

GETTING SERIOUS ABOUT
MEDICAID COMPLIANCE:
SECTION 6402 OF PPACA AND
THE DUTY OF DISCLOSURE OF
"IDENTIFIED" OVERPAYMENTS
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JAMES G. SHEEHAN
NEW YORK MEDICAID INSPECTOR GENERAL
James.Sheehan@OMIG.NY.GOV
518 473-3782

OMIG WEBINARS-FULFILLING OMIG'S SECTION 32 DUTY-

- "17. to conduct educational programs for medical assistance program providers, vendors, contractors and recipients designed to limit fraud and abuse within the medical assistance program"
- These programs will be scheduled as needed by the provider community. Your feedback on this program, and suggestions for new topics are appreciated.
- Next program: Compliance with Medicaid third party billing and payment obligations-AUGUST 18, 2010

Limiting fraud and abuse within the program

- “Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.” 42 CFR 455.2-similar provision in state regulations 18 NYCRR 515.1 (b)
- “Abuse” does not require intentional conduct-it is measured by objective measures
 - Medically unnecessary care
 - Care that fails to meet recognized professional standards
 - “provider practices that are inconsistent with sound fiscal . . .practices”
 - no accounts receivable transaction reports (capturing accounting treatment of amounts billed to and paid from multiple payors)
 - failing to bill other payors

THE MARCH 2010 PPACA (Obamacare) AND THE MAY 2009 FERA (False Claims Act Amendments)

- PPACA = Patient Protection and Affordable Care Act -On March 23,2010 President Obama signed into law H.R. 3590, PPACA.
- FERA = Fraud Enforcement and Recovery Act, signed by the President in May, 2009.

THE THREE MOST IMPORTANT MEDICAID INTEGRITY PROVISIONS OF PPACA

- MANDATORY REPORTING, REPAYMENT, AND EXPLANATION OF OVERPAYMENTS BY "PERSONS"
- RETENTION OF OVERPAYMENT BEYOND 60 DAYS IS A FALSE CLAIM (invokes penalties and whistleblower provisions)
- MANDATORY COMPLIANCE PLANS (first in nursing homes, later in other providers)

THE CURRENT STATE OF MANDATED COMPLIANCE

- CORPORATE INTEGRITY AGREEMENTS (US HHS-OIG)-early 1990s
- MANDATED COMPLIANCE DISCLOSURES FOR NON-PROFITS ON IRS 990 (2008) (not required to have compliance standards on conflicts, disclosure, etc. only to report whether you do)
- MANDATED COMPLIANCE PROGRAMS FOR MEDICARE ADVANTAGE AND PART D (CMS-2009) (72 FR 68700 and program memos)
- MANDATED COMPLIANCE PROGRAMS FOR FEDERAL CONTRACTORS (2009) (FAR 52.203-13) (reporting of “significant overpayment(s)” on the contract)
- MANDATED “EFFECTIVE” COMPLIANCE PROGRAMS FOR NY MEDICAID PROVIDERS-(New York OMIG 2009) (18 NYCRR 521)
- MANDATED REPAYMENT OF MEDICARE AND MEDICAID OVERPAYMENTS (PPACA Section 6402 (2010))
- MANDATED COMPLIANCE PROGRAMS FOR NURSING HOMES AND SOME OTHER HEALTH PROVIDERS-Patient Protection and Affordable Care Act Sections 6102, 6401 (2013 for nursing homes)

PPACA SECTION 6402 MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS

- *“(d) REPORTING AND RETURNING OF OVERPAYMENTS—*
- *“(1) IN GENERAL — If a person has received an overpayment, the person shall—*
- *“(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and*
- *“(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.*

RETURNING OVERPAYMENTS IN NEW YORK TO THE MEDICAID PROGRAM

- Report and return the overpayment *to the State* at the correct address
- In New York, overpayments should be returned, reported, and explained to OMIG
- OMIG's correct address:
- Office of the Medicaid Inspector General,
800 North Pearl Street, Albany, New York
12204

VOIDS AND SMALL OVERPAYMENTS

- Providers may use void process through CSC (the eMedNY claims system) for smaller or routine claims. A void is submitted to negate a previously paid claim based upon a billing error or late reimbursement by a primary carrier.
- Overpayments of smaller or routine claims which cannot be attributed to billing error or late reimbursement by a primary carrier should be reported to CSC in writing. These should include known mistakes in CSC or DOH billing and payment programs.
- eMedNY call center: 1-800-343-9000, M – F, 7:30 am – 6:00 pm; email: HIPAADESK3@csc.com
- See <http://www.emedny.org/provider> manuals for instructions on submission of voids.

WHAT IS AN "OVERPAYMENT"?

- "(B) OVERPAYMENT—The term "overpayment" means any **funds** that a **person** receives or retains under title XVIII (Medicare) or XIX (Medicaid) to which the person, after applicable reconciliation, is **not entitled** under such title"
- "**funds**" not "**benefit**"

WHAT IS "NOT ENTITLED"?

- KICKBACK
- STARK
- ELIGIBILITY
- CONDITIONS OF PAYMENT

WHAT IS "APPLICABLE RECONCILIATION"?

- No definition in statute
- Interim payments prior to cost report based payment determinations
- reconciliations related to Medicaid best price determinations for prescription drugs
- CMS 838 – quarterly report of Medicare credit balances

WHO MUST RETURN THE OVERPAYMENT?

- A “person” (which includes corporations and partnerships) who has “received” or “retained” the overpayment
- Focus on “receipt”; payment need not come directly from Medicaid; if “person” “retains” overpayment due the program, violation occurs
- “person” includes a managed care plan or an individual program enrollee as well as a program provider or supplier
- Is a state agency a “person”? Vermont v. US 529 U.S. 765 (2000); is local government a state agency? Cook County v. US 123 S. Ct. 1239 (2003)

WHEN MUST AN OVERPAYMENT BE RETURNED?

- PPACA 6402(d)(2)
- An overpayment must be reported and returned . . .by the later of -
- (A) the date which is 60 days after the date on which the overpayment was **identified**; or
- (B) the date on which any corresponding cost report is due, if applicable

WHEN IS AN OVERPAYMENT “IDENTIFIED”?

- “identified” for an organization means that the fact of an overpayment, not the amount of the overpayment has been identified. (e.g., patient was dead at time service was allegedly rendered, APG claim includes service not rendered, charge master had code crosswalk error)
- Compare with language from CMS proposed 42 CFR 401.310 overpayment regulation 67 FR 3665 (1/25/02 draft later withdrawn)
 - “If a provider, supplier, or individual identifies a Medicare payment received in excess of amounts payable under the Medicare statute and regulations, the provider, supplier, or individual must, within 60 days of identifying or learning of the excess payment, return the overpayment to the appropriate intermediary or carrier.”

WHEN IS AN OVERPAYMENT “IDENTIFIED”?

- Employee or contractor identifies overpayment in hotline call or email
- Patient advises that service not received
- RAC advises that dual eligible Medicare overpayment has been found
- OMIG sends letter re deceased patient, unlicensed or excluded employee or ordering physician
- *Qui tam* or government lawsuit allegations
- Criminal indictment or information

WHAT IF THE IDENTIFICATION OF AN OVERPAYMENT (by an employee, contractor, patient or OMIG) IS WRONG?

- That is why the statute gives providers 60 days to report after the identification
- Need for internal review and assessment
- No obligation to report allegation if your investigation shows it is inaccurate
- BUT - risk is on provider who decides not to report

THE OBLIGATION TO RETURN AN IDENTIFIED OVERPAYMENT IS CONTINUING

- CRITICAL DATE: WHEN WAS THE OVERPAYMENT IDENTIFIED
- NOT: WHEN WAS THE OVERPAYMENT RECEIVED
- CONTINUING DUTY TO REPAY IDENTIFIED OVERPAYMENTS FROM PRIOR TIME PERIODS

WHAT DOES “the date on which any corresponding cost report is due, if applicable” MEAN?

- OMIG View: This section is designed to deal with providers whose payments are made on an interim basis but not finalized until after the submission of the cost report and cost report reconciliation.
- What about claim-based payment by cost reporting providers?
 - Nursing home submits claim and receives per diem payment for deceased patient
 - Could still be false claim but not based on improper retention theory

REDUCED PROTECTION FROM LIMITATIONS PERIODS

- WHAT EFFECT ON STATUTE OF LIMITATIONS: UNDER FEDERAL AND STATE FALSE CLAIMS ACTS, STATUTE OF LIMITATIONS RUNS FROM 60 DAYS AFTER DATE OF IDENTIFICATION, NOT DATE OF CLAIM OR DATE OF PAYMENT
- CREDIT BALANCE TRANSFERS AS "CONCEALMENT" UNDER FERA-STATUTE OF LIMITATIONS NEVER RUNS? "knowingly conceals" or "knowingly and improperly avoids or decreases an "obligation"

DOCUMENTING GOOD FAITH EFFORT TO IDENTIFY OVERPAYMENTS

- Create a record to demonstrate to the government that your organization collected or attempted to address allegations of overpayments
 - Develop standard form to document employee's internal disclosure
 - Document interviews
 - Document evidence and means to determine if credible
 - Record employees involved in deliberations and decisions

PROVIDER MUST STATE THE REASON FOR OVERPAYMENT

- Notify the State to whom the overpayment was returned in writing of the reason for the overpayment
- Use OMIG's Disclosure Protocol, available on the OMIG web site, www.OMIG.ny.gov
- COMPARE WITH PA 2010 Self-Audit Protocol:
<http://www.dpw.state.pa.us/omap/omapfab.asp>
- COMPARE WITH NJ Self-Disclosure Process www.nj.state.us/njomig
- Mass., Ct. do not yet have disclosure protocols
- COMPARE WITH federal OIG Self-Disclosure Protocol
<http://oig.hhs.gov/authorities/docs/selfdisclosure.pdf>
- COMPARE WITH CMS "unsolicited/voluntary refunds" to Medicare contractors (checked July 2, 2010)
- See, e.g., <http://www.wpsmedicare.com>

SOME REASONS FOR OVERPAYMENTS

- Payment exceeds the usual, customary or reasonable charge for the service.
- Duplicate payments of the same service(s).
- Incorrect provider payee.
- Incorrect claim assignment resulting in incorrect payee.
- Payment for non-covered, non-medically necessary services.
- Services not actually rendered.
- Payment made by a primary insurance.
- Payment for services rendered during a period of non-entitlement (patient's responsibility).

MORE REASONS FOR OVERPAYMENTS

- Failure to refund credit balances
- Excluded ordering or servicing person
- Patient deceased
- Servicing person lacked required license or certification
- Ordering provider deceased more than six months prior to date of service
- Billing system error

MORE REASONS FOR OVERPAYMENTS

- Service induced by false statement of ordering provider
- Service inconsistent with physician order or treatment plan
- Service not documented as required by regulation
- No order for service
- Service by unenrolled provider “billing through” enrolled provider

WHAT ABOUT "OVERPAYMENTS" RESULTING FROM "PURE" STARK VIOLATIONS? OMIG WILL DEFER TO CMS/OIG DISCLOSURE PROTOCOL

- §6409, "Medicare Self-Referral Disclosure Protocol": HHS, in conjunction with OIG, must establish a self-disclosure protocol for 'pure' Stark Law violations that will detail:
 - Instruction on to whom self-disclosures will have to be made
 - Implications that self-disclosures will have on CIAs and CCAs
 - How HHS will consider repayment in amounts less than claims made, based on:
 - Nature and extent of improper or illegal practice
 - Timeliness of self-disclosure
 - Cooperation in providing information related to self-disclosure
 - Other factors

CONSEQUENCES OF FAILURE TO REPORT

- *PPACA 6402(d)(3) "ENFORCEMENT" — Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an **obligation** (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title. (False Claims Act)*
- False Claims Act imposes liability for a person who "knowingly conceals or knowingly and improperly avoids or decreases an **obligation** to pay or transmit money or property to the Government" **new** 31 U.S.C. 3729(a)(1) (G) added by FERA
- "knowingly" includes reckless disregard, deliberate ignorance
- An overpayment which is timely reported and explained will not give rise to FCA liability even if the provider is unable to repay it within 60 days, unless there is evidence of improper "avoidance"

SEC. 6402 (d) MEDICARE AND MEDICAID PROGRAM INTEG- RITY PROVISIONS

- *“(4) DEFINITIONS — In this subsection:*
- *(A) KNOWING AND KNOWINGLY — The terms “knowing” and “knowingly” have the meaning given those terms in section 3729(b) of title 31, United States Code.*
- *(B) OVERPAYMENT — The term “overpayment” means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.*

GOVERNMENT IS USING DATA TO DETECT OVERPAYMENTS

- EXCLUDED PERSONS
- DECEASED ENROLLEES
- DECEASED PROVIDERS
- CREDIT BALANCES
- WHAT IS GO-BACK OBLIGATION WHEN PROVIDER IS PUT ON NOTICE THAT SYSTEMS ARE DEFICIENT?

"OVERPAYMENT" INCLUDES:

- PAYMENT RECEIVED OR RETAINED FOR SERVICES ORDERED OR PROVIDED BY EXCLUDED PERSON "no payment will be made by Medicare, Medicaid or any of the other Federal health care programs for any item or service furnished by an excluded individual or entity or at the medical direction or on the prescription of a physician or other authorized individual who is excluded . . ." 42 CFR 1001.1901

DOES "OVERPAYMENT" INCLUDE:

- PAYMENT "RECEIVED OR RETAINED" FOR SERVICES WHERE ORDER FOR SERVICES INDUCED BY KICKBACK
- DRUG REBATES? (*"after applicable reconciliation"*)
- PAYMENT INDUCED BY OFF-LABEL MARKETING INVOLVING FALSE STATEMENT OR OMISSION OF KNOWN SAFETY RISKS (SYNTHESES THEORY)?

"OVERPAYMENTS" INCLUDE:

- INACCURATE COST REPORTS
- NEVER EVENTS NOT REPORTED
- TRANSFER/DISCHARGE
- PRESENT ON ADMISSION INACCURATE REPORTING
- DISCHARGE/READMIT WITHIN 30 DAYS (UNTIL 2011)
- DRUGS BILLED FOR INPATIENTS AS IF OUTPATIENTS
- MISCHARGED 340B DRUGS

SEC. 6402 (d) MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS

- *(2) DEADLINE FOR REPORTING AND RETURNING OVERPAYMENTS — An overpayment must be reported and returned under paragraph (1) by the later of—*
 - *(A) the date which is 60 days after the date on which the overpayment was identified; or*
 - *(B) the date any corresponding cost report is due, if applicable*

PPACA SECTION 6402 (d) MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS

- *(3) ENFORCEMENT — Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title. (False Claims Act)*

SEC. 6402 (d) MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS

- *“(g) In addition to the penalties provided for in this section or section 1128A, a claim that includes items or services resulting from a violation of this section (i.e., a kickback) constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31, United States Code.” (False Claims Act)*

SEC. 6402 (d) MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS

- *WHERE:*
- *“the State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of section 1862(o) and this subparagraph, unless the State determines in accordance with such regulations there is good cause not to suspend such payments”*
- *CMS may recover payments from state*
- *SIGNIFICANT CONGRESSIONAL PRESSURE ON CMS TO RECOVER FROM STATES FUNDS IMPROPERLY PAID TO PROVIDERS-MAKES STATES GUARANTORS OF ACCURATE BILLING BY PROVIDERS*

PPACA SEC. 6508 GENERAL EFFECTIVE DATE

- *Except as otherwise provided in this subtitle, this subtitle and the amendments made by this subtitle take effect on January 1, 2011, without regard to whether final regulations to carry out such amendments and subtitle have been promulgated by that date. (This “subtitle” appears to be only section 65, not Section 64, so that the 6402 repayment statute has been in effect since March 2010.)*

THE MAY, 2009 FERA Amendments to the False Claims Act (FCA)

1. Expand FCA liability to indirect recipients of federal funds
2. Expand FCA liability for the retention of overpayments, even where there is no false claim
3. Add a materiality requirement to the FCA, defining it broadly
4. Expand protections for whistleblowers
5. Expand the statute of limitations
6. Provide relators with access to documents obtained by government

Defendant violates FCA if it:

- “knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government” **new** 31 U.S.C. 3729(a)(1) (G)

FERA + OMIG + PPACA = ?

- “knowingly and improperly avoids or decreases an obligation to pay or transmit money”
- Plus
- New York mandatory compliance and repayment obligation
- Or plus-the duty to repay overpayments w/i 60 days under PPACA
- Equals
- Improper avoidance of an obligation to pay money

knowingly conceals or knowingly and improperly avoids or decreases an "obligation" to pay or transmit money

- "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment **new 31 U.S.C. 3729(b)(3)**

Expands “reverse false claims” to liabilities that are not “fixed”

- A duty to repay the government need not be fixed for FCA liability to attach
 - Nursing home penalties? Environmental violations?
- Accelerates the point at which recipients of federal funds must decide if a repayment is due
 - For example, interim payments under Medicare
- Combined with “reckless disregard” standard, this amendment will result in relator actions against providers where intent is unclear
 - Will turn on meaning of “improperly” retaining overpayments

§ 6401 – Provider Screening & Disclosure Requirements

- applicants/providers re-enrolling would be required to disclose current or previous affiliations with any provider or supplier that has uncollected debt, has had their payments suspended, has been excluded from participating in a Federal health care program, or has had their billing privileges revoked.

Additional Medicaid Program Integrity Provisions

- § 6501 – Termination of Provider Participation
 - States are required to terminate individuals or entities from Medicaid programs if individuals/entities were terminated from Medicare or other state plan under same title.
- § 6502 – Exclusion Relating to Certain Ownership, Control and Management Affiliations
 - Exclude if entity/individual owns, controls or manages an entity that: (1) failed to repay overpayments, (2) is suspended, excluded or terminated from participation in any Medicaid program, or (3) is affiliated with an individual/entity that has been suspended, excluded or terminated from Medicaid.
- §6503 – Billing agents, clearinghouses, or other alternate payees that submit Medicaid claims on behalf of health care provider must register with State and Secretary in a form and manner specified by Secretary

NY Mandatory Compliance

- New York Mandatory Compliance Program
 - NY Medicaid law and regulation: every provider receiving more than \$500,000 per year must have, and certify to, an effective compliance program with eight mandatory elements. 18 NYCRR 521
 - Statute – November 2006; Regulation – 7/1/09
 - Mandatory compliance includes
 - Audit program,
 - Disclosure to state of overpayments received, when identified (over 80 disclosures in 2009)
 - Risk assessment, audit and data analysis
 - Response to issues raised through hotlines, employee issues
 - Effective program required by 10/1/09
 - Certification of effective compliance program – 12/31/09
 - Evaluation - ongoing

OMIG SELF DISCLOSURE FORM FROM WWW.OMIG.NY.GOV

- You must provide written, detailed information about your self disclosure. This must include a description of the facts and circumstances surrounding the possible fraud, waste, abuse, or inappropriate payment(s), the period involved, the person(s) involved, the legal and program authorities implicated, and the estimated fiscal impact. (Please refer to the OMIG self-disclosure guidance for additional information.)

OMIG DISCLOSURE GUIDANCE

- “OMIG is not interested in fundamentally altering the day-to-day business processes of organizations for minor or insignificant matters. Consequently, the repayment of simple, more routine occurrences of overpayment should continue through typical methods of resolution, which may include voiding or adjusting the amounts of claims.”

CONCLUSION: THE THREE MOST IMPORTANT MEDICAID INTEGRITY PROVISIONS OF PPACA

- MANDATORY REPORTING AND REPAYMENT OF OVERPAYMENTS BY "PERSONS"
- RETENTION OF OVERPAYMENT IS A FALSE CLAIM (invokes penalties and whistleblower provisions)
- MANDATORY COMPLIANCE PLANS

FREE STUFF FROM OMIG

- OMIG website - www.OMIG.ny.gov
- Mandatory compliance program-hospitals, managed care, all providers over \$500,000/year
- Over 1500 provider audit reports, detailing findings in specific industry
- 66-page work plan issued 4/20/09 - shared with other states and CMS, OIG (new one coming in July, 2010)
- Listserv (put your name in, get emailed updates)
- New York excluded provider list
- Follow us on Twitter: NYSOMIG