Vaya Monitoring Trends: Fraud, Waste and Abuse, and the False Claims Act

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What You Will Learn *or* Be Reminded You Know…

- Definitions of Fraud, Waste and Abuse (FWA)
- What the False Claims Act is, and its importance to providers of health services reimbursed by federal dollars
- How healthcare providers can prevent and identify FWA

But Wait, There's More!

- Vaya Health Provider Network monitoring trends
- Vaya's Monitoring Plan for fiscal year 2021-22

Why do we keep having this conversation?

- It’s the right thing to do
- Vaya’s contract with Division of Health Benefits (DHB) says Vaya shall have policies and procedures that guard against fraud and abuse, including “process for informing 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.

Fraud, Waste and Abuse Definitions

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

NC – “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 Centers for Medicare & Medicaid Services (CMS) 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."

The False Claims Act

The Federal False Claims Act

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?

Meaning 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

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*

Per the Office of the Inspector General…

"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."

Healthcare Provider Responsibility to Self-Report

- As a provider, you have an affirmative obligation to identify and return overpayments.
- The Office of Inspector General's (OIG) 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.

How Can Providers Prevent Fraud, Waste and Abuse?

Don’t Do This …

- Cashing in on the dead: Former NC couple lived lavishly on Medicaid fraud money :: WRAL.com

Do This …

- Have a comprehensive Compliance Program
- Cultivate an organization wide culture of compliance
- Train your employees about FWA prevention, including:
    - Maintaining proper documentation
    - Reducing inappropriate claims submission
    - Protecting patient and provider identity information
    - Reporting suspected FWA
- Educate your members about protecting their Medicaid Card

What's Going On in the Vaya Provider Network?

Most Common Findings from Non-FWA Investigations

- 54% of investigations had no findings out of compliance!
- Protection from abuse, neglect or exploitation not met
- Incident Reports not completed or submitted on time
- Non-compliant documentation (missing docs, missing required elements, not completed and/or signed timely)
- Clinical Coverage Policy (CCP) rules and regulations out of compliance

Most Common Findings from FWA Investigations

- 50% of investigation referrals for FWA are ruled out prior to investigation!
- Non-compliant documentation (missing info, documentation that does not support the duration of treatment billed or service billed)
- Billing for services not rendered
- Missing information in staff records (insufficient or no documentation to verify experience with population to be served, insufficient or no documentation of meeting education and/or training requirements)

Takeaways

- 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* Records Management and Documentation Manual (RMDM)
- Submit Incident Reports as required
- Work with your HR team to ensure personnel files are complete
- Conduct ***regular*** self-audits to identify areas that may be out of compliance, and report findings to Vaya

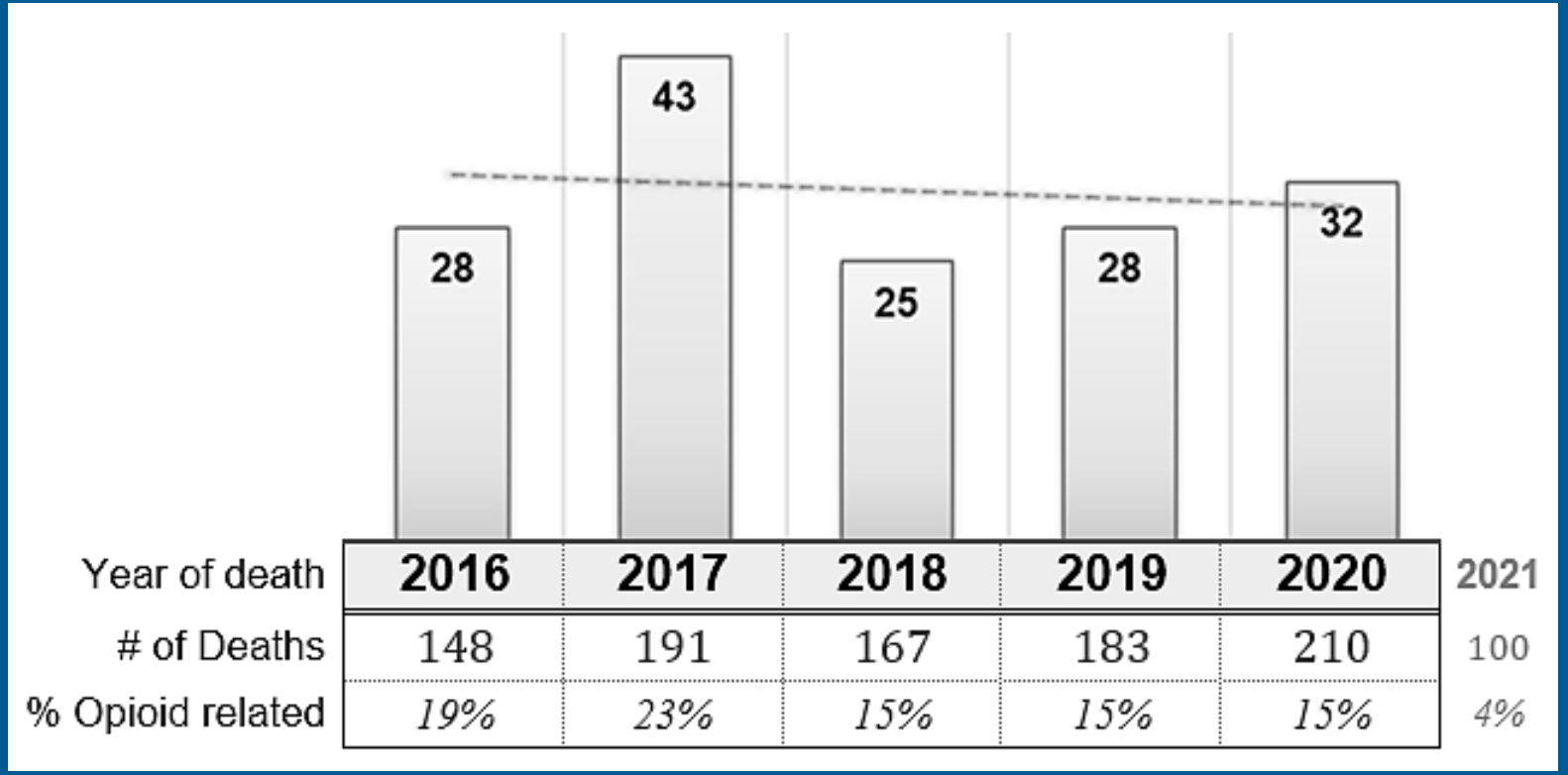
Opioid-Related Deaths

Opioid-Related Deaths in the Vaya Catchment Area

(Jan. 1, 2016 - June 30, 2021)

Deaths reported over the past few years show a ***slightly declining trendline*** in opioid associated deaths.

*This data only includes deaths reported by providers via incident report submissions to IRIS, and for which Vaya has received a medical examiner's report or death certificate.

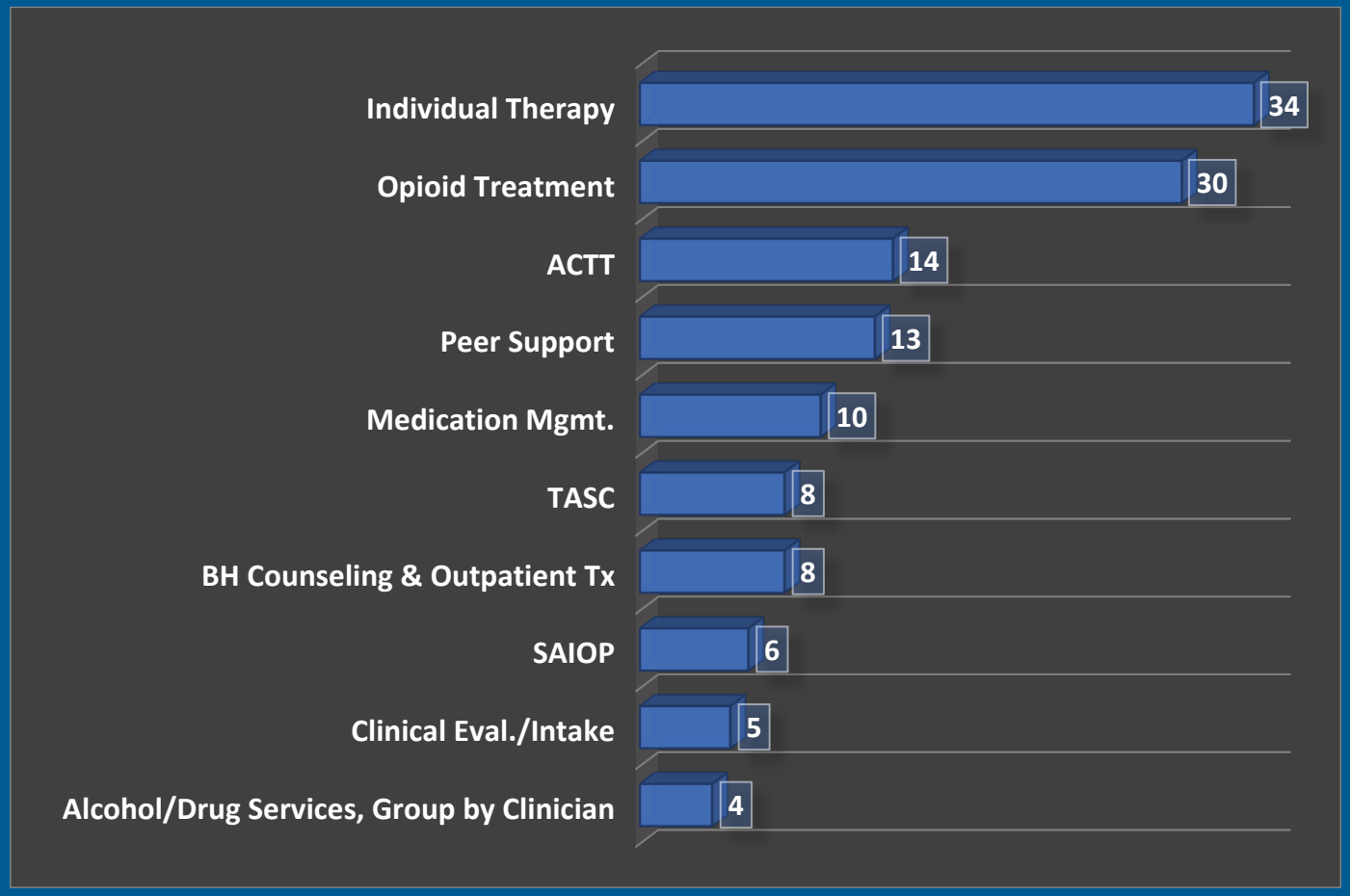


Year of death	2016	2017	2018	2019	2020	2021
# of Deaths	148	191	167	183	210	100
% Opioid related	*19%*	*23%*	*15%*	*15%*	*15%*	*4%*

Since 2021 is an incomplete year, it has not been included in the trendline calculation for better accuracy

Services Being Delivered at the Time of Opioid-Related Deaths in the Vaya Catchment

(Jan. 1, 2016 - June 30, 2021)



Individual Therapy was the service most frequently being provided to individuals at the time of an opioid-related death, closely followed by those in **Opioid Treatment**.

Provider Monitoring Plan for Fiscal Year 2021-22

Monitoring Plan

- Policy review, updates and new policies as needed
- Provider training, education and communication bulletins
- Network Performance Integrity and other Vaya staff training
- Complaint Investigations: The Special Investigation and Network Performance Units (NPU) will continue to investigate all applicable referred allegations

Monitoring Plan (continued)

- Site Visits: NPU Site Review Specialists will continue to conduct reviews of unlicensed Alternative Family Living homes (annually and when a new member moves in) and reviews for credentialing and recredentialing

- NC-TOPPS: NPU staff will continue to monitor provider submission of NC-TOPPS interviews for accuracy and timeliness, provide technical assistance as needed and Plan of Correction (POC) as warranted

- Block Grant Providers: NPU staff will conduct random and/or targeted monitoring of provider recipients of block grant funding for compliance with regulations and contractual obligations

Monitoring Plan (continued)

- Technical assistance, when appropriate, will continue to be ***our first approach*** to addressing provider performance
- Routine Post Payment Review of all provider services not subject to Division of Health Service Regulation oversight will continue until the end of the fiscal year, DHB has announced that this required monitoring will sunset
- Focused Monitorings are planned for the following:
  - Random post payment reviews of COVID-19 flexibilities
  - Random monitoring of providers who received CARES Act dollars to ensure appropriate use of funds
  - Monitoring of any provider identified on the Bi-Annual Benchmark Report as having three or more findings of non-compliance for the same or similar issues

Resources

- CMS Fraud Prevention Toolkit
- OIG Compliance Program Guidance
- Code of Federal Regulations - 42 CFR 455
- NC DHHS Clinical Coverage Policies
- NC DHHS Records Management and Documentation Manual
- Vaya Provider Operations Manual

Questions?