New York State Office of the Medicaid Inspector General

What Providers Need to Know about Payment Suspension

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Introduction

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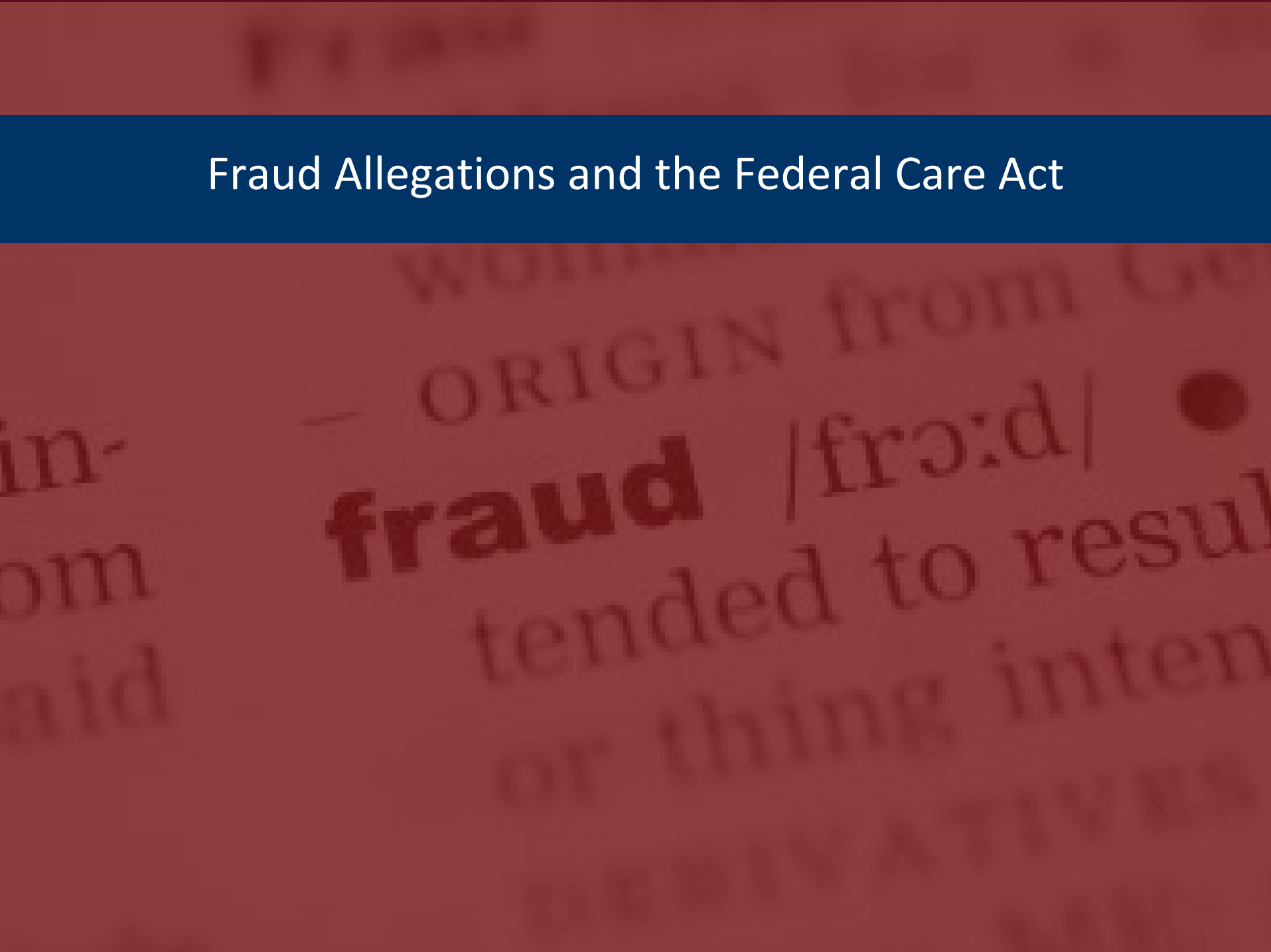
Today's Agenda

Fraud Allegations and the Federal Care Act

Definitions, Guidance and Examples

Preparation & Implementation

Fraud Allegations and the Federal Care Act



Reporting and returning of overpayments:

- Section 6402(a)
  - Adds Section 1128J(d)(1)(A) to the Social Security Act
  - Reporting and returning of overpayments: “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.”

Subpoena Authority

- Section 6402(e):
  - Provides state governments with **new testimonial subpoena authority** in exclusion actions.
  - In New York, this was already in place prior to the Care Act.

Violation without Intention

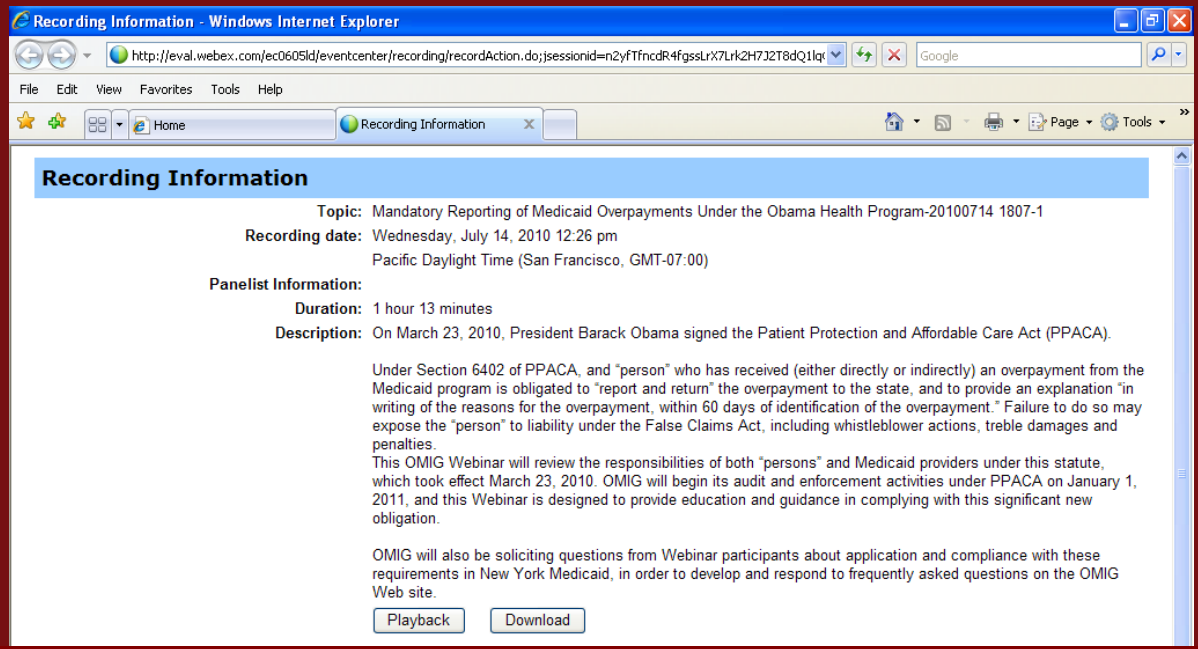
- Section 6402(f)(2):
  - Adds new subsection 1128B(g) of the Social Security Act
  - Amends the federal health care program anti-kickback statute by adding a provision to clarify that **"a person need not have actual knowledge of this section or specific intent to commit a violation of this section."**

False Claims

- Section 6402(g):
  - In addition to the penalties provided for in 6402, **a claim that includes seeking reimbursement for provision of items or services that violate this section constitutes a false or fraudulent claim** for purposes of Subchapter III of Chapter 37 of Title 31 USC.

REMINDER:

We covered some of these sections in a July 2010 Webinar (see our website):



<u>Mandatory Reporting of Medicaid Overpayments Under the Obama Health Program</u>

TODAY'S FOCUS

Today, we will focus on a specific section of the Care Act which structures suspension of payment as a result of a credible allegation of fraud.

Pre-Care Act: Social Security Law 1396(i)(2)

- **Prevented payment for any amount expended for an item or service furnished by an excluded:**
  - **Individual**
  - **Entity**
  - **Physician**

Care Act 2010

- Signed into law March 23, 2010.

Section 6402(h):

- Prevents payment to any individual or entity during any period "when there is pending an investigation of a credible allegation of fraud…unless there is good cause not to suspend…"

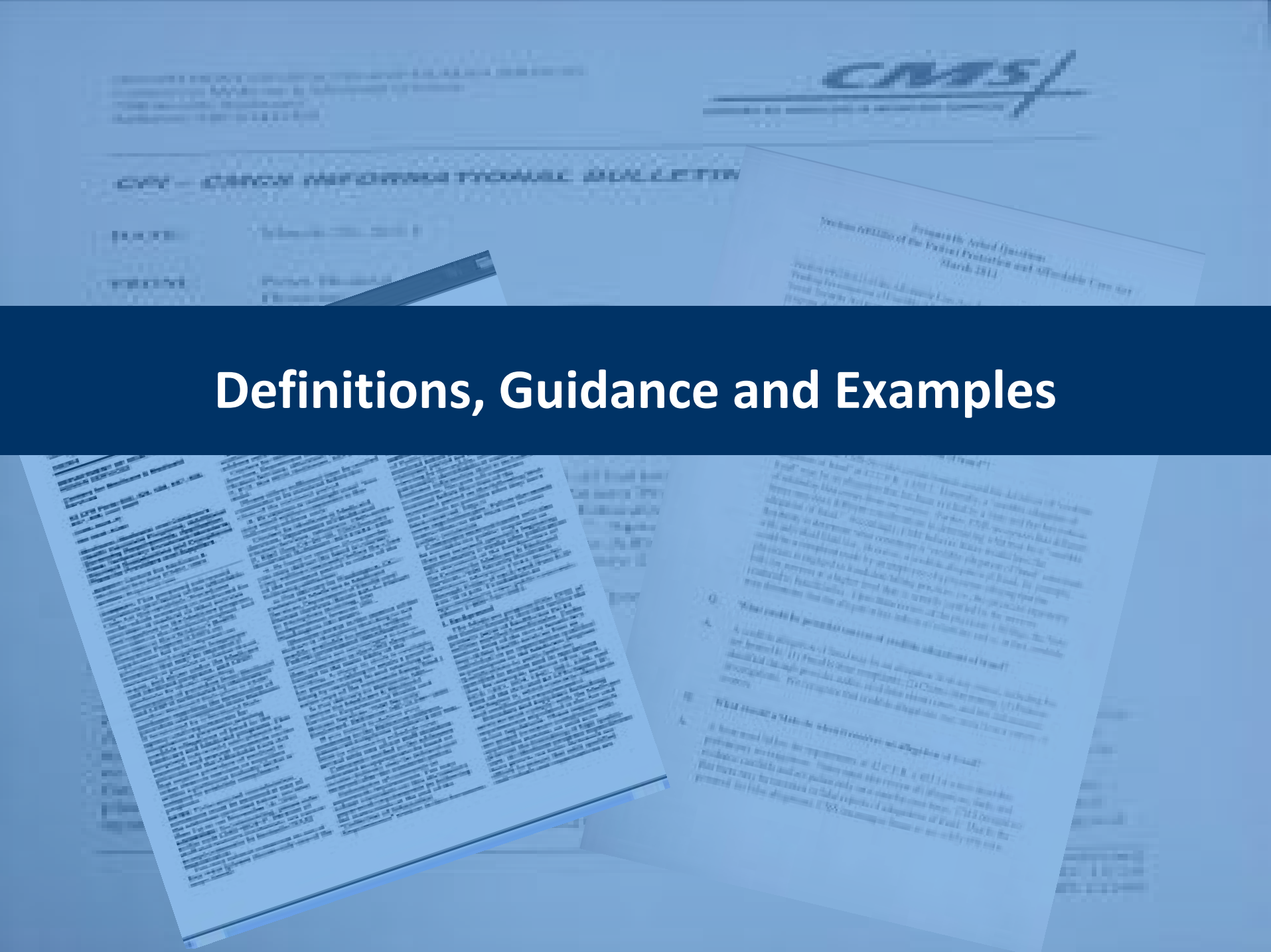
What's the difference?

- In the pre-Care Act period, payment would have been prevented when there was a determined status of exclusion
- Post-Care Act federal law now says that when a credible allegation of fraud against the individual or entity is pending or under investigation, payment must be suspended.
- The change to the law lowers the threshold to suspend payments to a provider in cases of credible allegations of fraud.

What Does This Mean?

- Federal financial participation stops when a determination is made that a credible allegation of fraud against the individual or entity is pending or under investigation.
- Allegation is transmitted to New York's Medicaid Fraud Control Unit.
- Pending and future referrals to the Medicaid Fraud Control Unit will be placed on suspension (with good cause exceptions – more on this later).

Definitions, Guidance and Examples



Credible Allegation of Fraud

- Verified allegation that has “indicia of reliability”
- Can come from any source:
  - Complaint made by former employee
  - Fraud hotline
  - Claims data mining
  - Patterns identified through:
    - audits
    - civil false claims
    - investigations

Important Points

- NYOMIG is required to review evidence and carefully consider the totality of facts and circumstances.
- Suspension or even partial suspension is an extraordinary action, not a routine matter.
  - reserved only for cases where there are pending investigations of credible allegations of fraud.

Good Cause Exceptions: What does that mean?

- CMS regulations allow for discretion in cases where the best interest of law enforcement or the Medicaid program come into play as a result of an allegation of fraud.
- These are called “good cause” exceptions.

Law Enforcement Good Cause

Law enforcement-related reasons to not suspend payments, such as where:

- There are requests by law enforcement.
- It might give a “heads up” to a perpetrator, or it might expose undercover investigators, whistleblowers or confidential sources.

Other Good Causes

Good cause exceptions may be invoked, such as where:

- suspension is not in the best interests of the Medicaid program.
- access to necessary items or services may be jeopardized.
  - This involves working with the other regulating agencies on access to care.

Other Good Causes

- Examples could fall into either category depending on context, such as where:
  - other available remedies could more effectively or quickly protect Medicaid funds than would implementing (or continuing) a payment suspension
  - immediate enjoinment of potentially unlawful conduct

Process Notes

- The suspension process needs to be documented and maintained by NYOMIG.
- The 6402(h) suspension process will be coordinated with regulating agencies and the Medicaid Fraud Control Unit.
- Regulating agencies may be required to work with providers to accommodate patients who need care.

Common Question: Fraud Hotline

- We've received the question several times – does the new requirement mean that a single phone call will cause a 100 percent suspension of payment?
- The answer is *not necessarily* – but let's take a look at the process for a more detailed understanding.

Fraud Hotline Process Example

- Hotline call comes in with an allegation that there is overbilling at a medical facility.
  - NYOMIG reviews and investigates the matter to determine the facts of the case:
    - Maybe the allegation is unfounded
    - Maybe there is a credible allegation of fraud.
  - NYOMIG will work with our partners at the other regulating agencies as it relates to access to care.

Fraud Hotline Process Example

If a credible allegation exists:

- NYOMIG checks to make sure there is not a good cause exception and then decides whether to suspend and by how much.
- NYOMIG will inform the other regulating agencies of the determination.

If there's *not* a credible allegation:

- No suspension is placed into effect.

TAKEAWAY: A single phone call does not **automatically** trigger a suspension

Common Question: Data Mining

- We've been asked whether the new requirements mean data matches will require a suspension.
- Let's take a look at the process for a more detailed answer…

Data Mining Process Example

- Data mining identifies an outlier payment to an identifiable caregiver.
  - First, NYOMIG would identify whether there was a pattern or whether this overpayment was part of an overall concern.
  - As in the previous case, NYOMIG would review and investigate the matter to determine the facts of the case:
    - Maybe the allegation is unfounded
    - Maybe there is a credible allegation of fraud.
  - NYOMIG would work with our partners at the other regulating agencies regarding access to care.

Data Mining Process Example

If a credible allegation is identified:

NYOMIG checks to make sure there is not a good cause exception and then decides whether to suspend and by how much, after which NYOMIG will inform the other regulating agencies of the determination.

If there's *not* a credible allegation:

Maybe, for example, there was a data error which looked like an outlier but wasn't .

No suspension is placed into effect.

TAKEAWAY: In accordance with federal guidance, NYOMIG will review all evidence and carefully consider the totality of facts and circumstances.

Notice of Suspension Elements, Part 1

- Notice needs to:
  - Be given within five days of taking action (unless the Medicaid Fraud Control Unit or law enforcement requests otherwise).
  - Detail general allegations as to the nature of the suspension action; state that the suspension is for a temporary period.
  - State circumstances under which suspension will be terminated.

Notice of Suspension Elements, Part 2

- Specify, when applicable, which type or types of Medicaid claims or business units are affected by the suspension.
- Inform the provider of the right to submit written evidence for consideration by the state Medicaid agency.

- Notice does not need to:
  - Disclose any specific information concerning an ongoing investigation.
- Provider may request an administrative appeal.

Other Related Information

- Federal regulations Issued March 1, 2011, with effective date of March 25, 2011
- Managed care also covered
- Applies to institutional providers as well as providers who are employed and contracted by institutional providers

SHORT TERM IMPACT:

Pending cases with credible allegations of fraud

LONG TERM IMPACT:

New cases with credible allegations of fraud

Payment Suspension

- State suspends payment upon formal referral to the Medicaid Fraud Control Unit.
  - Formal referral comes in the form of a letter to the Medicaid Fraud Control Unit
  - Informal communications do not constitute a referral
- If the Medicaid Fraud Control Unit rejects the referral:
  - State can refer to local law enforcement
- If the Medicaid Fraud Control Unit and/or local law enforcement reject,

  payment suspension under the Care Act is released immediately. This does not preclude the state from taking other administrative actions.

When does implementation of this new requirement begin?

- It already has. Implementation started in March with our office taking steps to implement this new law.
- The Care Act requires ongoing cases to be placed on suspension.
- OMIG collaborated with the Medicaid Fraud Control Unit to work through ongoing cases.
- This work resulted in a number of cases which face immediate suspension.
- New cases will also be subject to potential suspension of payment.

Federal Oversight

- Annual report to CMS by program integrity agency
- CMS will want to review when our office has suspended, when it hasn't and why.

What Records does the State Have to Maintain?

- Five-year document retention requirement from date of determination includes all:
  (1) notices of suspension of payment in whole or part;
  (2) fraud referrals to the Medicaid Fraud Control Unit or other law enforcement;
  (3) quarterly certifications by the Medicaid Fraud Control Unit/law enforcement that a matter continues to be under investigation; and
  (4) notices documenting the termination of a suspension.

What Actions Does the Medicaid Fraud Control Unit/Local Law Enforcement Need to Do?

- Upon request, provide quarterly certifications to the NYOMIG that an accepted matter continues to be under active investigation.
- Quarterly certifications must continue in order to continue a suspension.
- Provide for a 30-day period (renewable in writing up to twice for a total not to exceed 90 days) by which law enforcement may, in writing, request the state agency to delay notification to a provider.

Preparation and Implementation

Preparation

- NYOMIG realized that implementation of the Care Act section 6402(h) would be a state-level issue.
- Partners at other state agencies were informed of the implications of this change in law.
- The state's overriding interest was to ensure that education and outreach to all affected entities would be part of our approach.
- Several action items needed to be carried out to accomplish this objective.

Actions Taken: NYOMIG

- Coordination with Partner Agencies:
  - Attorney General's Medicaid Fraud Control Unit
  - Commission on Quality of Care for People with Developmental Disabilities
  - Department of Health
  - Office for Alcoholism and Substance Abuse Services
  - Office for Persons with Developmental Disabilities
  - Office of Mental Health
  - Office of Temporary Disability and Assistance

Actions Taken: NYOMIG

- Sent letter to Commissioners
  - Asking for advice on outreach and implementation
- Informed the New York State Association of Counties (NYSAC), the New York State Association of County Health Officials (NYSACHO) and local social service districts
- Briefed Legislative Chairs

Working with Providers and Provider Advocates

NYOMIG has collaborated with providers and provider advocates by organizing:

- Face-to-face meetings with providers, provider advocacy groups and patient advocates
- Phone conferences
- E-mails
- Sharing guidance documents
- Updates
- Webinars
- Requests to spread the word

Working with Providers and Provider Advocates

- Samples of Meetings with Providers:
  - Greater New York Hospital Association
  - New York City Health and Hospitals Corporation
  - Medical Society of the State of New York
  - Healthcare Association of New York State
  - Chain Pharmacies
  - Independent Pharmacies
  - New York State Conference of Local Mental Hygiene Directors
  - Home Care Association of New York
  - New York Association of Home Care Providers

Working with Provider Advocates and Patient Advocates

- Cerebral Palsy Association of New York
- Medicaid Matters
- Community Health Care Association of New York
- New York State Association of Counties
- New York State Association of County Health Officials
- Long Term Care Community Coalition
- Health and Welfare Council of Long Island
- Southern Tier Independence Center
- Alcohol and Substance Abuse Providers of New York
- Continuing Care Leadership Coalition

Proposed Plan – Action items

- Partner Agencies:
  - Information to providers
  - Advice to NYOMIG
  - Build process for reporting allegations to NYOMIG
- Providers
  - Contribute to implementation
  - Work with NYOMIG
  - Self-disclose

Actions In Process: NYOMIG

- Issue Care Act-related regulations
- Dedicated page on NYOMIG Web site
- Continue work with
  - local governments
  - state level partners
  - providers and provider associations
  - patients and recipients
- OMIG article for *Medicaid Update* (published monthly by DOH)

IMPLEMENTATION

- NYOMIG has been working to implement this law since March
- Throughout this process, NYOMIG has:
  - proactively managed the implementation
  - coordinated with our partner regulating entities and state law enforcement
  - partnered with the provider community
  - committed to continuing these efforts.

RECAP

- State-level implementation will follow current processes.
- NYOMIG will follow federal law and guidance in carrying out suspensions or granting exceptions. A suspension is an extraordinary action used in cases where there are credible allegations of fraud.
- NYOMIG will soon release regulations and other guidance that will speak to this issue.
- Suspension is an extraordinary measure.
- If you know of a fellow provider who is not participating in this Webinar, please pass along the information – we will be posting this presentation on our Web site.

- **Thank you for listening – now it's our turn to listen to you. Please write to us, send emails, or give us a call. Contact information follows at the end of this webinar.**

Reporting Allegations To NYOMIG

Fraud Hotline

1-877-87- FRAUD

(1-877-873-7283)

Email us at:

bac@omig.ny.gov

or

information@omig.ny.gov

NYSOMIG

800 North Pearl Street

Albany, NY 12204

Other Ways to Participate with NYOMIG

- Join our listserv; receive information about upcoming events (sign-up information on home page)
- Follow us on Twitter: NYSOMIG
- Linked In
- Corporate integrity agreements, *Compliance Alerts* and compliance check lists
- Audit reports and protocols
- Excluded provider list
- And much more on www.omig.ny.gov