kickbacks. View the guidance at http://oig.hhs.gov/fraud/docs/complianceguidance/nhg_fr.pdf.

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