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MEDICAID COMPLIANCE NEWS

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

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Medicaid RACs Gear Up While MICs Find Significant Recoveries in Some States

CMS recently took the initial step to get the Medicaid version of recovery audit contractors (RACs) rolling. Meanwhile, Medicaid integrity contractors (MICs) are coming back with significant recoveries in certain states while others are still digging.

The health reform law required states to contract with RACs by Dec. 31, 2010, to identify underpayments and recoup overpayments in their Medicaid programs. CMS posted in the Sept. 10 *Federal Register* an "information collection request" about Medicaid RACs, the first step taken to get the program running.

CMS says state contracts with RACs should be similar to Medicare's program, but that states will have broad discretion in their design. "States will be able to tailor the Medicaid RAC's activities to the uniqueness of the Medicaid program in their State, as well as identify and propose targeted areas or susceptibility regarding improper payments," CMS said in a supporting statement.

States must submit amendments to their state plans attesting that they are establishing a RAC program.

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Excluded Providers, Excessive Payments Are Risk Areas in 2011 OIG Work Plan

With the unveiling of the HHS Office of Inspector General's 2011 work plan Oct. 1, hospitals should adjust their Medicaid compliance monitoring plans to reflect the heightened scrutiny certain areas will receive. OIG's tentacles will reach far and wide, from hospital outliers to drugs.

The work plan is OIG's annual description of Medicare, Medicaid and other HHS oversight activities it plans to begin or continue — audits, evaluations, legal reviews and investigations. Compliance officers use it as one roadmap during their risk-assessment process.

"I feel like they have left no stone unturned," says Wendy Trout, director of corporate compliance and revenue management for WellSpan Health in York, Pa.

One OIG target that raised eyebrows is "potentially excessive Medicaid payments for inpatient and outpatient services." Lawyers wonder how many different entities can scrutinize their Medicaid claims. "We have the MICs, state Medicaid auditors and even OIG looking at the exact same issues and soon we'll have the RACs," says Washington, D.C., attorney Andy Ruskin, with Morgan Lewis Bockius. "The auditing is endless and the possibility for inconsistencies and redundancies is substantial."

Ruskin says states have to implement the findings and providers can appeal them in a state proceeding. "However, if the federal government's auditors are the ones responsible for the findings, one has to question whether it is a foregone conclusion that the state proceeding will be unsuccessful. I think many states would assume that if the provider were successful in such an appeal, the state would still lose its federal match because the federal government had already decided otherwise. Accordingly, there is

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at least a presumption against the provider in all such cases." Ruskin says states would have to take a central role in these audits to get around what he calls the problem of "guilty until proven innocent," but he doubts that will happen.

And there may be a tipping point with Medicaid audits. "The costs imposed by all these Medicaid audits may lead some hospitals simply to opt out of Medicaid altogether, leading to huge access issues," Ruskin says.

It appears from the language of the work plan's item on inpatient and outpatient hospital services that OIG might focus on whether states have adequate controls to prevent Medicaid inpatient and outpatient overpayments, says Miami attorney Joanne Erde, with Duane Morris. It's unclear exactly how this would play out in terms of providers, but the bottom line is, "the pressure is increasing on post-payment review of Medicaid claims." She notes OIG will put the classic hospital risk areas under the microscope: mistakes in diagnosis codes, admission codes, discharge codes, procedure codes, charges, HCPCS codes, and number of units billed.

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Medicaid payments to excluded or terminated providers and Medicaid payments to entities that employ or contract with them (including hospitals and managed care organizations) are a theme of the OIG work plan, making more than one appearance. There is no question that enforcers and auditors are cracking down in this area, and providers are self-disclosing alleged problems in this area as well, as indicated by the recent spate of civil monetary penalty settlements for billing for the services of excluded providers.

"We have been shouting from the rooftops for a year and so has CMS," says New York State Medicaid Inspector General Jim Sheehan, a former longtime federal prosecutor. CMS and the New York Office of Medicaid Inspector General (OMIG) "have put out notices and bulletins to providers saying you can't bill for excluded providers or accept orders from excluded providers," he says. OMIG was surprised to learn there is still a lack of awareness of this prohibition. Even after sending out such notices, "we called up several home health agencies and said 'tell us what you do to prevent excluded physicians from billing home health services,'" and the home health agencies were essentially unresponsive, Sheehan says.

He's glad to see OIG is approaching payments to excluded and terminated providers as an evaluation/inspection rather than an audit. Audits focus on recovering overpayments while evaluations and inspections focus more on identifying system weaknesses so they can be fixed to prevent widespread payment errors.

Integrating the Work Plan Into Compliance

After reviewing the OIG work plan, Trout identified five Medicaid areas she will add to her annual compliance monitoring program. Here's her process: "I read every project in the work plan and identify what the focus is," she says. Is OIG homing in on a managed care organization? Is it targeting the provider directly or indirectly by scrutinizing the states, CMS or a third party? Or is the risk area relevant to her organization type, a hospital system with various ancillary services?

Once she whittles down the work plan's list of items to areas that pertain generally to health systems, Trout then determines whether WellSpan actually provides the services (e.g., it doesn't own nursing homes, so she skips those items). "Then my next step is to see how much exposure we may have in that area," she says. This requires looking at volume (i.e., how much revenue the service generates or how many claims are submitted to Medicaid) and the effectiveness of internal procedures at preventing errors in billing for that service. "You get a sense from management how they feel you are doing," she says. If the risk in that area seems significant enough,

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Trout will spot check to evaluate the integrity of claims. The results of the spot checking dictate whether the service lands on the audit list.

Five Areas Have High Risks

But eyeballing the work plan, Trout says "there are five Medicaid areas I will probably look at" — areas that may be high risks for other health systems:

◆ ***Medicaid hospice services:*** OIG says it will "review Medicaid payments for hospice services to determine whether the services were provided in accordance with Federal reimbursement requirements....We will also conduct a medical review of claims for a sample of Medicaid recipients receiving hospice care to determine that services were reasonable and necessary." This is a new audit.

◆ ***Federal upper payment limit drugs:*** OIG plans to "review prescription drug claims to determine whether pharmacies have altered prescriptions to maximize reimbursements by avoiding certain dosage forms for drugs that have Federal Upper Limits (FUL) on reimbursements. The Social Security Act, § 1927(e)(4), establishes FULs for all multiple-source drugs. As a result of whistleblowers' actions, several pharmacies have admitted changing dosage forms for some commonly prescribed Medicaid drugs, thereby inflating reimbursements by avoiding FULs established on other dosage forms. We will determine whether there has been manipulation of FULs." This is a new audit.

◆ ***Rehabilitative services:*** Claims will be scrutinized by OIG to determine whether they were recommended by a physician "or other licensed practitioner of the healing arts for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." This is a new audit.

◆ ***Medicaid medical equipment:*** OIG will review Medicaid payments for medical supplies and equipment to check whether "the equipment and/or supplies billed were properly authorized by physicians, the products were received by the beneficiaries, and the amounts paid were within Medicaid payment guidelines." This is a new audit.

◆ ***Payments to terminated and/or excluded Medicaid providers and suppliers:*** OIG will review Medicaid payments to suppliers and providers to figure out the extent to which payments were made when they were excluded from Medicaid. Payments during exclusion are forbidden. This is an ongoing review. Trout notes that WellSpan checks the Medicaid exclusion list on a monthly basis.

OIG is also going to weigh in on the program-integrity activities of other entities as they relate to Medicaid. For example, Medicaid integrity contractors (MICs) will get the once-over. OIG says it will examine their progress at preventing and detecting Medicaid fraud, waste and abuse and the results of their efforts so far.

OIG also will analyze an independent medical review organization's evaluation of the Payment Error Rate Measurement (PERM) Medicaid 2008 calculations. "We will also evaluate the methodology and medical review determinations underlying the error rate testing conducted by the PERM contractor," OIG says. PERM is a CMS initiative to calculate the Medicaid payment error rate state by state.

And OIG will look at "Medicaid Program Integrity Best Practices" in state Medicaid agencies to identify what works and verify they are operating as intended (e.g., identifying payment risks or collecting overpayments).

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With Federal Amendments to FCA, States May Have to Update Laws

Legislation signed by New York Gov. David Paterson (D) in August will fill some significant gaps in the state's false claims law that stemmed from the federal government's updates of the False Claims Act (FCA). While some states are following New York's lead, others are waiting for guidance from the HHS Office of Inspector General on whether the federal amendments will affect how much they can recover from Medicaid fraud cases.

The state's Fraud Enforcement and Recovery Act (FERA), which bears the same name as a federal law that amended the FCA in 2009, makes New York's false claims law the most robust in the nation, and even stronger in some areas than the federal law, according to New York attorney Neil Getnick.

Congress first amended the FCA in 1986 to make whistleblower provisions stronger and give citizens more incentive to file suits on behalf of the government. But a number of court decisions over the years have diluted the strengths of the FCA, so Congress aimed to correct that, explains Getnick, who is with Getnick and Getnick LLP, a firm that has handled many whistleblower cases. The corrections occurred in two waves with the federal FERA and the health reform law, which served to "clear out some of the brush from those confusing and counterproductive court decisions," he tells *MCN*.

The federal version of FERA, signed in May 2009, extended the FCA to claims submitted to government contractors and subcontractors. This was needed because the U.S. Supreme Court's ruling in *Allison Engine Company Inc. v. United States ex rel Sanders* stated that an FCA

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case requires government involvement in the payment decision. With this interpretation, providers' lawyers were arguing that the government isn't actually involved when an intermediary — such as a Medicaid claims processer (or a fiscal intermediary on the Medicare side) — makes a payment.

'Original Source' Is Contended

There were also conflicting opinions on what constituted an "original source" (i.e., where allegations first come from) and the public disclosure bar in the FCA. If information had already been disclosed generally to the public, such as in a news report, that could have prevented a whistleblower from bringing a suit — until the changes took effect.

While the amendments were needed, they may have thrown a wrench in the works for states. In 2006, the Deficit Reduction Act (DRA) offered states an extra 10% of recoveries from Medicaid suits. For them to be eligible, the DRA mandated that states' laws must mirror the federal False Claims Act. "Now that the federal statute has been ramped up, our thought was to follow suit so as not to fall short and retain those bonuses," says Getnick, who also is chairman of Taxpayers Against Fraud.

The state's changes were needed to close significant loopholes, acknowledges Mark Thomas, counsel to the Healthcare Association of New York State. "Without its passage, the state false claims act would not have been as strict as the federal FCA, meaning the state would have lost extra federal dollars on state FCA recoveries," he tells *MCN*.

But Thomas also has fears about what the state's changes will mean to providers. "It means that we'll have not only enforcement of the FERA at the federal level, but will probably have more aggressive enforcement of the [state] FERA…by" the New York Office of Medicaid Inspector General. OMIG isn't "waiting for guidance… and can interpret the state law and start enforcing it" right away, he points out. The law took effect Aug. 27, according to state records.

"The state law is the primary platform on which the OMIG's enforcement will be based…and if history is a teacher, it will be aggressive," says Thomas, who is with Wilson Elser.

State Law Protects, Clarifies

New York's FERA surpasses federal law in its whistleblower protections, says Getnick. For one thing, it establishes anti-blacklisting protections against whistleblowers so a company can't refuse to hire someone because he or she reported another company for fraud. "Federal law says if a whistleblower pursues a case, the company that a whistleblower works for cannot retaliate. New York state says *no* company in the industry can retaliate against a whistleblower," he says. "That's very important because after blowing the whistle, [the company] may not be a compatible place to keep working….It's very important that you're not barred from the industry."

Additionally, it bans employers from suing employees who provide evidence of fraud to investigators in a false claims case.

The New York FERA attempts to clarify many of the areas that court decisions have mucked up over the years. First, it states that whistleblowers who use the Freedom of Information Act are not barred from filing a *qui tam* case against a company because — by using the FOIA — he or she created a public disclosure of information. This is timely, Getnick says, because the Supreme Court just agreed to hear a case dealing with whether a federal agency's responsibility to a FOIA request constitutes a report or investigation under the FCA. "Apparently the U.S. Supreme Court thinks it is necessary to rule on that subject to clarify it," says Getnick. "In New York state, that point has been fully clarified. [The FERA] specifically provides that an action is not barred because a relator uses the FOIA to gather evidence," he says.

NY FERA Clarifies Public Disclosure

It also clarifies the meaning of the public disclosure bar with respect to government reports and news media. "Government reports must be broadly disseminated or on the record to bar them," Getnick explains. "Also, an Internet post does not necessarily create a public disclosure in the news media." This is important, Getnick says, because of all the blogs out there. "We don't want to see after-the-fact combing of the Internet and someone saying this is a publicly disclosed matter because of an obscure posting on a blog."

Another major provision in the New York law clarifies the state's position on Rule 9(b) of the Federal Rules of Civil Procedure. The federal rule says "in alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake."

The New York FERA clarifies that "the plaintiff or relator must identify a fraud scheme and notify the government of the fraud, but is not required to identify every false claim," Getnick explains. That could be important in situations where, for example, a sales person is brought into a meeting and is instructed to engage in a kickback scheme, and he or she receives a manual explaining how to go about offering and delivering the kickbacks. Then, when his or her colleagues report their figures back to the company, that information could show a fraud scheme and help the government.

"So a doctor ordering up so many prescriptions on a certain date to a certain patient in a certain dollar

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amount...that type of information is no longer the deciding factor under the new amendments," Getnick says.

Getnick says other states are also updating their laws to account for the federal law changes so they will be assured of getting their share of Medicaid recoveries. Illinois recently updated its law, "although not quite as broadly as New York's," Getnick says.

But many other states are waiting for guidance from OIG. "I believe other states are likewise examining their false claims acts while waiting to understand what will be the ultimate position of OIG [on] the requirements that the state will be held to with respect to the DRA," he says. "It still remains to be seen whether...states that passed a law will be grandfathered in or will be required to update their laws, or whether there will be some type of grace period provided. The important part from New York state's perspective is that New York is covered and protected."

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Proposed Rule Describes Payment Suspension, Provider Screening

A proposed rule posted in the Sept. 23 *Federal Register* explains how state and federal agencies will coordinate the suspension of provider payments during Medicaid fraud investigations, as required by the health reform law. It also lays out the level of screening providers can expect according to the risk of fraud they pose.

CMS already had the authority to suspend payments when fraudulent activity is suspected based on possession of "reliable information." But the health reform law required that HHS consult with OIG in determining if there is a "credible allegation of fraud" against a provider or supplier. In the rule, CMS proposes to clarify "credible allegation" by saying it can come from sources such as fraud hotlines, data mining, patterns found during audits, civil false claims cases and law enforcement investigations.

This definition is very broad, says San Francisco attorney Judy Waltz. "I think they are going broader in the definition than providers and suppliers would want in order to protect CMS and its options, but it really is so broad that I think they will get allegations that may appear credible, that down the line may not be."

"It would be not too hard to take some mistakes and turn them into credible allegations of fraud and a payment suspension," Waltz continues. The message: "Make sure your Medicaid billings are correct. The latitude being given to CMS and what it's giving to the states is going to result in a lot of hardships for providers. It's really scary," she says.

CMS says states should be careful in what they deem credible allegations so as not to disrupt services. "We continue to believe that state agencies must review all allegations, facts, and evidence carefully and act judiciously on a case-by-case basis when contemplating a payment suspension, mindful of the impact that payment suspension may have upon a provider," CMS says. Payments will resume once an inquiry has been settled or closed for lack of evidence, the rule says.

The state should notify the provider of the payment suspension within five days of taking the action unless doing so could jeopardize an investigation, in which case the state could delay notification up to 90 days. Officials could then re-evaluate whether the suspension should continue.

Waltz points out that investigations can take years and can do significant damage to providers if they're not receiving payments during that time. California has already been clamping down, she says. "What we're seeing [here] is that the state resources are so thin that everything takes longer....And you can put a provider out of business. An allegation could come from someone who may want that to happen," she says.

The states' screening methods vary widely, CMS notes in the rule. The health reform law required the secretary and OIG to establish screening procedures for

Category of Risk and Required Screening for Medicaid and CHIP Providers

Type of Screening Required	Limited	Moderate	High
Verification of any provider-specific requirements established by Medicaid/CHIP	X	X	X
Conduct license verifications (may include licensure checks across state lines)	X	X	X
Database checks (to verify Social Security number, the National Provider Identifier, the National Practitioner Data Bank, licensure, an OIG exclusion, Taxpayer Identification Number, tax delinquency, death of individual practitioner, and persons with an ownership or control interest or who are agents or managing employees of the provider)	X	X	X
Unscheduled or unannounced site visits		X	X
Criminal background check			X
Fingerprinting			X

SOURCE: CMS

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Medicaid providers, to include licensure checks, criminal background checks, fingerprinting, unscheduled or unannounced site visits and database checks (see table, p. 5). The cost of screening will be covered by fees charged to providers, the rule says.

States may rely on the results of a provider screen if it has already been completed by a Medicare contractor or a neighboring state's Medicaid program, the rule says — so providers don't have to go through the process for each program. But for Medicaid-only providers, CMS says states should use the same risk levels it is assigning to categories of Medicare providers:

◆ ***Limited risk.*** Physicians, nonphysician practitioners, medical clinics and group practices "pose limited risk because these professionals are state licensed." Also, publicly traded entities are a limited risk because of the financial oversight by investors, corporate boards of directors and the Securities and Exchange Commission.

Screening Groupings Defined

CMS explains in its proposed rule how and why Medicaid providers need to be evaluated and categorized.

§ 455.450 Screening categories for Medicaid providers.

A State Medicaid agency must screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment request based on a categorical risk level of "limited," "moderate," or "high." If a provider could fit within more than one risk category described in this section, the risk category with the highest level of screening is applicable.

(a) Screening for providers designated as limited categorical risk. When the State Medicaid agency designates a provider as a "limited" categorical risk or the provider is publicly traded on the New York Stock Exchange (NYSE) or National Association of Securities Dealers Automated Quotation System (NASDAQ), the State Medicaid agency must do all of the following:

(1) Verify that a provider meets any applicable Federal regulations, or State requirements for the provider type prior to making an enrollment determination.

(2) Conduct license verifications, including State licensure verifications in States other than where the provider is enrolling, in accordance with § 455.412.

(3) Conduct database checks on a pre- and post-enrollment basis to ensure that providers continue to meet the enrollment criteria for their provider type, in accordance with § 455.436.

(b) Screening for providers designated as moderate categorical risk. When the State Medicaid agency designates a provider as a "moderate" categorical risk, a State Medicaid agency must do both of the following:

(1) Perform the "limited" screening requirements described in paragraph (a) of this section.

(2) Conduct on-site visits in accordance with § 455.432.

(c) Screening for providers designated as high categorical risk. When the State Medicaid agency designates a provider as a "high" categorical risk, a State Medicaid agency must do both of the following:

(1) Perform the "limited" and "moderate" screening requirements described in paragraphs (a) and (b) of this section.

(2)(i) Conduct a criminal background check; or (ii) Require the submission of set of fingerprints in accordance with § 455.434.

(d) Denial or termination of enrollment. A provider, or any person with an ownership or control interest or who is an agent or managing employee of the provider, who is required by the State Medicaid agency or CMS to submit a set of fingerprints and fails to do so may have its—

(1) Application denied under § 455.434; or

(2) Enrollment terminated under § 455.416.

(e) Adjustment of risk level. The State agency must adjust the categorical risk level from "limited" or "moderate" to "high" when any of the following occurs:

(1) The State Medicaid agency imposes a payment suspension on a provider based on credible allegation of fraud, waste or abuse, the provider has an existing Medicaid overpayment, or the provider has been excluded by the OIG or another State's Medicaid program within the previous 10 years.

(2) The State Medicaid agency or CMS lifts a temporary moratorium for a particular provider type.

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Also in this category: ambulatory surgical centers, federally qualified health centers, hospitals (including critical access hospitals), rural health clinics, public- or government-owned or affiliated ambulance services suppliers and skilled nursing facilities (SNFs).

◆ ***Moderate risk.*** Nonpublic, non-government-owned or affiliated ambulance service suppliers, community mental health centers, comprehensive outpatient rehabilitation facilities, hospice organizations and independent clinical laboratories "are generally highly dependent on Medicare [and] Medicaid…to pay their salaries and other operating expenses and are subject to less additional other government or professional oversight."

◆ ***High risk.*** "We are especially concerned about newly enrolling [home health agencies] and suppliers of durable medical equipment because of the high number of HHAs and suppliers of [DME] already enrolled in the Medicare program and program vulnerabilities that these entities pose to the Medicare program," the rule says. Any owner, authorized or delegated officials, or managing employees of one of these providers, will be subject to screening.

CMS Broadens Reasons for Terminations

The proposed rule also recommends that states terminate providers if:

◆ ***Timely and accurate disclosure information is not submitted*** by the owners or persons who are agents or managing employees of a provider;

◆ ***The provider has been terminated*** on or after Jan. 1, 2011, from Medicare or another Medicaid program; or

◆ ***Fingerprints have not been submitted*** by the provider, owner or managing employee within 30 days of an agency's request.

And states should deny enrollment in the program if:

◆ ***Accurate information was not provided*** by the owner or managing employee;

◆ ***The provider fails to provide access to officials for site visits; or***

◆ ***The provider, owner or managing employee has been convicted*** of a criminal offense related to a federal health care program in the last 10 years.

"It is smart for both Medicare and Medicaid to be focused on enrollment and to be flushing out providers who shouldn't be in the program to begin with," says Waltz. Enrollment is getting more complicated now, she says, and it will take more resources for providers to make sure that forms are completed appropriately. "This has to be a much higher priority than it was in the past."

The law gave states the authority to impose moratoria, numerical caps and other limits on payments to providers that are identified as being a high risk for fraud, waste or abuse.

This is another program-integrity tool California has been using, and CMS has tried implementing moratoria in the past on home health agencies, Waltz says. "In some respects, what this does is put a premium on existing providers. So anyone who wanted to go into that business had to buy an existing business," she explains. "And at the end of the day, you have fewer that you have to keep track of, but I'm not sure that it gets rid of the fraudulent conduct. I don't know if this is going to produce the result they're hoping for."

So for Medicaid providers, all this means "it's time to pay more attention to the Medicaid rules. I think, historically, people have put the bulk of their resources into Medicare compliance. But I think the states are at least as high or moving higher on the Medicaid side."

CMS has requested feedback on many of these issues. To submit public comments by Nov. 16, visit www.regulations.gov and refer to file code CMS-6028-P. To read the proposed rule, go to AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "2010 *Federal Register*." Contact Judy Waltz at jwaltz@foley.com. ✧

Guilty Verdict for Missouri Couple Who Ran Residential Homes

In a case discovered not by auditors, or by whistleblowers, but in the aftermath of a local tragedy, a federal judge in Missouri found the owners of a chain of residential care facilities guilty Sept. 30 of defrauding Missouri Medicaid. The husband-and-wife team hid the fact that one of them was running things even though he had already been excluded from participating in federal health care programs, the judge ruled.

Recent changes at the federal level will make it much more difficult to keep excluded owners and executives hidden and could mean trouble for other employees who are affiliated with companies banned from Medicaid.

Robert and Laverne DuPont were charged with defrauding Medicaid by concealing the fact that an executive of their company — Robert — had a previous conviction and was excluded from participation. Their daughter, Kelley Wheeler, and the company, Joplin River of Life, Inc. (JROL), also were originally charged in the indictment.

The judge found the DuPonts not guilty of money laundering charges. Stewart Huffman, an attorney for the

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DuPonts, says they plan to appeal the case after sentencing, which he says will occur in about four to six months.

In 2000, Robert DuPont was charged with defrauding Medicare and Medicaid. He pleaded guilty to one count of conspiracy to defraud the federal government in February 2002 and was sentenced to 21 months in prison. Having been convicted of a program-related crime, he was automatically excluded from operating a licensed Medicaid provider or participating in federal health care programs. Wheeler also was excluded for submitting false applications for Medicaid benefits.

But before the judge handed down the sentence, DuPont signed articles of incorporation to create JROL, which operated five long-term residential care facilities in southwest Missouri, the feds allege in a 2007 indictment. The document listed him and Laverne DuPont as board members, as well as owners and landlords of the facilities. Two days before he started his prison term, the feds say DuPont oversaw a board meeting at which he announced that his wife would be executive director of the company.

The feds allege that Robert DuPont was actually running the day-to-day operations of JROL even before his release from prison (which occurred in 2004). "In the day-to-day operation of JROL, Robert DuPont made unilateral hiring decisions, terminated employees, directed staffing levels, [and] unilaterally decided whether to accept potential residents referred by local hospitals," among other things, the feds say in the indictment.

Directed From on High?

To illustrate the control he had, the feds quote letters that DuPont sent to board members while he was in prison. Laverne DuPont "keeps me informed....Our services in the Guest House is down. This allows me to see something. I want you to take a good look at the Guest House in Carl Junction. We will be able to put at least 20 women in that home....I will put the license at C-J on temporary closure....River of Life Ministries can meet the needs of 176 mentally ill, 22 children, 20 women today....It's being directed by God through a person in prison."

Also, the feds say, when the homes came up for license renewal, Laverne DuPont signed the forms, which among other things, seek to affirm that there is no excluded individual who is an operator or principal in the operation of the provider.

The feds say JROL received about $725,000 from Medicaid while DuPont was excluded from participation. They eventually dismissed the charges against JROL. Wheeler entered a plea agreement and was given three years of probation.

JROL came under intense scrutiny after a tragic fire in November 2006 at one of the homes. Fire department officials said faulty wiring caused the blaze, which killed 10 residents and one employee. Neither JROL nor the DuPonts were charged with any crime, but it prompted a state report on fire safety at residential facilities. According to local reports, the state stripped the other JROL facilities of their licenses in the aftermath. The federal fraud charges followed.

The DuPonts vigorously fought the case, saying that Robert DuPont was an employee of the company, but was not in charge *(MCN 11/07, p. 11)*. "Our arguments were based on the exclusion letter that [DuPont] received while he was in prison," which explained that he could not bill federal programs for services, Huffman says. "It did not exclude him from working [for a provider]....In fact, it did not exclude his ability to work in a facility that receives Medicaid."

DuPont received a salary, as all JROL employees did, Huffman says. But he notes that Wheeler's letter of exclusion said specifically that federal funds could not cover her salary, expenses or fringe benefits. DuPont's letter made no such specifications, Huffman says.

He also points out that neither DuPont's salary, nor JROL's operations, was solely dependent on Medicaid payments. The company also received payments from the Veterans Administration, Social Security Administration and private insurers. Medicaid was not even their biggest payer, Huffman says.

Hiding Exclusions Will Be More Difficult

Federal rules on excluded providers have always been clear, but new laws are also making states get more involved.

"OIG has long prohibited individuals who are excluded from continuing to participate in federal health care programs," says attorney Howard Young, in the Washington, D.C., office of Morgan, Lewis and Bockius. OIG has made it clear over the years that "exclusion extends to the involvement of management, the owner or the director," he says. "The notice of exclusion that individuals receive makes it explicit that they not be involved in the provision of services in entities that participate in Medicare or Medicaid."

Under the health reform law, HHS established procedures to better screen providers and suppliers participating in Medicaid and Medicare by monitoring state licensure organizations, doing background checks, fingerprinting and conducting unannounced visits *(MCN 4/10, p. 1)*. The law requires states to comply with all of these changes and amend their state plans to include them.

"I think there have long been instances where excluded individuals remain lurking in the background," says Young. "One of the things that health reform did was enhance the screening capability of CMS and the

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states to determine who owns, who's involved, who is the controlling individual in connection with enrolled health care providers." The feds and the states are increasingly relying on databases, which will assist in matching up data on excluded persons, he points out.

And a bill that was recently passed in the House of Representatives and is under consideration in the Senate would make things even tougher on executives who were running sanctioned providers when improper conduct occurred. The Strengthening Medicare Anti-Fraud Measures Act of 2010 (HR 6130) would expand OIG's permissive exclusion authority. The bill also would apply to Medicaid. According to the bill, anyone with an ownership or controlling interest in a sanctioned entity who knows or should have known about the misconduct may be excluded. And officers and managing employees of sanctioned entities may be excluded even if they were not aware of the misconduct.

"Right now, there is exclusion authority with individuals, but it's present tense," Young explains. "If they divest their interests or resign as an officer, then OIG can't rely on [the current] exclusion authority. They can seek to exclude them on other bases. The new [authority] would be easier for OIG because they just have to prove that you were an owner or officer — they just have to prove that an individual was involved in the misconduct."

Contact Young at hyoung@morganlewis.com and Huffman at sph@wandwlaw.com. To read more about the case, visit www.justice.gov/usao/mow. ✧

Federal Agent Went Undercover to Catch Alleged Sham Docs in the Act

An undercover FBI agent posed as a patient to catch a New Jersey physician's office in the act of letting unlicensed employees treat Medicaid beneficiaries, according to the U.S. Attorney's Office for the District of New Jersey. The feds also depended on confidential sources, plus audio and video recordings, to make the case.

Yousuf Masood, M.D., has a medical practice in Elizabeth, N.J. A "significant portion" of his patients are Medicaid beneficiaries, the feds say. His wife, Maruk Masood, was the office manager and was in charge of billing. They are both charged with conspiracy to commit health care fraud and money laundering.

Although they do not hold licenses to practice medicine in the state, three of Masood's employees — Hamid Bhatti, Hakim Muhammad and Carlos Quijada — allegedly pretended to be physicians during office visits with patients. They are charged with conspiracy to commit health care fraud.

The feds allege that from July 2009 through July 2010, the three unlicensed employees were conducting visits with patients, but Masood's office was billing Medicaid for the visits as if he was performing the services. For these visits, Masood's office billed one of the evaluation and management (E/M) codes 99205, 99213, 99214, 99215, 99244 or 99354, which require face-to-face contact with a physician.

Other staff members in the office referred to the three fake physicians as Dr. B., Dr. Q., Dr. Bhatti, Dr. Quijada or Dr. Muhammad in front of the patients, the feds allege. The three defendants allegedly introduced themselves to patients using these titles as well, according to the complaint.

The feds are using travel records in the case to show that the Masoods were out of the country when some of the services were performed and then billed to Medicaid using Yousuf Masood's ID number. For example, Masood was in Bermuda in early August 2010 and could not have been conducting or supervising services. But during that time, his office submitted claims to Medicaid for 315 E/M services resulting in payments of about $30,000, the feds say.

According to the complaint, two "confidential sources" set up appointments in Masood's office and witnessed Quijada, Bhatti and Muhammad acting as physicians. An FBI special agent visited the office in May and June 2010 and saw Quijada.

Other employees in Masood's office told the feds that about two-thirds or more of the patients were seen by one of the three fake doctors between July 2009 and July 2010, not by Masood. During that period, the practice submitted more than 20,000 claims for E/M services to Medicaid. The feds estimate that the practice obtained at least $1.8 million from Medicaid based on fraudulent billings during that period.

Attorneys for the Masoods and other defendants could not be reached for comments.

Read more at www.justice.gov/usao/nj. ✧

Medicaid RACs, MICs Get Moving

continued from p. 1

This tidbit from CMS mainly means the agency wants states to put RACs in their state plans now, says Pam Owens, assistant inspector general for the Maryland state Department of Health and Mental Hygiene. "If we were going to characterize something as a big deal, the [Medicaid] RAC program is. It's the first time that they're requesting that the state do something like this. We are trying to figure out, in absence of guidance,

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what they expect from us. We anticipate that they are going to publish guidance about what the program has to look like."

What CMS means by "broad discretion" is still up for debate. "I think it means that we are not going to get nailed down by specific guidelines....We are all too different. All of our procurement rules and Medicaid programs are very different," says Owens. She suspects that guidance will say states should include the majority of provider groups, have a risk assessment built in and make sure the program is contingency-based.

"Medicaid is 50 programs, not one. In Florida, we're one of the more complex programs with our rules and regulations, so that makes it difficult to go from one state to the other," says Mike Blackburn, in the Bureau of Medicaid Integrity of Florida's Agency for Health Care Administration (AHCA).

The Florida RAC will likely look at medical necessity, compliance with Medicaid program rules, requirements of providers and general analyses to make sure transactions are compliant with Florida policies. "But these will be comprehensive audits," says Ken Yon, who is also in AHCA's Bureau of Medicaid Program Integrity. "They will be pulling records and looking at claims and there will be nurses on staff and peers to look at items and make sure the claims are appropriate."

MICs Get Recoveries in Florida, Texas

The MICs are still drilling down since they started in early 2009 and are finding recoveries in some states. Overall, there are around 1,250 audits now underway in 39 states, a CMS spokesperson tells *MCN*. More audits will begin as data analysis activities are completed and providers are identified for audit. At the end of federal fiscal year 2009, which ended Sept. 30, the MICs had identified about $8.5 million in overpayments and found about $13 million through test audits, CMS reports.

MIC audits involve "review MICs," which comb through data and refer anomalies to CMS and state Medicaid integrity officials. The state checks to see if the provider is already being audited or whether there is some easy explanation for the anomaly such as nuances in the state's payment policies. If the state gives the all clear, CMS gets the "audit MIC" involved and decides on a general review or more focused probe, and the MIC engages the provider *(MCN 2/09, p. 1)*.

Hot spots are Florida, Texas and California, according to Owens.

A spokesperson for the Texas Health and Human Services Commission says 151 audits were initiated, and 38 of them have been closed with recoveries totaling $679,701. More than 100 audits are still open.

There has yet to be a recovery in Maryland, Owens says. "I think we have five to 10 audits open now," says Owens. "It's going smoothly. The provider community appears to know who they are, and if they don't right away, we can help them understand that."

"We are working very hard directly with [the review MIC] to understand what it is they're seeing in our claims data. That's seamless for the providers — they never see it. There are still no audit reports or recovery amounts yet," says Owens. "These are still ongoing here and we anticipate seeing some recoveries, but it takes a while to understand the program."

Florida MIC Recovers $300,000

In Florida, the MIC has recovered about $300,000. There have been 28 audits since the start of the program, and five of those are closed now. Three of them resulted in the recoveries, according to Yon.

"I think at any point when we are conducting an investigation, it's never as simple as you would think it would be. There's a lot to look at because you don't want to make a bad decision or go after someone who hasn't done anything wrong....You want to make any allegations stand," Liz Dudek, interim secretary for the Agency for Health Care Administration (AHCA), tells *MCN*.

Now, with RACs in the mix, "the challenge is going to be coordinating everyone — making sure we're not tripping over each other, looking at different things and not duplicating our efforts," says Pete Williams, inspector general for AHCA.

"We were one of the early states in the MIC pilot program. I feel that we have been a leader working with CMS on this and we have lectured on the issues we've encountered," says Williams. "We try to be a real partner with the feds. There is a lack of resources to audit Medicaid fraud, so the more the better. It's not as easy as it sounds to detect it, so it takes time. It's not like street drugs. It's white collar. It's different," he says.

"When we put out bids [for contractors], very few companies had the right experience. They don't find it cost effective. In our audits, you do a large number of audits with small overpayments, so there are a lot of audits to recover [a small amount of] money. It takes a lot of work," Williams adds.

Contact Dudek, Yon and Williams through Tiffany Vause at tiffany.vause@ahca.myflorida.com. Contact Owens through Karen Black at kblack@dhmh.state.md.us. To read the CMS request, go to Government Resources at the Compliance Channel at www.AISHealth.com and click on "2010 *Federal Register*." Read more about MICs at www.cms.gov/DeficitReductionAct/Downloads/fy09reporttocongress.pdf. ✧

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NEWS BRIEFS

◆ **The owner of a nursing home in Totowa, N.J., pleaded guilty to Medicaid fraud for billing for more than $300,000 in improper and unsubstantiated costs,** the New Jersey Attorney General's Office said in August. Victor Napenas owned the Valley Rest nursing home, which closed in 2007. He admitted that he fraudulently obtained payments from Medicaid for personal expenses unrelated to patient care. The case began when state officials found "severe deficiencies" in patient care and ordered a financial audit, which showed irregularities on the facility's 2005 Medicaid cost report. The state is recommending that Napenas be sentenced to 90 days in jail as a condition of three years probation. He must repay $302,877 to Medicaid and more than $45,000 in penalties. Visit www.nj.gov/oag.

◆ **Omnicare Inc. has entered into settlement agreements with Michigan and Massachusetts to resolve allegations of inappropriate billing to their Medicaid programs,** the company said Sept. 21. Omnicare, which provides medications for residents in nursing facilities, will pay Michigan $11.6 million and Massachusetts $9.45 million. According to the Massachusetts AG's office, Omnicare did not follow MassHealth's pharmacy "usual and customary" pricing regulations requiring that pharmacies bill Medicaid at the lowest price they charge or accept from private customers for the same drug. Omnicare says it did not admit liability or wrongdoing in the settlement, and cooperated in the investigations. Visit www.omnicare.com and click on "News," then click on "SEC Filings."

◆ **Clinical Science Laboratory, Inc. in Mansfield, Mass., has agreed to pay $525,000 to the state to resolve allegations that it improperly billed Medicaid for urine drug tests,** the state attorney general's office said Sept. 10. The state has settled a handful of cases in an ongoing investigation into urine drug tests billed by independent clinical laboratories. A physician must order every urine test and attest to its medical necessity in order for a lab to receive payment from Medicaid. The program would not pay for tests for sobriety, for example. The state found that Clinical Science billed Medicaid for unauthorized urine drug tests between 2004 and 2009. Visit www.mass.gov.

◆ **The owner of a home health agency in Cleveland Heights, Ohio, was given a four-year suspended prison sentence for forging criminal background checks for her employees,** the Ohio AG's office said Sept. 3. Denise Marsh also has been ordered to repay more than $740,000 to the state. She made it appear that workers had clean records, when many of them had criminal convictions that disqualified them for jobs in home health care, the state says. She pleaded guilty in July to one count of theft by deception and six counts of forgery. She was the sole owner of Beta Services Inc., which does business as Home Helpers/Direct Link. The firm also pleaded guilty to theft by deception. Read more at www.ohioattorneygeneral.gov.

◆ **Denise McCreary of Chesterfield, Va., was sentenced to 55 months in prison Sept. 17 for submitting false and fraudulent Medicaid claims,** according to the state AG's office and the U.S. Attorney's Office for the Eastern District of Virginia. She was also ordered to pay more than $600,000 in restitution. McCreary owned and operated Camp Hope Youth Services, a Medicaid-contracted provider of home therapy services for children and adolescents at risk of being removed from their homes. Medicaid requires that they be treated by qualified mental health workers. McCreary allegedly billed for services that did not address the children's needs or were not provided by qualified workers. She also billed for services that were never provided, the feds say. Visit www.oag.state.va.us.

◆ **Percival Wignall, the owner and operator of Sunnyman Retirement home in Miami, was charged with defrauding Florida Medicaid of $45,000,** the Florida AG's office said Sept. 30. The state says Wignall billed for the same recipients as another Medicaid provider for the same services on the same dates. He also allegedly billed for Medicaid beneficiaries who never lived in his facility, the state says. The conduct occurred between October 2005 and February 2006. If convicted, Wignall faces 45 years in prison and a $30,000 fine. An attorney for Wignall could not be reached for comment. Visit www.myfloridalegal.com.

◆ **A health system's program giving a free one-night hotel stay to the families of children who've just had a tonsillectomy can be extended to Medicaid beneficiaries,** OIG says in Advisory Opinion 10-18. There is "minimal risk" that the program would generate prohibited remuneration under the

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NEWS BRIEFS (continued)

anti-kickback statute, so OIG would not impose sanctions, it says. The health system is in a "largely rural area." Some of the tonsillectomies are performed on an outpatient basis at outpatient surgery centers or clinics when medically appropriate. The specialists who perform the surgeries do not have privileges at or perform tonsillectomies at hospitals outside the health system. For the patients who receive outpatient tonsillectomies, the hospital offers the family the option to stay at a hotel adjacent to the facility at no cost for the night after the surgery. The patients often live very far away from the facility, so this is offered in case complications arise, according to the opinion. OIG says the program is at low risk of abuse because the specialists have no improper incentives to steer patients to facilities within the health system. Their salaries are not affected by the volume or value of surgeries performed. Also, the program is unlike other deals where a provider gives free services to patients with the expectation that the patient is likely to continue to use the services because "it is only in the unlikely event of complications arising from the surgery that a patient would be likely to utilize additional hospital items or services related to the tonsillectomy," OIG says. Finally, the health system is providing a valuable service in a rural area. To read the opinion, go to AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "OIG Advisory Opinions."

◆ **Northridge Healthcare and Rehabilitation in Arkansas should return more than $28,000 in Medicaid overpayments from credit balances, $20,000 of which is the federal share,** OIG says in an audit report (A-06-09-00105) posted Oct. 1. Credit balances occur when reimbursement exceeds the program payment ceiling or when the reimbursement is for unallowable costs, resulting in an overpayment. They can also occur when a provider receives payments for the same services from the Medicaid program and a third-party payer. A Northridge representative told OIG that the facility did not return the overpayments because it "believed that the state would offset the facility's payment by the amount of the credit balance before Northridge could reimburse the state," the report says. OIG recommends that the state (1) recover the $28,476 from Northridge and refund $20,866 to the federal government, (2) work with Northridge to see if any portion of its remaining credit balances ($2,146) were due to overpayments, and (3) work with the facility to ensure that future credit balances are reviewed and overpayments are returned. The state generally agreed. To read the audit, go to AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "OIG Audit Reports."

◆ **Novartis Pharmaceuticals Corp. has agreed to plead guilty and pay a criminal fine of $185 million for the off-label marketing of one drug, plus pay $237.5 million to resolve civil liabilities for the off-label marketing of several other drugs and payment of kickbacks to providers,** the Department of Justice said Sept. 30. A criminal information filed by DOJ and other agencies charges Novartis with introducing misbranded drugs into interstate commerce between July 2000 and December 2001. The feds allege that Novartis promoted the epilepsy drug Trileptal for treatment of neuropathic pain and bipolar disease, which were not FDA-approved uses. In a separate civil settlement, Novartis agreed to pay the federal government and participating states $237.5 million to settle allegations that it caused invalid claims for six drugs to be submitted to Medicare, Medicaid and other federal programs. The company also has entered into a corporate integrity agreement with the HHS OIG. Novartis says in a statement that it cooperated with the investigation and is pleased to have reached a resolution. The settlement stems from whistleblower cases filed by former Novartis employees in Florida and Pennsylvania. Visit www.justice.gov and www.novartis.com.

◆ **Bronx Lebanon Hospital Center in New York should repay more than $4,600 in Medicaid overpayments for laboratory and other ordered ambulatory services billed during an inpatient stay,** the New York State Office of Medicaid Inspector General (OMIG) says in an audit report. "When Medicaid pays for such outpatient service for a hospitalized recipient, it is paying twice for the same service: first when it pays the inpatient rate and again when it pays the outpatient provider's separate claim," OMIG's report says. "Inpatient hospital rates include all the costs incurred for the care of inpatients." The hospital received $2,025 for lab services and $472 for ambulatory services that should have been billed to the original hospital, resulting in $2,638 in overpayments, according to OMIG. To read OMIG audit reports, go to http://omig.ny.gov and click on "Audit."

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