SCHOOL SUPPORTIVE SERVICES-MEDICAID COMPLIANCE 4/27/11

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2011

- GOVERNOR CUOMO'S STATE OF THE STATE
  - MEDICAID AS ONE OF THREE PRIMARY FOCUS AREAS
  - NOT BUDGET CUTTING OR TRIMMING, BUT - REINVENTING, REORGANIZING, AND REDESIGNING PROGRAMS AND AGENCIES
  - MEDICAID REDESIGN TEAM (MRT)
  - THOROUGH REVIEW OF MEDICAID PROGRAMS AND AGENCY PRACTICES
  - ON-TIME BUDGET 2011-FIRST IN MEMORY

PURPOSE OF OMIG WEBINARS- FULFILLING OMIG'S DUTY IN NYS PHL SECTION 32 -

- § 32(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: May 25: Home Health Conflict and Exception reports.**

GOALS OF THIS PROGRAM

- Education for Medicaid providers, billing entities, and municipal/county governmental entities on compliance with Medicaid payment requirements
- Compliance expectations for providers & billers
- Federal funding brings federal oversight-provider and municipality responsibilities under Medicaid
- The CMS Integrity Agreement with New York
- Responsibilities of OMIG, DOH, SED
- Audit process and approach
- Compliance Officer

CONCERNS OF THIS PROGRAM

- Involves both Medicaid and Individuals with Disabilities Education Act (IDEA)
- School districts, Section 4201 schools and counties are not required to bill Medicaid for services included in a student's IEP; they are obligated to provide services pursuant to a student's IEP
- School districts and counties required to provide a free, appropriate public education

NEW YORK MEDICAID IN EDUCATION ALERT 11-02 (April 22, 2011)

- Billing for SSHSP services furnished on or after September 1, 2009 has resumed.
- School districts and Section 4201 schools can bill for SSHSP Targeted Case Management services provided prior to July 1, 2010 (refer to:

  http://www.oms.nysed.gov/medicaid/medicaid_alerts/alerts_2011/Medicaid_Alert_11-2_Billing_SPA0961.pdf
- Extensive training has been provided to clarify Medicaid billing and claiming requirements under SSHSP State Plan Amendment #09-61 (more than 40,000 school district, county and 4201 school relevant employees trained via online and in-person training sessions; school district, county and 4201 “relevant employees” must be trained to resume billing).

NEW YORK MEDICAID IN EDUCATION ALERT 11-02 (April 22, 2011)

- All documentation supporting the provider's right to bill Medicaid for services must be in place **prior to the submission of claims for Medicaid reimbursement:**
- Verification of medical necessity (e.g., written order/referral),
- Verification that the service was provided by a Medicaid qualified provider, including fulfillment of "under the direction of" or supervision requirements,
- A contemporaneous record of each encounter, and
- An Individualized Education Program (IEP) which identifies the service being billed.
- http://www.oms.nysed.gov/medicaid/medicaid_alerts/alerts_2011/Medicaid_Alert_11-2_Billing_SPA0961.pdf

MEDICAID IN EDUCATION-A PRIORITY ISSUE FOR FEDERAL HHS/OIG

- 2010 SEPT *Review of New Jersey's Medicaid School-Based Health Claims Submitted by Public Consulting Group, Inc.* A-02-07-01052 Report
- 2010 APR *Review of New Jersey's Medicaid School-Based Health Claims Submitted by Maximus, Inc.* A-02-07-01051 Report
- 2010 MAR *Review of Arizona's Medicaid Claims for School-Based Health Services* A-09-07-00051 Report
- 2009 APR *Review of Timeliness of West Virginia's Retroactive Claims for Medicaid School-Based Services.* A-03-06-00201 Report
- 2008 FEB *Review of New Jersey's Medicaid School-Based Rates.* A-02-04-01017 Report
- 2007 OCT *Medicaid School-Based Services in Utah – Review of Payment Rates.* A-07-06-04069 Report
- 2007 MAY *Review of Medicaid Reimbursement Rate for School-Based Health Services in Maryland.* A-03-05-00206 Report

MEDICAID IN EDUCATION-A PRIORITY ISSUE FOR HHS/OIG

- **Findings: "**Our reviews through fiscal year (FY) 2010 found that states' claims for the Federal share of Medicaid included school-based services that did not always fully comply with Federal and State standards. We identified Medicaid overpayments for school-based health services with the Federal share of the overpayments totaling an estimated $1.4 billion."
- HHS/OIG "Compendium of Unimplemented Recommendations March 31, 2011" | Part III page 7

NEW YORK/CMS Compliance Agreement-2009

- Compliance agreement has a number of components, including mandatory training of relevant employees and confidential disclosure of suspected fraud, waste and abuse
- $540 million repayment in whistleblower case:
  - $440 million payment by New York State
  - $100 million repayment by New York City
- OMIG audits
- Independent audit
- Annual written reports
- Annual training

Compliance Agreement

Confidential Disclosure Contact

Rose Firestein
Compliance Officer
New York State Department of Health
Office of General Counsel
90 Church Street, 4th Floor
New York, New York 10007
Telephone: 212/417-4393
Facsimile: 212/417-4392
ref01@health.state.ny.us

OMIG MEDICAID IN EDUCATION AUDITS

Audits **required** by CMS

- Over $1,000,000 – all will be audited (NYC on an annual basis)
- $250,000 - $1,000,000 – randomly audit 25 providers (districts or counties) annually
- Up to $250,000 – randomly audit 10 providers (districts or counties) annually

Audit Standards: Medicaid State Plan Amendment (09-61) – Written Orders/Referrals

Written Orders and Referrals must include:

- The name of the child for whom the order is written;
- The complete date the order was written and signed;
- The service that is being ordered;
- Provider's contact information (office stamp or preprinted address and telephone number);
- Signature of a NYS-licensed and registered physician, a physician assistant, or a licensed nurse practitioner acting within his or her scope of practice (for psychological counseling services this also includes an appropriate school official and for speech therapy services, a speech-language pathologist*);

Audit Standards: Medicaid State Plan Amendment (09-61) – Written Orders/Referrals

Written Orders and Referrals must include (continued):

- The time period for which services are being ordered;
- The ordering practitioner's National Provider Identifier (NPI) or license number; and,
- Patient diagnosis and/or reason/need for ordered services.

*For purposes of the SSHSP, where written referrals are permitted (e.g., speech therapy services, psychological counseling services), the written referral must include the information listed above.

Audit Standards: Medicaid State Plan Amendment (09-61) – Session Notes

- Session notes must include:
  - Student's name
  - Specific type of service provided
  - Whether the service was provided individually or in a group (specify the actual group size)
  - The setting in which the service was rendered (school, clinic, other)
  - Date and time the service was rendered (length of session – record session start time and end time)
  - Brief description of the student's progress made by receiving the service during the session
  - Name, title, signature and credentials of the person furnishing the service and signature/credentials of supervising clinician as appropriate

Documentation Required to Support Medicaid Reimbursement

- IEP
- Written orders
- Written referrals
- Documenting service delivery
  - Session notes
- UDO/Supervision if applicable
- Provider credentials kept on file
- Special Transportation
  - Medical/Behavioral need (included in IEP)
  - Documented receipt of Medicaid covered service
  - Transportation logs

Compliance Agreement

- Training
  - Relevant employee database http://www.forms2.nysed.gov/oms/medicaid/shsp.cfm
  - Annual relevant employee training
  - Relevant employee listings from each school district, county and 4201 school
  - SED is following up with school districts, counties and 4201 schools that are not in compliance with the relevant employee mandatory training requirement; training requirement needs to be met before school district, county or 4201 is permitted to bill Medicaid

SCHOOL SUPPORTIVE SERVICES-MEDICAID

- Total Medicaid expenditures in NY 2009-10 school year: $159.8 million
- Federal share $98.4 million
- NY City=$ million total reimbursements:
  - Calendar year 2009: $14,903,539
  - Calendar year 2010: $60,903,843

SCHOOL SUPPORTIVE PROGRAM FEDERAL LAW AND REGULATIONS

- *Individuals with Disabilities Education Act*, Part B (ages 3-21)

SCHOOL SUPPORTIVE PROGRAM FEDERAL LAW AND REGULATIONS

- Part 200 of the NYSED Commissioner's Regulations: http://www.p12.nysed.gov/specialed/lawsregs/part200.htm
- NYSED's special education department's Web site:
- http://www.p12.nysed.gov/specialed/

CORE MEDICAID REQUIREMENTS 18 NYCRR 504.3 FOR ALL PROVIDERS

- Medicaid is payment in full-no balance billing
- Bill for only services which are medically necessary and actually furnished
- Bill only for services to eligible persons
- Permit audits. . . of all books and records relating to services furnished and payments received, including patient histories, case files, and patient-specific data
- Provide information in relation to any claim . . . Which is true, accurate, and complete.
- “To comply with the rules, regulations, and official directives of the department.”

WHO MAY AUDIT MEDICAID SCHOOL SUPPORTIVE SERVICES PAYMENTS?

- Office of Medicaid Inspector General (NY)
- HHS and Education Office of Inspector General (federal)
- Medicaid Fraud Control Unit (NY)
- Medicaid Integrity Contractor (CMS)
- Office of State Comptroller (NY)
- Counties and County Comptrollers
- GAO

OTHER AUDIT/INVESTIGATIVE RISKS

- New York Attorney General actions under the New York False Claims Act
- Whistleblower actions under the New York False Claims Act (these cases limited to private entities)
- Claims under the federal False Claims Act

WHO MAY BE AUDITED?

- School districts, counties and Section 4201 schools submitting claim
- Contracted provider of services
- Service bureau, billing service, or electronic media billers preparing or submitting claims (See 18 NYCRR 504.9)

WHAT YOU HAVE PROMISED

- Keep any records necessary to disclose the extent of services the provider furnishes to recipients receiving assistance under the New York State Plan for Medical Assistance;

- On request, furnish the New York State Department of Health, or its designee, and the Secretary of the United States Department of Health and Human Services, and the New York State Medicaid Fraud Control Unit any information maintained under paragraph (A) (1), and any information regarding any Medicaid claims reassigned by the provider to the school districts, counties and section 4201 schools.

Limiting fraud and abuse within the Medicaid 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"
  - –failing to bill other payors

THE FOUR GREATEST MEDICAID PROGRAM RISKS IN SCHOOL SERVICES

- RISK #1: Using excluded persons to provide services reimbursable by Medicaid.
- RISK #2: Failing to refund identified overpayments to the Medicaid program.
- RISK #3: Failing to maintain an “effective” compliance program as required by 18 NYCRR 521 (if more than $500,000).
- RISK #4: Failing to supervise service bureaus or billing companies submitting claims or receiving payment.

RISK #1: Using Excluded Persons to Provide Services Reimbursable by Medicaid

- See OMIG's Exclusion Webinar on our website at http://www.omig.ny.gov/data/images/stories/Webinar/6-8-10_exclusion_webinar_final.ppt

Program Exclusions

- Statute
- Regulation
- Federal OIG Guidance
- Federal CMS Guidance
- State Guidance Mandated by CMS
- Condition of NY provider enrollment or NY state contract
- Virtually no case law (criminal, civil, or administrative) on extent and effect of exclusion

CMS EXCLUSION REGULATION

- "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 when the person furnishing such item or service knew or had reason to know of the exclusion." 42 CFR 1001.1901 (b)
- Focus is not on the relationship but on the **payment.**

PROGRAM EXCLUSION

- Federal authority and requirement on providers
  - No claims based on work of excluded persons
- Federal authority and mandate on state Medicaid programs
  - No state Medicaid claims to CMS based on work of excluded persons

Impact of Exclusion on Health Care Providers

- Once exclusion occurs, health care providers:
  - May employ or contract with excluded persons, but may not allow excluded persons to provide or to direct the ordering or delivery of services or supplies, or to undertake certain administrative duties (CSE/CPSE members, service providers)
  - Whether or not direct care activities are involved
  - If any part of the task is reimbursed by federal program (Medicaid) dollars
  - Note: Staffing agencies must screen potential candidates to ensure that they have not been excluded prior to being sent to providers for work. Providers must develop and enforce contractual agreements to ensure prescreening occurs.

THE NEW YORK STATE EXCLUSION REGULATION

- **18 NYCRR 515.5** Sanctions effect: (a) No payments will be made to or on behalf of any person for the medical care, services or supplies furnished by or under the supervision of the person during a period of exclusion or in violation of any condition of participation in the program.

RISK #2: Failing to Refund Identified Overpayments to the Medicaid Program- ACA § 6402

- *(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 . . .**

ACA § 6402 and False Claims Act

- Failure to report, refund, and explain overpayments within 60 days of identification can give rise to a claim of "knowing" failure to repay under the False Claims Act
- See OMIG Webinar: http://www.omig.ny.gov/data/images/stories/Webinar/7-14-10_ppaca_webinar.ppt

RETURNING OVERPAYMENTS IN NEW YORK TO THE MEDICAID PROGRAM

- **Report and return the overpayment *to the State* at the correct address**
- **In New York, Medicaid 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 Computer Sciences Corporation (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**"

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 an individual program enrollee or subcontractor 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?

- ACA § 6402(A)
- 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

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

SOME REASONS FOR OVERPAYMENTS

- Duplicate payments of the same service(s)
- Incorrect provider payee
- Payment for services not authorized
- Services not actually rendered

MORE REASONS FOR OVERPAYMENTS

- Failure to refund credit balances
- Excluded ordering or servicing person
- Patient deceased
- Servicing person lacked required license or certification
- Billing system error

"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

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."

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.)

RISK #3: Failing to Maintain an "Effective" Compliance Program as Required by 18 NYCRR 521 (if billing over $500,000 per year)

- See OMIG Webinar: Evaluating Effectiveness of Compliance Programs
- http://www.omig.ny.gov/data/images/stories/Webinar/compliance_webinar_11-17-10.ppt

Maintaining an "Effective" Compliance Program

- 18 NYCRR 521
- Requires an eight-step effective compliance program
- Requires an annual certification by December 31 of each year
- Applies to both governments and providers (directly or indirectly): school districts, counties, Section 4201 schools, agency service providers

NY Mandatory Compliance Program- Prior to ACA

- 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 – annually in December, started 12/09
- Evaluation - ongoing

Risk #4: Failing to Supervise Service Bureaus or Billing Companies Submitting Claims or Receiving Payment

- See OMIG Webinar-Third Party Billing in the Medicaid program
- http://www.omig.ny.gov/data/images/stories/Webinar/1-12-11_third_party_billing_final.ppt

Duty to Supervise Service Bureaus or Billing Companies Submitting Claims or Receiving Payment

- Who is responsible if the billing company makes a mistake?
- The school district, county or Section 4201 school is responsible and must ensure that contractors (if used) bill appropriately.

Questions for Health Care Providers About Third-Party Billers

- If any non-employee submits your claims, checks enrollment, or obtains authorizations, have you received a written representation that the person or entity has a records preservation policy consistent with EMEDNY-414601 (i.e., six years from the date of claims submission) for material and data your organization submits, and 10 NYCRR 69-4.26 requirements (to age 21 for educational records)?

"Compliance Program Guidance for Third-Party Medical Billing Companies," 63 FR 70138-70152 (December 18, 1998)

- billing for items or services not actually documented;
- unbundling and upcoding of claims;
- computer software programs that encourage billing personnel to enter data in fields indicating services were rendered though not actually performed or documented;
- knowing misuse of provider identification numbers which results in improper billing in violation of rules governing reassignment of benefits;
- billing company incentives that violate the anti-kickback statute;
- percentage billing arrangements.

New York State Regulation- Required Enrollment

- “Persons submitting claims, verifying client eligibility, . . . Except those persons employed by providers enrolled in the medical assistance program, must enroll in the medical assistance program. . . “ 18 NYCRR 504.9
- Is your billing company enrolled?

Additional Medicaid Program Integrity ACA Requirements: ACA § 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 ACA Provisions

- STATE REQUIREMENTS:
- § 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.
- ALTERNATE PAYEE REQUIREMENTS:
- §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.

Additional Resources

- Medicaid-in-Education homepage:
  http://www.oms.nysed.gov/medicaid/
- Medicaid-in-Education Questions & Answers
  http://www.oms.nysed.gov/medicaid/q_and_a/
- Office of Professions homepage:
  http://www.op.nysed.gov
- National Alliance for Medicaid in Education
  http://medicaidforeducation.org/
- LEAnet
  http://www.theleanet.com/

SSHSP Technical Assistance

- Technical assistance questions should be directed to the Med-in-Ed mailbox (MedinEd@mail.nysed.gov)
- Compliance issues should be forwarded to local compliance officer or Rose Firestein if they cannot be resolved at the local (district, county level)

UPCOMING WEBINAR INFORMATION

- May 25 Webinar: Home Health Care: Conflict and Exception Reports
- Previous Webinars (www.omig.ny.gov)
  - Excluded parties
  - Self disclosures, overpayments
  - Effective compliance program and whistleblower issues, evaluating effectiveness of compliance programs
  - Third-party billing
  - Early Intervention

FREE STUFF FROM OMIG

- OMIG website - www.OMIG.ny.gov
- Mandatory compliance program-hospitals, managed care, all providers over $500,000/year
- More than 3,000 provider audit reports, detailing findings in specific industry
- 2011 Work Plan (2012 Work Plan to come in October 2011)
- Listserv (put your name in, get emailed updates)
- New York excluded provider list
- Follow us on Twitter: NYSOMIG