Network Performance & Integrity: Preventing and Identifying Fraud, Waste and Abuse

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November 4, 2019

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Network Performance & Integrity Roles

Contract Performance Unit:

- Routine Post-Payment Reviews (on-site or desk)
- Health and Safety Reviews
- AFL Site Reviews
- Credentialing/Re-credentialing Site Reviews
- Complaint Investigations
- Focused Monitoring
- Technical Assistance

Special Investigations Unit:

- Required by Section 14 of DHB Contract and 42 CFR Part 438
- Investigations of potential fraud and referral to MID
- Investigations of potential billing abuse to identify overpayments

Incident Report Team:

- Track, triage and respond to incidents filed in “IRIS” system
- Support Critical Incident Review Committee (CIRC)

Why is This Training Important?

Section 14.2.6 (g) of DHB contract: Vaya shall have policies and procedures that guard against fraud and abuse, including “process for informing PIHP employees, subcontractors **and providers regarding the False Claims Act .**”

Why the **Emphasis** on Fraud?

- Medicaid is the single largest payor for behavioral health services in the United States.
- It is estimated that fraud and abuse of funds meant for North Carolina Medicaid beneficiaries account for up to 10% of all Medicaid expenditures annually.

Does Provider Fraud Impact Health?

"Patients treated by health care professionals later excluded from the Medicare program for committing fraud and abuse were between 14 and 17 percent more likely to die than similar patients treated by non-excluded physicians, nurses, and other professionals."

From: Nicholas LH, Hanson C, Segal JB, and Eisenberg M et al. Association Between Treatment by Fraud and Abuse Perpetrators and Health Outcomes Among Medicare Beneficiaries. *JAMA Internal Medicine.* 2019*;* October 28.

What is the Federal False Claims Act?

It prohibits anyone from ***knowingly*** presenting or causing to be presented a false or fraudulent claim to the government for payment or approval

- Civil Liability (31 USC 3729)
  - Knowingly presenting a false claim
  - Knowingly making a false statement
  - Reverse False Claims (avoidance of payment)
  - Conspiracy
- Criminal Liability (18 USC 287)
- Anti-retaliation Provisions (31 USC 3730)

“Knowingly?”

- This means a person:
  - Has knowledge of the information OR
  - Acts in deliberate ignorance of the truth or falsity of the information OR
  - Acts with reckless disregard or lack of concern for the truth or falsity of the information
- *A person does not have to have knowledge of the laws or specific intent to commit a violation*

Per the Office of the Inspector General (OIG)

"By submitting a claim for reimbursement for an item or service, the provider affirmatively represents that the claim is truthful and the services were provided consistent with program requirements."

What is the FCA "*Qui Tam*" Provision?

- *Qui tam* is an abbreviation from the Latin phrase meaning "who as well for the king as for himself sues in this matter." **Whistleblower!**
- Private citizens may file on behalf of the United States ("Relator")
- The "Relator's Share"
  - 15% to 25% of proceeds if the government intervenes
  - 25% to 30% of proceeds if the government declines
- *Your employees have the right to be whistleblowers, and are protected against retaliation by this provision*

False Claims Act Penalties

- In 2018 the DOJ recovered $2.8 billion dollars in FCA penalties, 85% of which were from healthcare
  - The bulk of these cases came to the government's attention as the result of whistleblower cases
  - $301 million paid to Relators
- In 2019 False Claims Act civil penalties are expected to increase to between $11,463 minimum and $22,927 maximum ***per claim***, plus three times the amount of damages that the federal government sustains because of the false claim.

North Carolina FCA Laws

North Carolina has two state false claims acts:

- The North Carolina Medical Assistance Provider False Claims Act, N.C.G.S. Chapter 108A, Article 2, Part 7 ("Medicaid FCA")
  - The Medicaid FCA was not replaced by the NCFCA, and is limited to Medicaid program fraud claims
- The North Carolina False Claims Act, N.C.G.S. Chapter 1, Article 51 ("NCFCA")

Contract Performance Unit

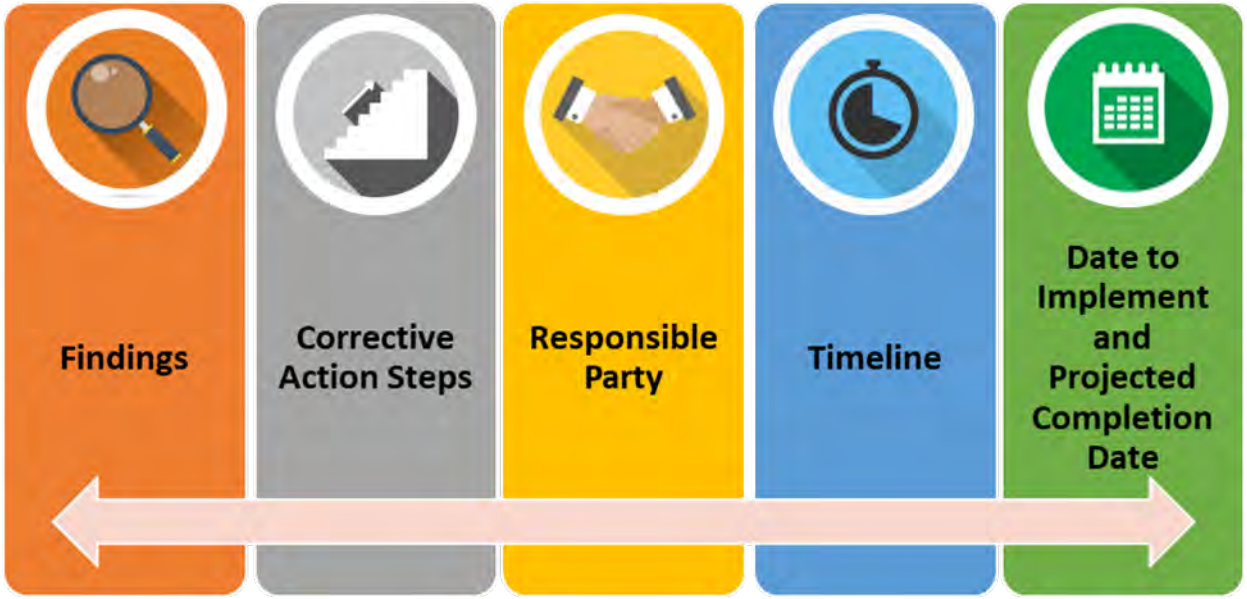
Mission: to assure provision of services to Vaya members meets the highest standards of quality, while working collaboratively with our Provider Network

Most Common Findings/Issues

- Lack of staff training on front end
- Failure to complete required annual training(s)
- Inadequate (bare minimum) ongoing supervision, may result in:
  - Poor documentation
  - Delivery of lower quality service that does not meet intent or requirements of CCP
  - Wasted services
  - Referrals to higher levels of care
- Missing documentation

“Don’t dwell on what went wrong. Instead, focus on what to do next. Spend your energies on moving forward toward finding the answer.”
~Denis Waitley

Successfully Completing a Plan of Correction Form



Incident Report Team

Mission: to minimize negative Incident outcomes for Members by coordinating the review of Incidents filed by providers in IRIS

What is a Level III Incident?

An incident that results in:

- a death, sexual assault, or permanent physical or psychological impairment to a client;
- a substantial risk of death, or permanent physical or psychological impairment to a client;
- a death, sexual assault, permanent physical or psychological impairment caused by a client;
- a substantial risk of death or permanent physical or psychological impairment caused by a client; or
- a threat caused by a client to a person's safety.

Internal Review of Level III Incidents by Providers

The internal review team must:

- Review Member record to determine the facts and causes of the incident, making recommendations for minimizing reoccurrence
- Issue written preliminary findings of fact within five business days of incident to the LME/MCO
- Issue a final signed written report within three months of the incident to the LME/MCO
  - Address issues identified, include all public documents pertinent to the incident and recommendations for minimizing reoccurrence

Special Investigations Unit

Mission: to ensure responsible stewardship of public funds by promoting quality, accountability and integrity across our Provider Network

Fraud

An ***intentional*** deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person

42 CFR 455.2

Abuse

State – "Any incidents, services, or practices inconsistent with accepted fiscal or medical practices which cause financial loss to the Medicaid program or its beneficiaries, or which are not reasonable or which are not necessary."

10A NCAC 22F .0301

Federal – "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."

42 CFR 455.2

Overpayment

The CMS Medicaid Program Integrity Manual defines overpayment as

> "… payments made to a provider/supplier for services which were determined to be medically unnecessary or incorrectly and/or improperly billed. This includes any amount that is not authorized to be paid by the Medicaid program, whether paid as a result of inaccurate or improper cost reporting, improper claim submission, unacceptable practices, fraud, abuse, or mistake."

Common Findings Resulting in Overpayments

- Documentation that Does Not Support the Duration of Treatment Billed
- Non-compliant Staff Ratios per CCP
- Non-compliant Supervision Plans per CCP
  - Lack of a detailed, signed and dated plan
  - Not following the plan (i.e. frequency, goals, etc.)
- Errors/Missing Information in Staff Records
  - No indication of when staff was hired
  - No documentation to verify experience with population to be served

Responsibility to Self-Report

- As a provider, you have an affirmative obligation to identify and return overpayments.
- The OIG's Compliance Program Guidance states "the use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas" should be part of healthcare providers' Compliance Programs.

There are risks and costs to a program of action, but they are far less than the long-range risks and costs of comfortable inaction. ~JFK

Take-Aways

- Ensure staff are trained and well-versed in the requirements of CCP for ***any*** service they are rendering.
- Ensure staff are trained in documentation requirements for ***any*** service they are rendering (CCP *and* RMDM).
- Conduct ***regular*** self-audits to identify areas that may be out of compliance, and report findings to Vaya.

Resources

- Centers for Medicare and Medicaid Services
  - CMS Fraud Prevention Toolkit
- Office of Inspector General
  - OIG Medicaid Fraud Control Units
- Code of Federal Regulations
  - 42 CFR 455
- DHHS Clinical Coverage Policies for Mental Health, Substance Use and Intellectual or Developmental Disability Services
- DHHS Records Management and Documentation Manual (RMDM)