



# *HCCA's 12<sup>TH</sup> ANNUAL* COMPLIANCE INSTITUTE

APRIL 13–16, 2008 | NEW ORLEANS, LA | HILTON RIVERSIDE NEW ORLEANS

## *Federal and State Developments in Medicaid Enforcement and State False Claims Act Legislation*

**Brian Flood, KMPG**

**Frank Sheeder, Jones Day**

**Jim Sheehan, NY Medicaid Inspector General**



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# Usual Disclaimers

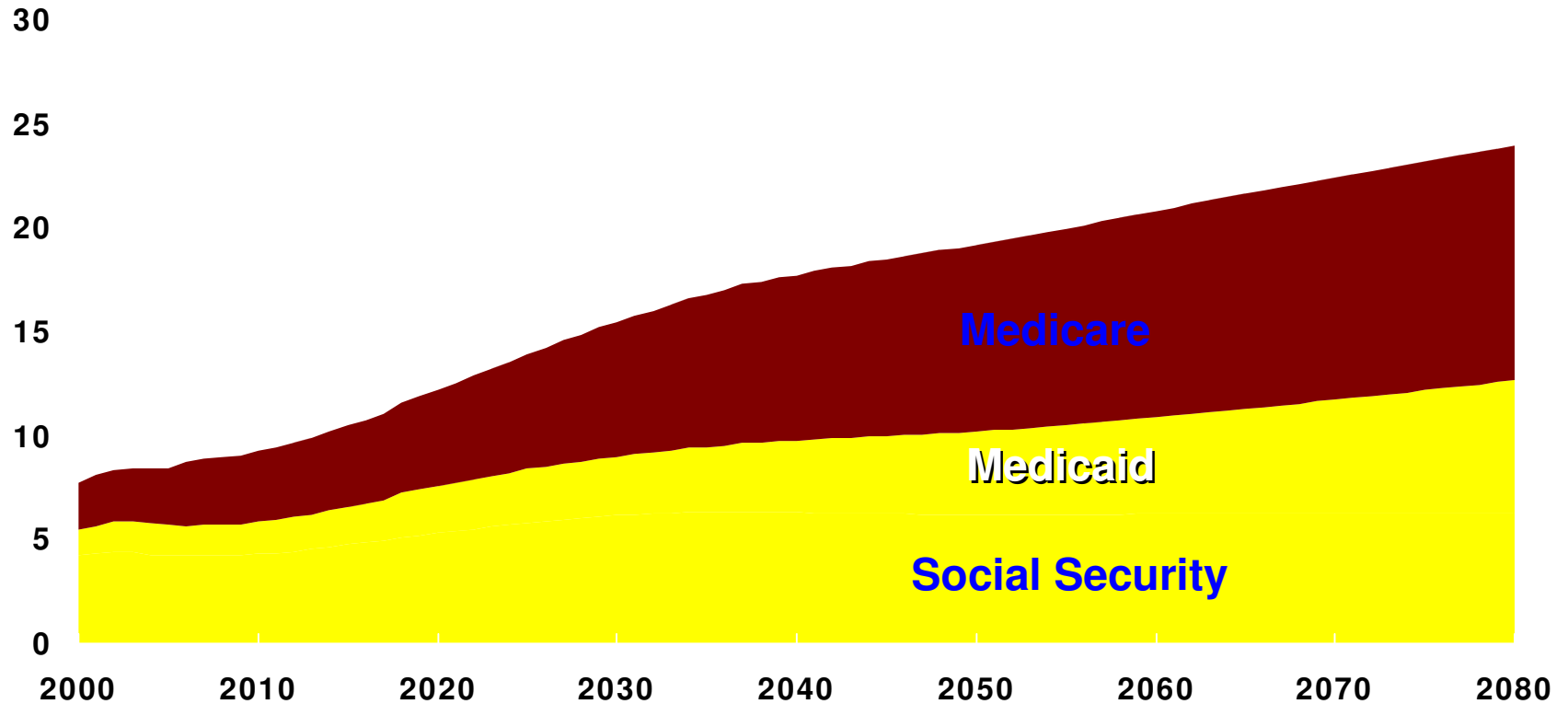
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- Personal opinions and ideas for collegial discussion
- Acknowledgement-ideas and some materials from many sources
- Presumption of good faith



# Social Security, Medicare, and Medicaid Spending as a Percent of GDP

Percent of GDP



Source: GAO analysis based on data from the Office of the Chief Actuary, Social Security Administration, Office of the Actuary, Centers for Medicare and Medicaid Services, and the Congressional Budget Office.

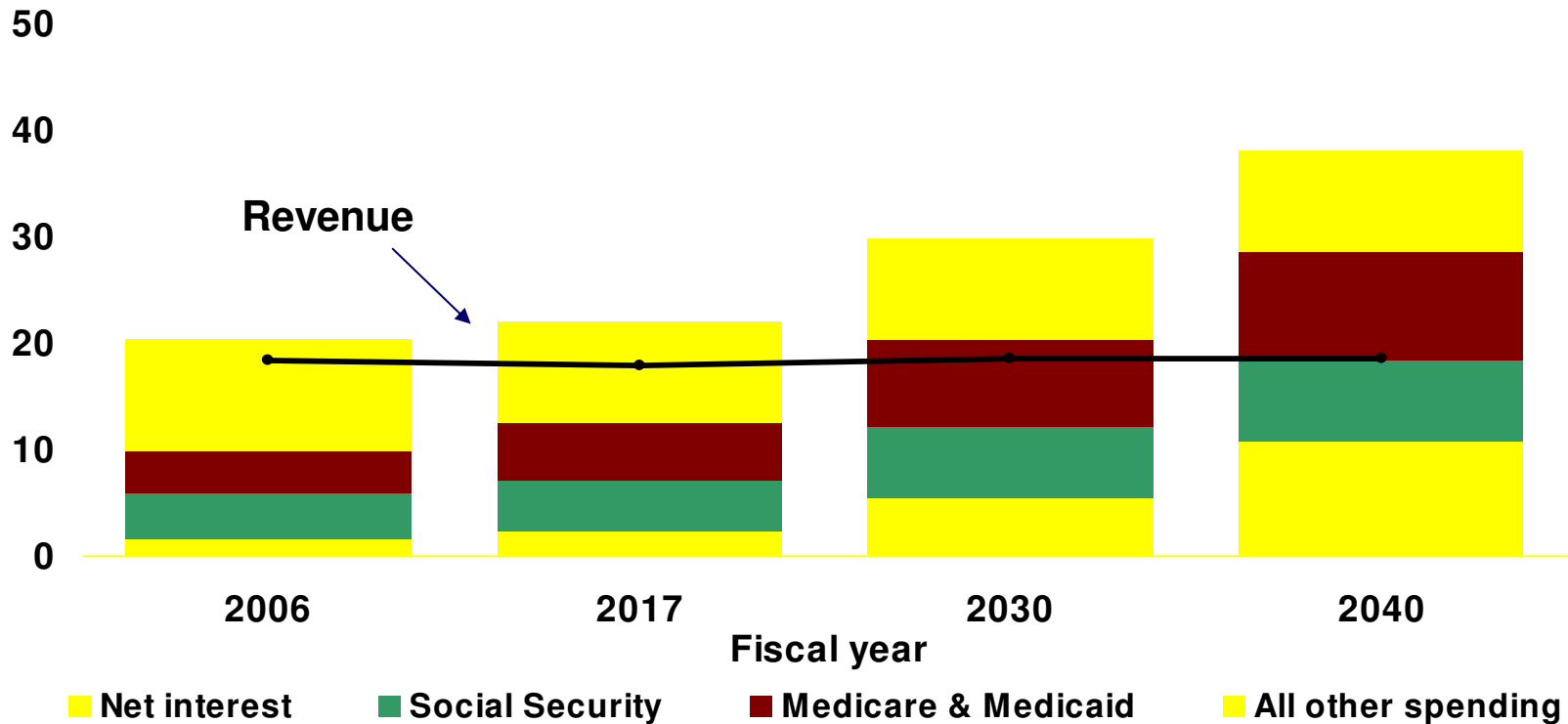
Note: Social Security and Medicare projections based on the intermediate assumptions of the 2007 Trustees' Reports. Medicaid projections based on CBO's August 2007 short-term Medicaid estimates and CBO's December 2005 long-term Medicaid projections under mid-range assumptions.



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# Discretionary Spending Grows with GDP After 2007 and All Expiring Tax Provisions Extended through 2017 (Thereafter Revenue Returns to Historical Average of 18.3% of GDP plus Deferred Revenue)

## Percent of GDP

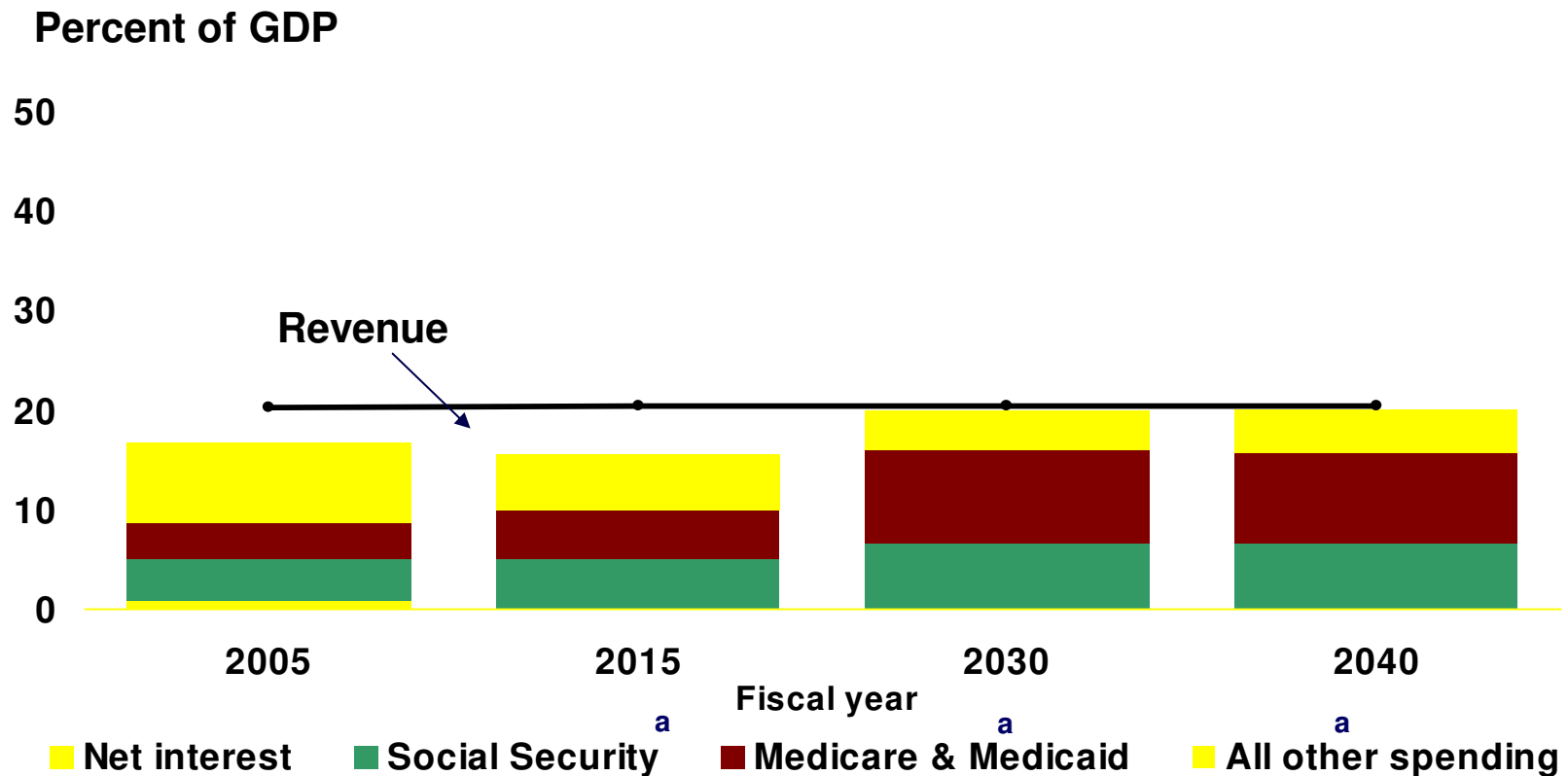


Source: GAO's January 2007 analysis.



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# Potential Fiscal Outcomes Under Baseline Extended (January 2001) Revenues and Composition of Spending as a Share of GDP

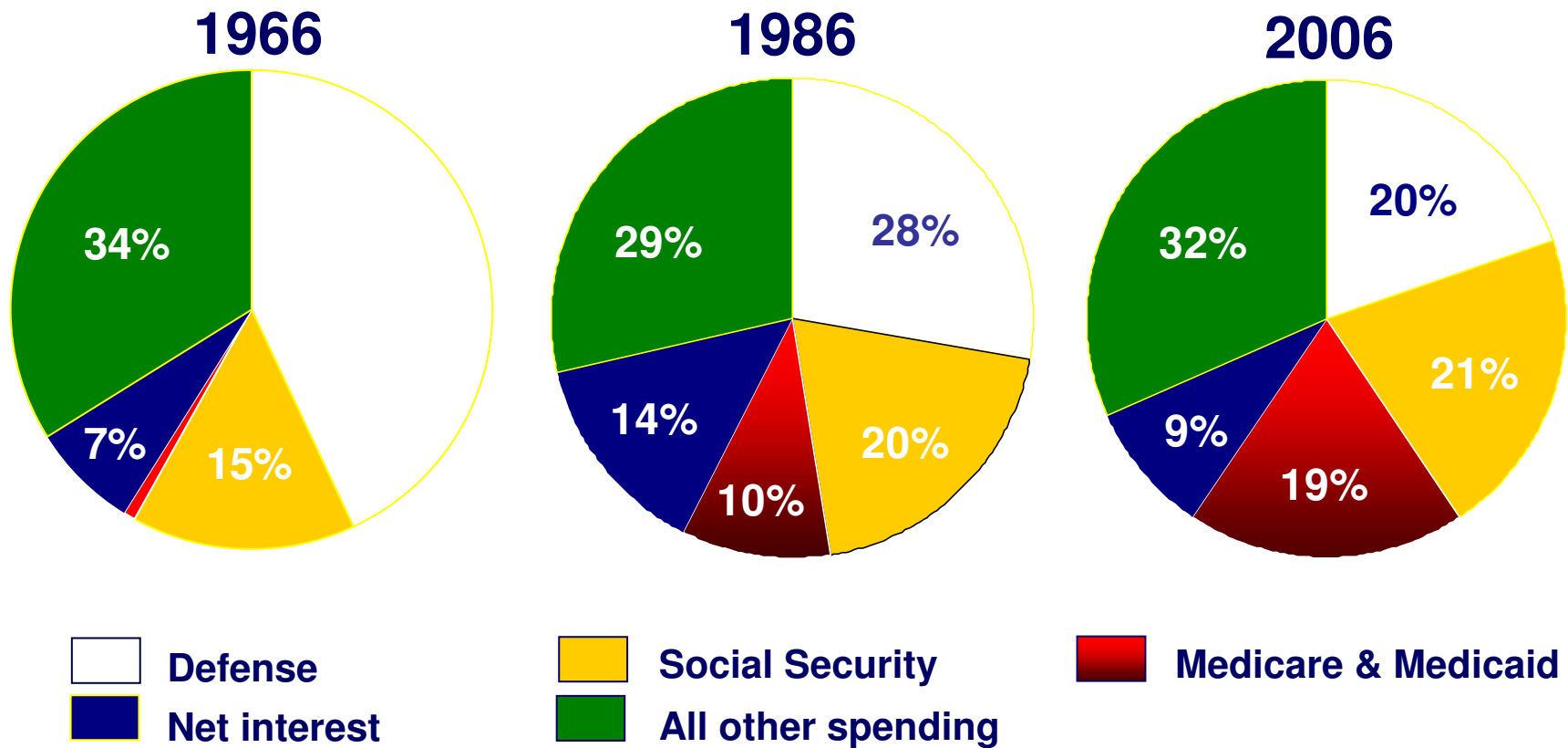


Source: GAO's January 2001 analysis.

Notes: In addition to the expiration of tax cuts, revenue as a share of GDP increases through 2017 due to (1) real bracket creep, (2) more taxpayers becoming subject to the AMT, and (3) increased revenue from tax-deferred retirement accounts. After 2017, revenue as a share of GDP is held constant—implicitly assuming action to offset the impact of bracket creep and to modify or offset the AMT.

<sup>a</sup>All other spending is net of offsetting interest receipts.

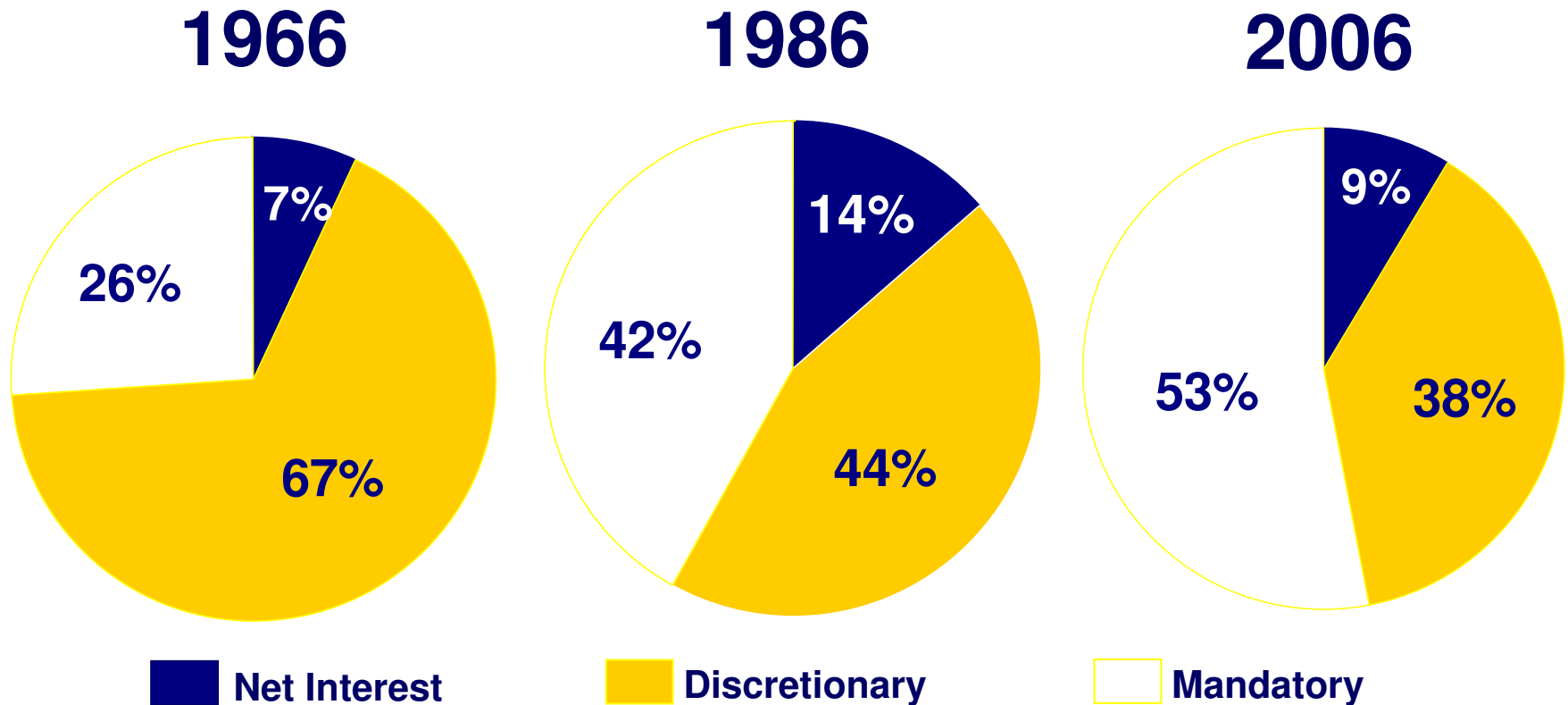
# Composition of Federal Spending



Source: Office of Management and Budget and the Department of the Treasury.

Note: Numbers may not add to 100 percent due to rounding.

# Federal Spending for Mandatory and Discretionary Programs



Source: Office of Management and Budget.



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# DRA-2005

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...”Evidence based approach...

...takes CMS’ partnership with and oversight of States to a new level...

...Unique opportunity to identify, recover, and prevent inappropriate Medicaid payments... pg 4  
CMS CMIP plan

MIP provides CMS with the ability to more directly ensure the accuracy of Medicaid payments...”



# Historical Medicaid Enforcement Climate

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- No plan at federal level
- No federal oversight
- Move to managed care changed mindset
- State attention varied, but was low priority
- Limited funding
- Limited data mining or matching
- Few prosecutions



# Economic Climate

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- Medicaid spending growing faster than Medicare
  - \$330 billion will be spent this year
- Medicaid = 1/3 of many states' budgets
- MFCUs now recovering record amounts
- Increasing demands, diminishing coverage and access, *e.g.*, kids



# Political Climate

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- Congress → CMS
  - Critical GAO and OIG Reports
  - Deficit Reduction Act of 2005 (DRA)
    - Increased pressure, but with funding
    - Medicaid Integrity Program
    - Incentives for State FCAs
    - Medi-Medi
- CMS → States
  - Bad OIG Report re: New York's lack of attention
  - Increased oversight of states
  - Direct audits of providers
- States → Providers
  - Direct audits and enforcement
  - Financial pressures
    - Initially, "low hanging fruit"
    - Need to maintain high ROI on MIP programs



# Medicaid Integrity Program (MIP)

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- Comprehensive Medicaid Integrity Program (CMIP)
  - 100 new staff, \$50 million now, \$75 million next FY
- CMS = “Bully Pulpit”
- Medicaid Integrity Contractors (MICs)
  - Newly formed, small, HUB
  - Audits, data mining, reporting tools, enforcement support
- Director of MIG = former Federal Prosecutor
- Field offices: NY, Atlanta, Chicago, Dallas, San Francisco



# New CMS Medicaid Integrity Program Initiative

September 2007

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- The first group of Medicaid audits is set to begin in September as CMS's Medicaid Integrity Program (MIP) hits the ground running... David Frank, the director of CMS's Medicaid Integrity Group (MIG) tells MCN... that “the contractor hired...will begin with audits of providers in Washington, Florida, Mississippi, and Texas. Frank, a former federal prosecutor, tells MCN that “MIP audits will go full-steam ahead” nationally by Spring 2008.”
- *HCCA-AIS Medicaid Compliance News (MCN)* , Volume 1, No. 1, September 1, 2007.



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# Beginning Spring of 2008

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## ROI-Return on Investment:

“MIP expects to identify significant overpayments through a carefully crafted audit program.”

-CMS Strategic Plan



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# CMS Medicaid Reform Initiative 2008

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- Director of Field Operations for the Center for Medicare and Medicaid Services Medicaid Integrity Group **Robb Miller** said September 25th that “Congress clearly intended a positive return on investment and the Office of Management and Budget is tracking how CMS spends the [DRA] money.
- Bureau of National Affairs, Inc. Vol. 11 No. 20, October 10, 2007.



## CMS Medicaid Reform Initiative 2008 (cont)

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- **Director Robb Miller** said the first step is a surveillance utilization review of providers, which Miller called “**robust and dynamic**”, to determine whether fraud, waste, or abuse is involved or whether there is a potential overpayment resulting in expenditure of funds in Medicaid that was not intended.
- Bureau of National Affairs, Inc. Vol. 11 No. 20, October 10, 2007.

# CMS Medicaid Reform Initiative 2008

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- *Medicaid Integrity Group Robb Miller* said the second step is an audit of the providers claims or services, including cost reports, consulting contracts, and risk contracts;
- The third step “is identifying providers receiving federal funds”.
- The fourth step is “educating providers on payment integrity and quality of care matters”.
- As a note, he said there is no federal mechanism to adjudicate audit findings, so states will be responsible for adjudication.
- *Bureau of National Affairs, Inc. Vol. 11 No. 20, October 10, 2007.*

# Medicaid Integrity Contractors

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Specific contractor functions:

“Review action of those seeking payment from State Medicaid plans

Audit of those claims

Identification of overpayments related to those claims

Education of providers AND others with respect to payment integrity AND quality of care.”



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# Texas Led the Way Early

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- Congressional Testimony
- Testimony before State Legislatures
- The “Texas Model”
- Big machine
- Big results. \$1.5 billion in 2 yrs, ROI = 17:1
- Voluntary disclosure program

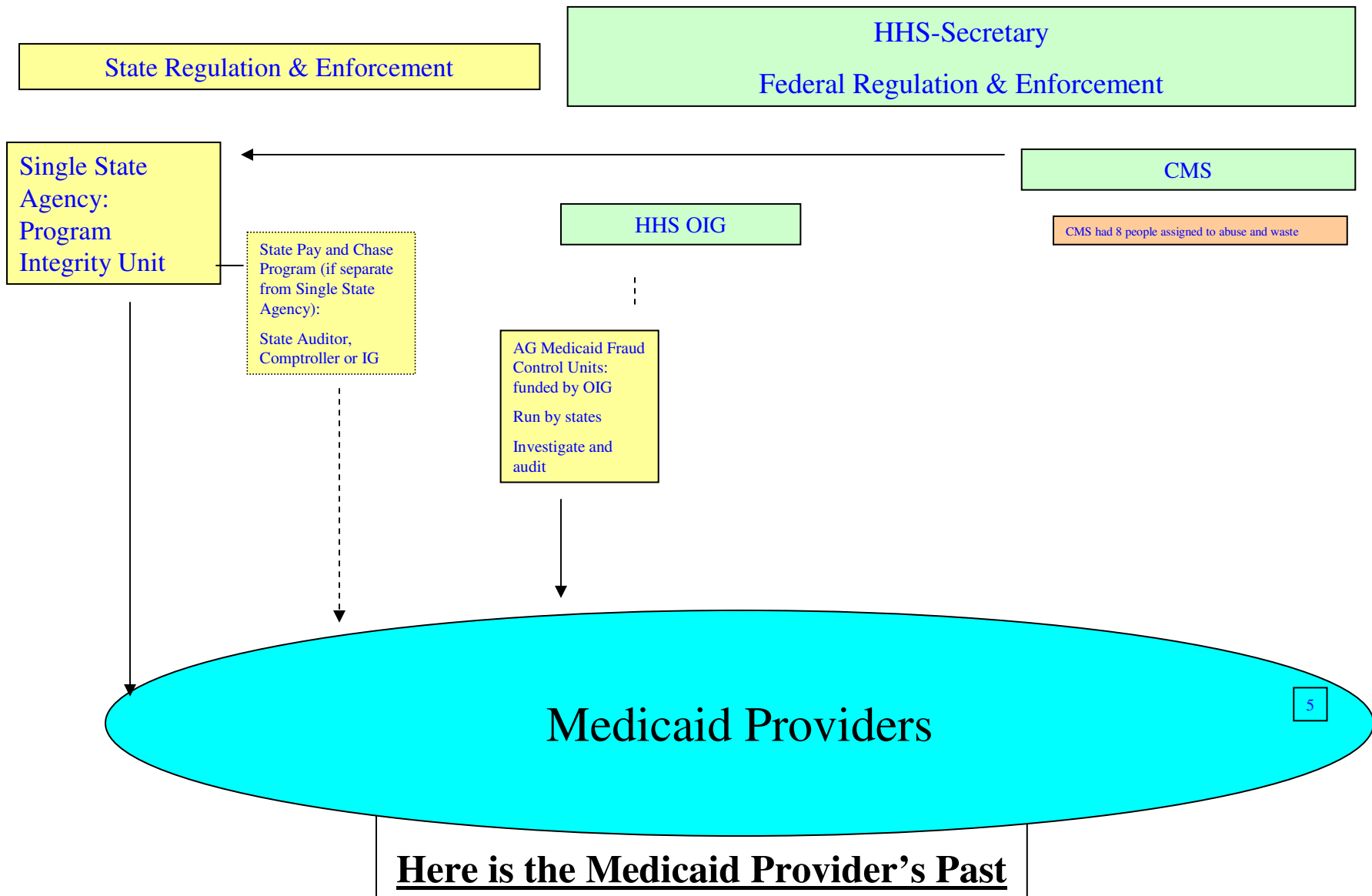


# New York Now Taking the Lead

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- Pressure through OIG Report, U.S. Senate Finance Committee Hearings, State Senate Report, NY Times series, CMS audit
- Adopted “Texas Model”
- Hired Jim Sheehan as first Inspector General
- 170 new positions, 90 current openings
- Specific recovery commitments
  - \$215 million FY 08 → \$644 million FY 2011
  - Bonus question #1: What were NY recoveries in 1Q 2007?
  - Bonus question #2: National fraud and abuse recoveries for all health programs in 2006?
- Other states will follow





**HHS-Secretary**  
**Federal Regulation & Enforcement**

**HHS OIG**

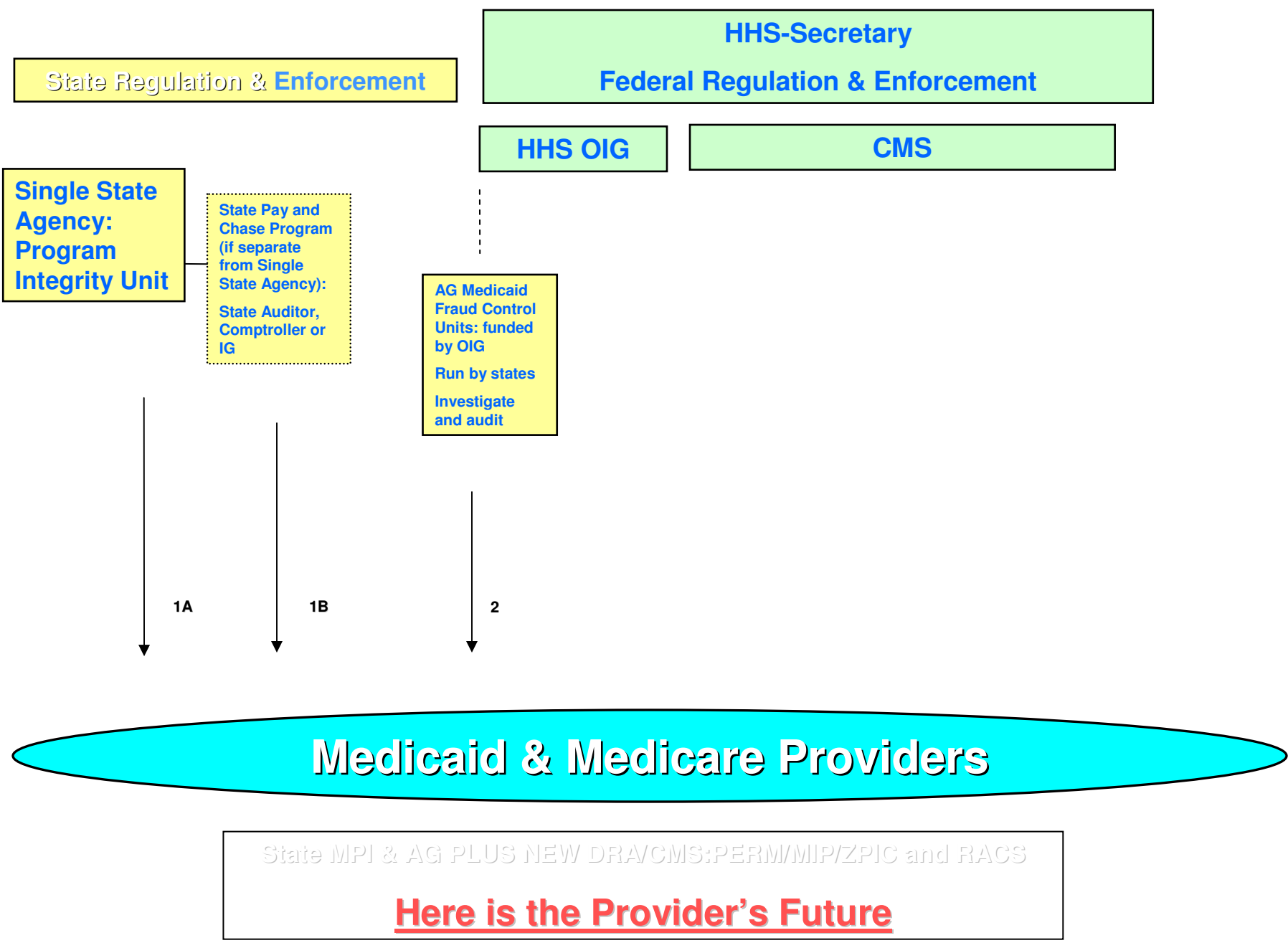
**CMS**

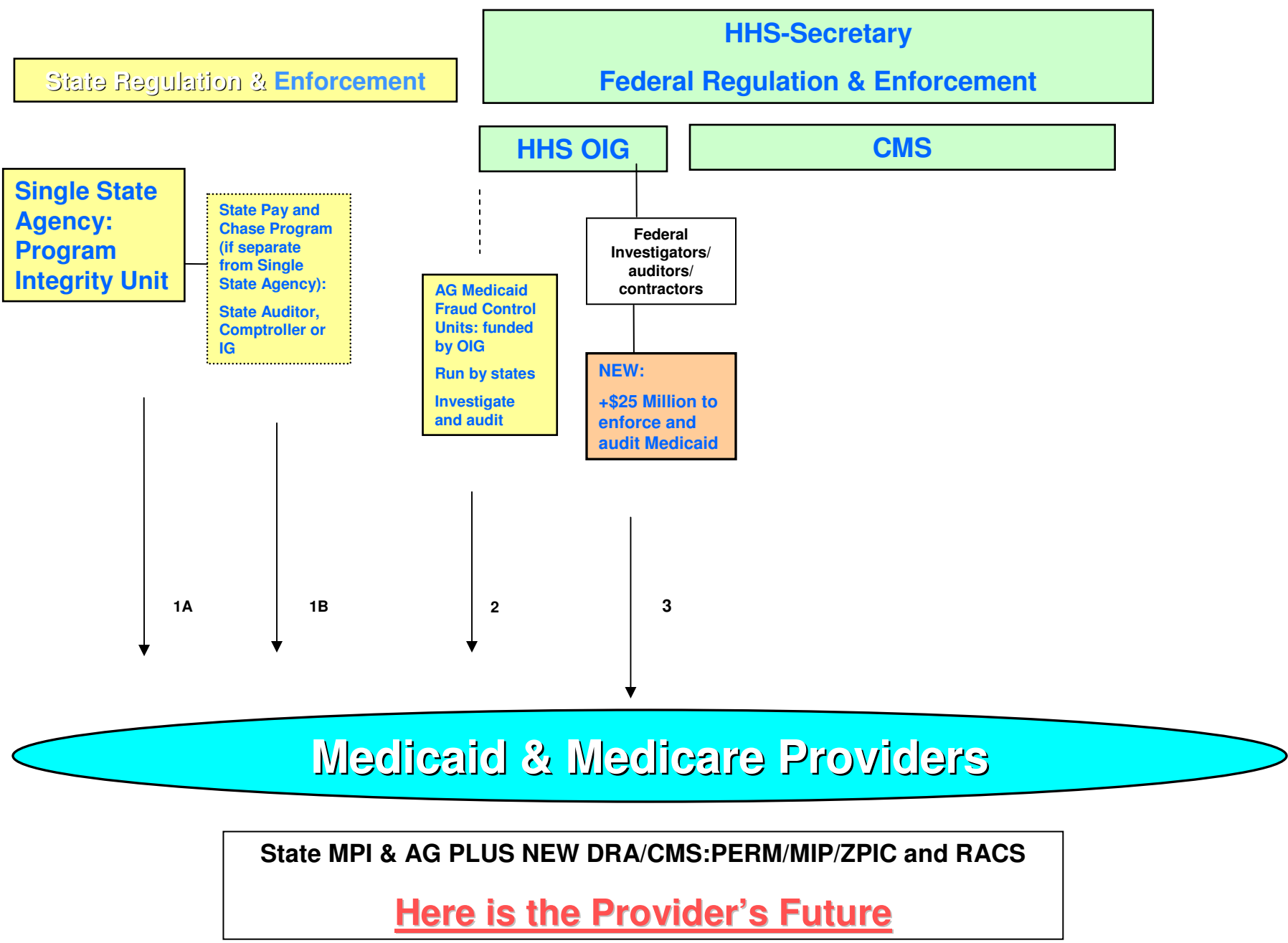
**OFM Medicare Integrity Program**

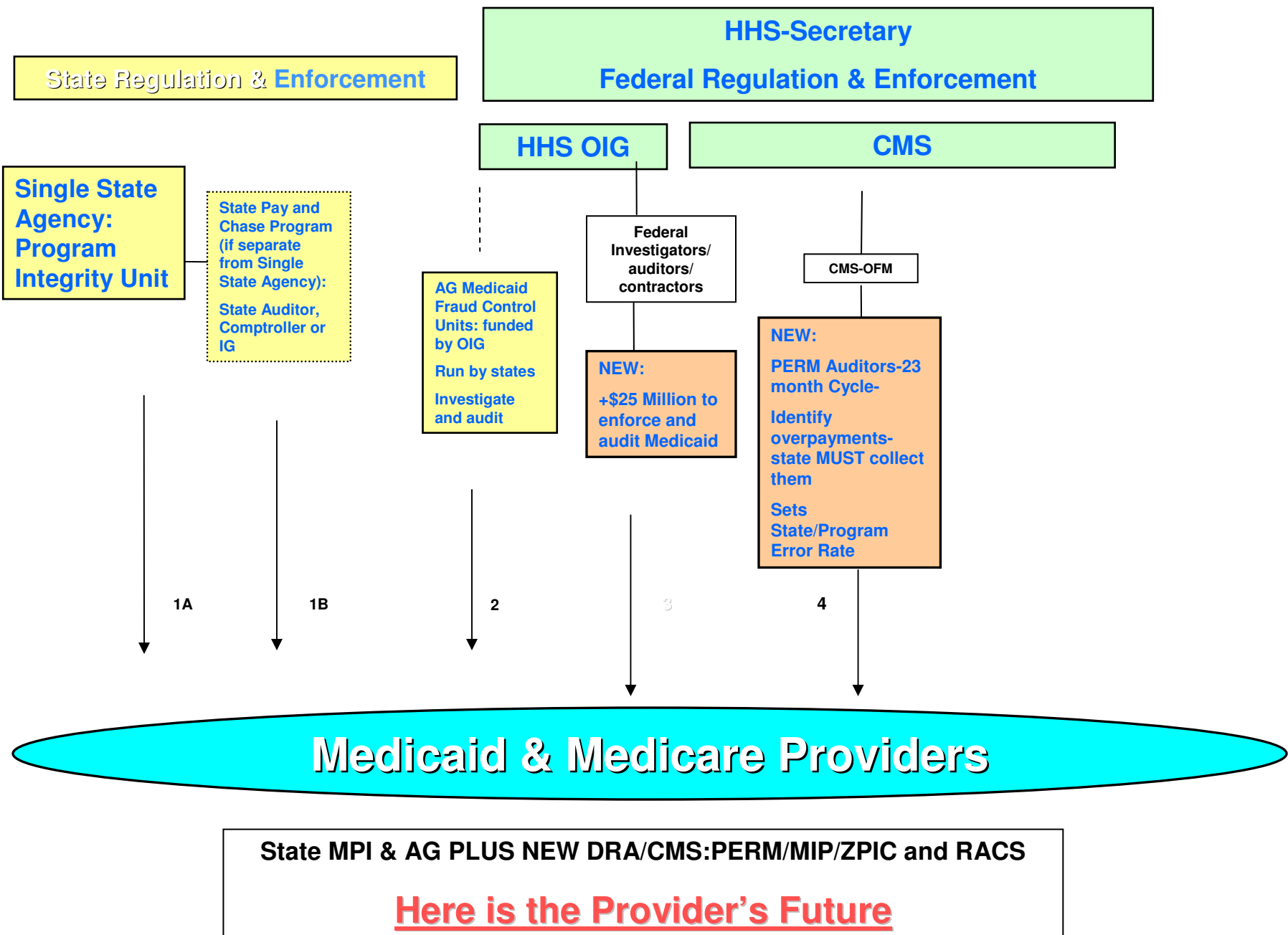


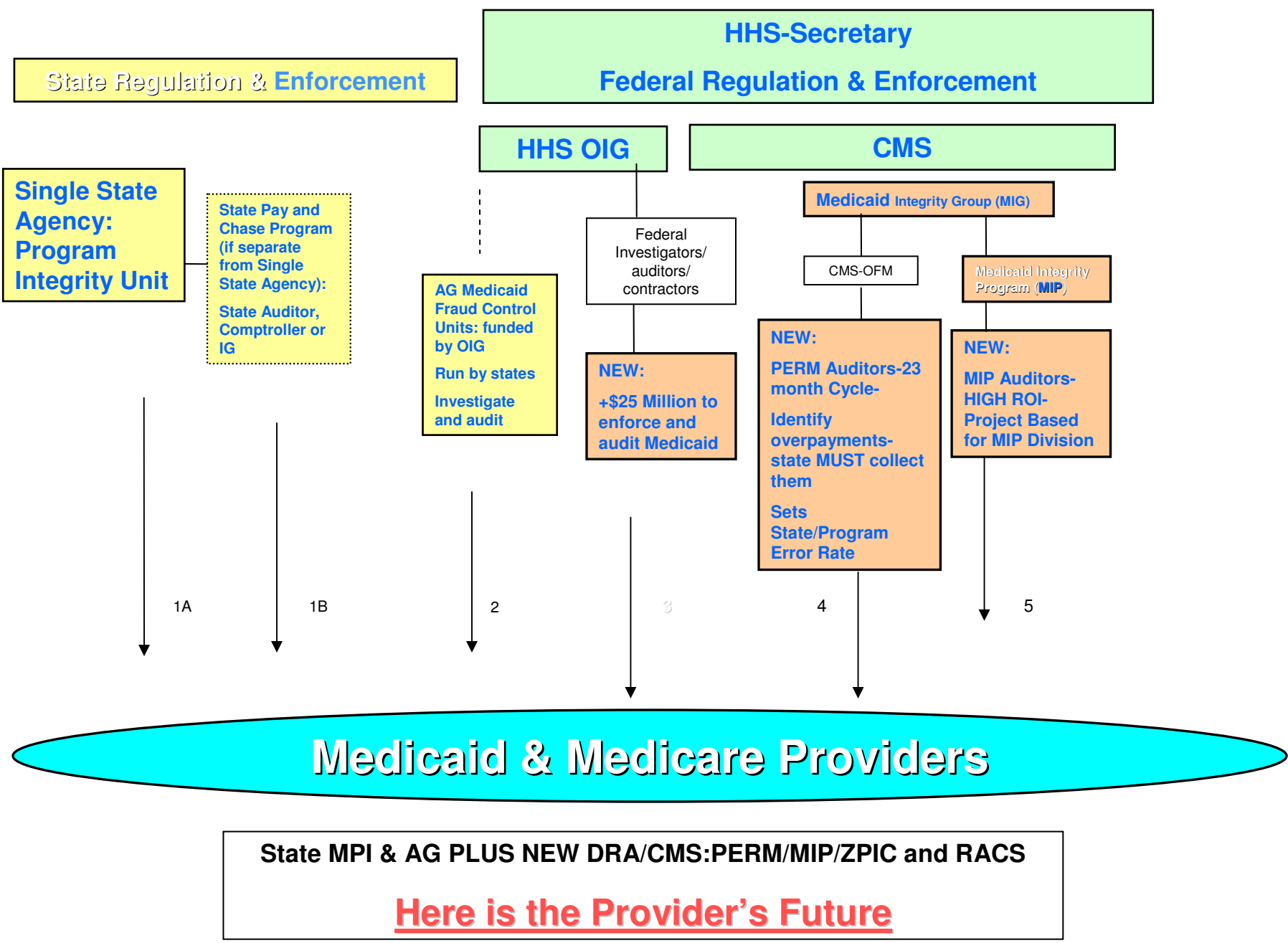
**Medicare Providers**

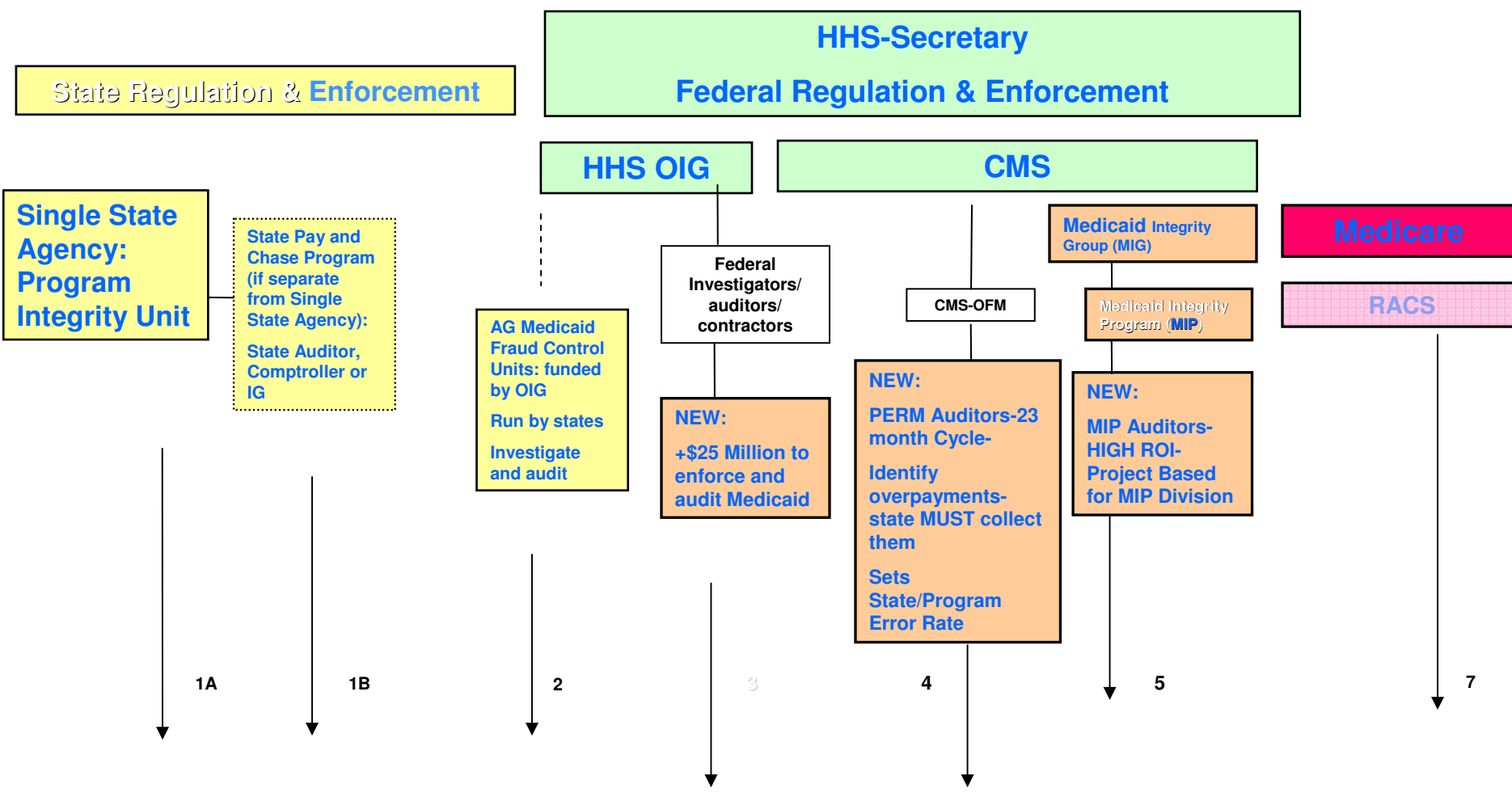
**Here is the Medicare Provider's Past**







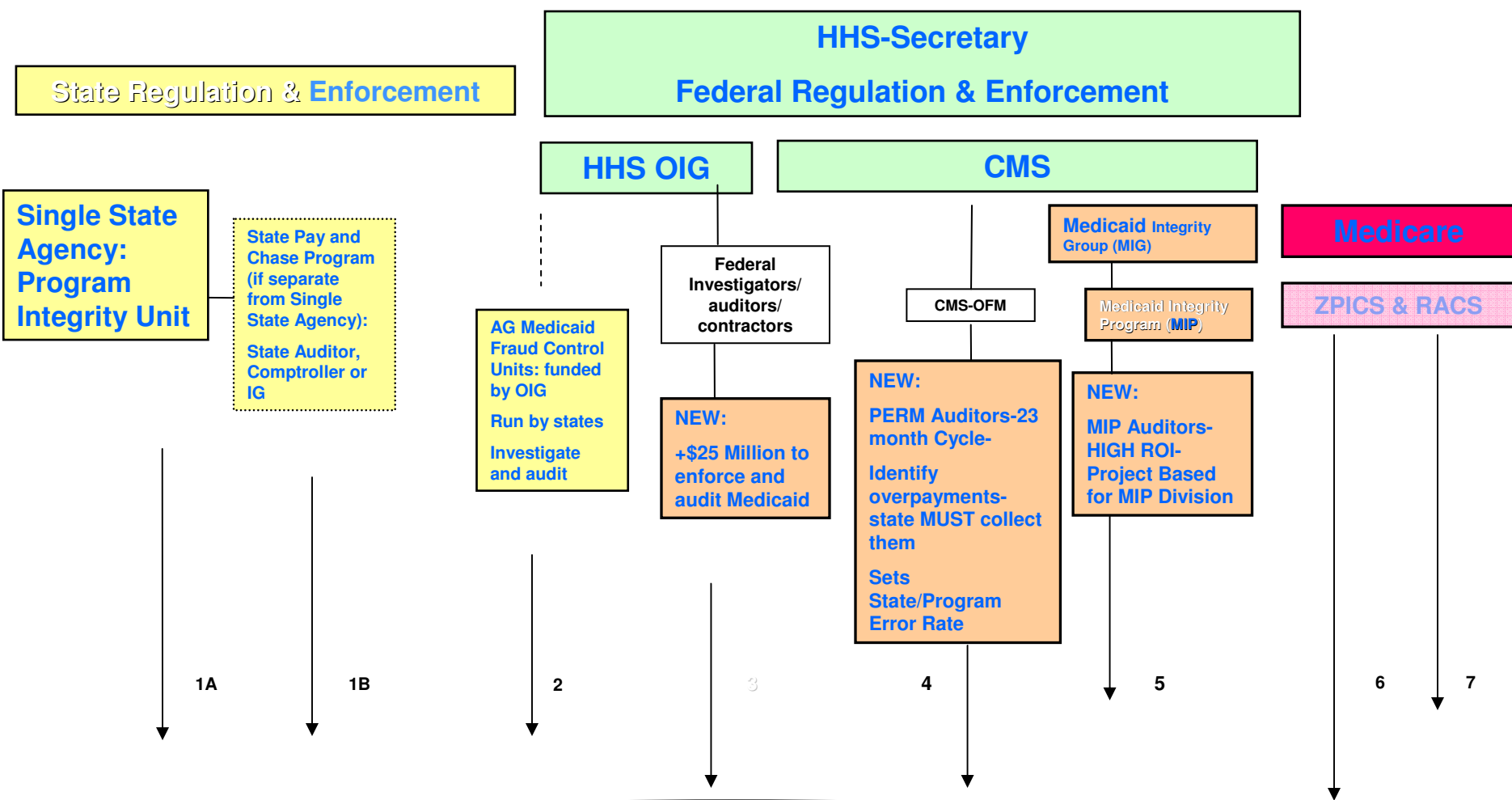




**Medicaid & Medicare Providers**

**State MPI & AG PLUS NEW DRA/CMS:PERM/MIP/ZPIC and RACS**

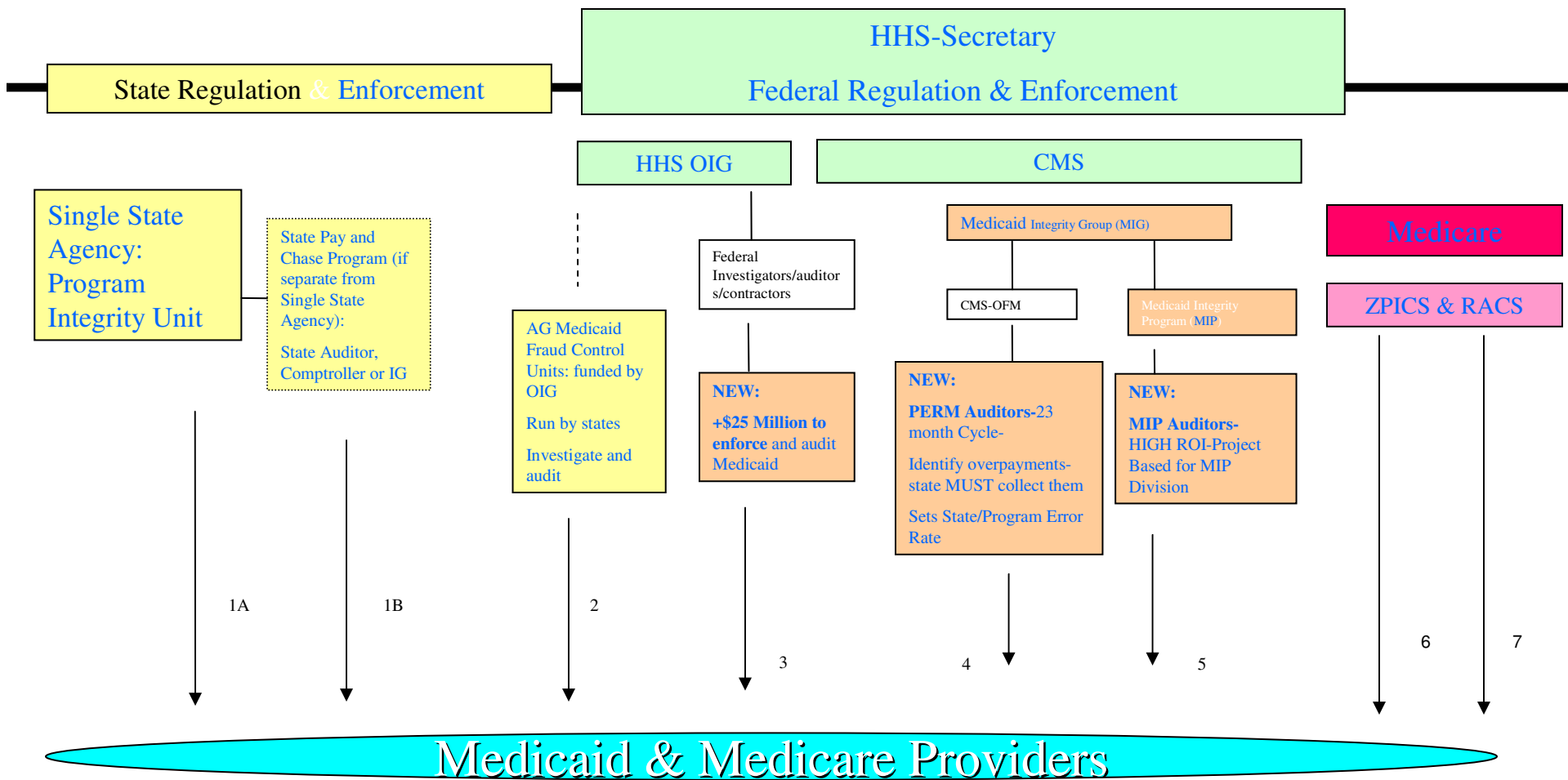
**Here is the Provider's Future**



**Medicaid & Medicare Providers**

**State MPI & AG PLUS NEW DRA/CMS:PERM/MIP/ZPIC and RACS**

**Here is the Provider's Future**



State MPI & AG PLUS NEW DRA/CMS:PERM/MIP/ZPIC and RACS

**Here is the Provider's Future**



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Medicaid Integrity Group  
Medicaid Integrity Contractors  
CMS--2007-DB01  
Awarded December 17<sup>th</sup> 2007



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# DUTIES

## Long Term Approach

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- *The contractor shall utilize the best practices as defined by CMS, data mining products, techniques, processes, algorithms, and models to identify payments and/or billing practices of Medicaid provider's and related entities at the greatest risk of being fraudulent or inappropriate.*
- *As a result of analysis the contractor shall produce reports containing suspect claims and/or relevant providers, with recommendations for **recovery action or audit as they deem appropriate**.*
- *These lists shall be in the form of specialized reports, estimate the overpayments, list the reason, or in the case of models the relative risk of overpayment, amount, and sufficient detail for follow-up audit.*

# DUTIES

## Review of Providers

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- *The contractor shall use data-mining and analysis techniques to develop models that combines healthcare quality indicators, billing practices and Medicaid specific business rules to predict aberrant provider patterns to identify and rank by risk providers to be audited.*
- *The contractor will develop reporting tools that show ranked providers according to risk of fraud/overpayment problems with sufficient detail for auditors to begin their audits.*

# Audits:

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## Audits of Providers, Fee for Service Providers, Managed Care Entities

- The Contractor shall plan individual audits of providers,  
including but not limited to
  - fee for service providers,
  - managed care entities, and
  - individual providers and institutional providers of Medicaid services within the region



# DUTIES

## Cost Report Audits

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- Some providers receiving payments under the Medicaid program are subject to cost report audits for all payments applicable to services rendered to Medicaid beneficiaries. Cost report audits of a selected provider's financial and statistical records are conducted in order to determine the propriety of the costs claimed on the Medicaid cost report.



# DUTIES

## Special Review Initiatives

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- Special Review Initiatives (SRIs) are used to implement new legislation and policy and respond to issues raised by agencies such as the Government Accountability Office (GAO), the OIG, and CMS. The SRIs may include reviews of Managed Care Organizations (MCOs).

# Targeting Programmatic Vulnerabilities:

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CMSO has identified several specific issues that will be audited by CMS and measured by PERM  
- [page 14](#)

## Strategic Plan:

- Nursing and personal care facilities/agencies
- Prescription drugs
- Durable medical equipment
- Improper claims for payment



- “In a major shift in its war on fraud, CMS is replacing program safeguard contractors (PSCs) with seven “zone program integrity contractors” (ZPICS). They will tackle all benefit-integrity activities across the country and form “rapid response teams” with a more aggressive fraud fighting mandate, said Kim Brandt, director of the CMS Program Integrity Group... Five of the seven ZPICS will be assigned to “hot spot” areas-California, Florida, New York, Illinois and Texas...CMS intends to resolve fraud-and-abuse and overpayment matters administratively more often, when possible... including sanctions and education...”
- *Report on Medicare Compliance, Volume 16, No. 35, October 1, 2007.*

# RFI Statement of Work for CMS MEDICARE Reform Initiative

October 2007

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- As result of contracting reform, seven zones have been created based on the newly established Medicare Administrative Contractor (MAC) jurisdictions. Included in the seven zones are five high risk areas. As a result of the seven zones, new entities entitled Zone Program Integrity Contractors (ZPICs) have been created to perform program integrity for Medicare Parts A, B, C, D, Durable Medical Equipment (DME), Regional Home Health Intermediary (RHHI) and Medi-Medi...



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# The following language comes from the public CMS' Statement of Work, SOW:

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## 1.1.4 - Fundamental Activities

- *Fundamental activities of the Zone Program Integrity Contractor (ZPIC) that will help ensure payments are appropriate and consistent with Medicare and Medicaid coverage, coding, and audit policy, and will also identify, prevent, or correct potential fraud, waste and/or abuse may include, but are not limited to, the following:*



## The following language comes from the public CMS' Statement of Work, SOW (cont):

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- Performing BI investigations;
- Referring cases to law enforcement;
- Making coverage and coding determinations;
- Review of audit, settlement, and reimbursement of cost reports;
- Reviewing bids for participation in the prescription drug program;
- Assisting CMS in developing a list of entities that may require future monitoring based upon past history;
- Conducting specified audits;
- Conducting specified complaint investigations (Part C and Part D only);



# Key Trends – State Arsenals

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- Creation of independent Medicaid Inspector General
- Unprecedented staffing levels
- Enactment or amendment of state False Claims Act
- Mandatory compliance programs
  - NY: Includes billing, quality, governance, business processes
- Some coordination
- New penal statutes
- Overlapping processes and turf wars
- Confusion over DRA “education” requirements



# Key Trends – Federal Arsenals

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- Creation of independent auditors nationwide to audit providers Medicaid payments
- Unprecedented new staffing levels
- Enactment or amendment of state enforcement programs
- Mandatory compliance programs
- Limited coordination
- Overlapping processes and turf wars



# Key Trends: Areas of Interest

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- Large providers
- Hospitals
- LTC, Mental health, substance abuse, disabilities remain targets
- Quality of care
- “Data Prospecting” for outliers in performance and cost
- Overlap with state tax and 990 issues
- Anti-Kickback and Stark
- Managed care programs
- Mandatory data reporting and data accuracy



# Key Trends: Tools and Theories

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- Measurement through PERM
- Extrapolation with loose tolerances
- Excessive services and charges
- Unacceptable recordkeeping
- Quality failures as false claims
- “Worthless services” and errors as basis for criminal indictment
- Unbelievable utilization: data mining and Medi-Medi
- Increasing use of exclusion authority



# Current Issues in FCA Litigation

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- Statute of limitations and “relation back”
- Original source rule
- Public disclosures
- Quality failures as false claims
- Lack of medical necessity as false claims
- Non-compliance with CIA as “causing to be submitted” false claims
- Express and implied certifications
- Materiality
- Knowledge
- Grassley’s proposed amendments to vitiate providers’ common defenses and recent decisions, including Rockwell



# State False Claims Acts

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- Pre-DRA, 17 State FCAs
  - Most did not map to Federal FCA
- Post-DRA, about 34 FCAs
  - Several created in response to DRA
  - Others modified to parallel Federal FCA
- Trouble for providers
  - Whistleblower creation
  - Multiple jurisdictions simultaneously



# Other New and Expanded Processes

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- Payment Error Rate Measure (PERM)
  - Failure to respond = error with *no appeal*
  - State *must* recover overpayment
  - Rolling out nationwide, currently 15 states
- Medi-Medi going national, through PICs
  - \$180 million funding over 5 years
  - Now in 10 states
- Recovery Audit Contractors (RACs)
  - Paid on contingency basis
- Rapid Response Teams (RRTs) for “flare ups”

*PART 2: What You Can Do and How You  
Can Prepare for and Respond to Risks  
including the Implementation of the DRA,  
PERM, MIP, ZPICS and RACs*

# “Patient-centered care” -The Spitzer Administration’s Plan for New York

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- Institute of Medicine 2001-Committee on Quality of Health Care in America-focus on individual patient-goal of 21st Century Health Care
- Spitzer Administration 2007-focus on care of patient, not needs of institutions
- How is this new?
- -1950’s focus(Hill-Burton)-build institutions
- -1980’s focus (Donabedian)-interventions which result in predictable improvement in the health of populations
- -1990’s focus-reduce costs by getting patients out of institutions



# Patient-Centered Care

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- BENCHMARKING AND MEASUREMENT
- CONTINUOUS IMPROVEMENT
- CARE MANAGEMENT/COORDINATION
- ALLOWING PATIENTS AND THEIR FAMILIES TO PARTICIPATE IN HEALTH CARE DECISIONS
- Information/Data
  - Accuracy
  - Availability
  - Transparency
  - Ease of use



# The new model of Patient-centered-you can look it up

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- <http://www.hospitalcompare.hhs.gov/Hospital>
- <http://www.healthgrades.com>
- <http://hospitals.nyhealth.gov>
- <http://www.consumerhealthratings.com>
- Data mining for outcomes, errors, clinical pathways



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# Health Insurance Protection, Not Welfare Benefit

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- Quality of care
- Respect for patients and insureds
- Accountability of providers
- Appropriate anti-fraud and abuse measures designed into program
- Early detection, graduated response



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# Where Does Office Of Medicaid IG Fit Into This?

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- Protecting patients
- Mandatory compliance plans/Model Compliance Guidance /focus on governance
- Enforcement of Conditions of Participation - basis for staying in the program, payment
- Exclusion/penalty authority-individual, entity
- Collaboration with DOH, O agencies, licensing
- Integrity plans
- Investigations/Criminal referrals
- Dollar recoveries



# How Is New York Addressing This Challenge?- Mandated Compliance Programs

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- “Every provider of medical assistance program items and services” (subject to IG regulatory inclusion) “shall adopt and implement a compliance program” including “the following elements. . .” Section 363-d of the Social Services Law.
- New York Compliance Guidance-appearing for hospitals in 2008; others to follow



# How To Respond To New Efforts?

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- Proactive-compliance programs
- Board involvement and role
- Privilege
- Voluntary disclosure/reporting
- Risk area identification



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# How To Respond To New Fraud Efforts?

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- New (2002) Audit Standard SAS No. 99, Consideration of Fraud in a Financial Statement Audit
- “Trust is not an internal control”
- Brainstorming, reviews, vulnerabilities
- How are auditors and Boards addressing this governance issue?

# Responding To Antifraud Efforts-Risk Areas

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- DRG Coding
- MDS (Minimum Data Set) Coding
- Cost Report analysis
- Match projects
- Dead/treated
- Hospitalized/outpatient
- Multiple locations/same time
- Credentialing



# Developing Board Legal Responsibilities

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- Board Duty to undertake reasonable efforts to assure that compliance programs are in place and effective (In Re Caremark-Delaware)-
- Board Duty to undertake reasonable efforts to become aware of signals of system weaknesses-"systematic failure of the board to exercise oversight" (Abbott Laboratories-7th Circuit)
- General Counsel Duty to advise Board of its monitoring obligations and its structural inability to satisfy them. (Pereira v. Cogan SDNY)

# The Medicaid Challenge For Attorneys: Advising Boards On Their Responsibilities

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- Pereira obligation of counsel to advise board that it is unable to perform its oversight responsibilities
- Going concern/internal controls analogies
- Form of advice/details of advice: “management letter”
- Whose responsibility? Audit, Compliance, Board Chair, CEO



# Anticipating Antifraud Efforts: Benchmarking And Environmental Review For Non-Profits

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- IRS GUIDANCES/FORM 990
- “Right From The Start”- AG’s Charities Bureau
- CONDITIONS OF PARTICIPATION
- HHS/OIG COMPLIANCE GUIDANCES
- NEW YORK MEDICAID INSPECTOR GENERAL COMPLIANCE GUIDANCE (1/08)
- OIG/AHLA RESOURCE DOCUMENTS PROVIDED TO EVERY BOARD MEMBER (OIG.HHS.GOV)
  - Corporate Responsibility and Corporate Compliance(2003)
  - An Integrated Approach to Corporate Compliance(2004)
  - Corporate Responsibility and Health Care Quality(2007)



# The New Health Care Enforcement

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- Me-too audits-what worked for Medicare will work for Medicaid-need to address common issues
- Conditions of participation
- Audit rule-if not documented, did not happen
- If falsely documented, not documented
- Payment for performance means audits for performance
- Not just hospitals –managed care, home health



# Who Is Responsible For Meeting Minimum Standards For Payment?

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- Licensed professionals/ordering physicians
- Holders of a certificate of need
- Participating provider
- Participating facility
- Hospitals, their boards, and their medical staffs
- Managed care organizations
- Home health providers



# How Does Board's Role Evolve With New Focus On Standards For Payment

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- Need to assure business processes to measure and report quality and compliance
- Increased role for compliance
- Integration of risk management, utilization review, peer review, mandatory reporting, quality improvement
- What are “system failures,” “signals,” “monitoring,” and “systemic inability to satisfy?”



# Boards

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- GOVERNANCE ROLE:
- What compliance systems do you have in place to address quality, errors, and outcomes? To whom do they report?
- What expertise does the Board have on clinical quality, outcomes, and errors? What formal orientation?
- What responsibilities for quality, errors, and outcomes have been delegated to the staff (or others) without adequate oversight?
- What is the Board doing to assure measurement and improve outcomes and quality and reduce avoidable adverse events (“errors”)



# Business Processes In Compliance

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- Reporting lines
- Audit, review, risk identification
- Medical staff, audit, counsel, quality assurance, patient safety officer ,risk management, patient advocate/case manager-what are their roles?
- Listening to patients and employees
- Evaluation, measurement, communication
- Role for compliance officer



# Quality Review/ Peer Review Are Not Optional

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- Mandated as conditions of participation for many health care facilities, including diagnosis and treatment centers
- Reporting, electronic medical records, and mining of large-scale databases (e.g., EMEDNY, New York's database) are going to identify significant outliers on results
- Medicare exclusion of payments for mistakes (e.g., decubiti developed in the inpatient setting) will identify participants in mistakes
- Payment for outcomes will identify poorer outcomes



# Quality And Peer Review Are Not Optional

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- Physician appraisals every two years
- Board certification is not alone enough
- Quality initiatives are required 42 CFR 481



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# The Next Way Paying For Data And Outcomes

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- Hospital Quality Incentive Demonstration(HQID) with PREMIER/ CMS-second full year 2005-reports 04/2007
- Pursuing Perfection Program-Institute for Healthcare Improvement (hospitals)
- RHQDAPU
- Pay for Performance-HMOs, Employer Coalitions, States



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# SECTION 501 Reporting-and payment

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- CMS FAQ RESPONSE:
- “Data from selected charts for each hospital that submits data will be audited; a successful audit is not required for the FY 2005 annual payment update. Additional requirements for data accuracy will likely be added for fiscal years 2006 and 2007.”
- 2007-27 measures, including patient survey
- 80% accuracy requirement for payment



# Conditions Of Participation

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- 42 U.S.C. 1395x(k), 42 CFR 482.30- utilization review requirements for hospitals
- Review of durations of stay
- Review of medical necessity of services, drugs
- Every outlier case; sampling of other cases



# Medical Errors and Care Failures Move to Criminal Cases

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- USA v. Martha Bell and Atrium I (W.D. Pa. 2005) Bell(nursing home administrator) convicted of health fraud and Atrium convicted of making false statements arising out of false records of care
- USA v. American Healthcare Management (W.D. Mo. November, 2005) – indictment charging violation of 18 U.S.C. § 1035 (False Statements concerning Health Care) because “the Defendants knew, at the time the claim was submitted, that the services were so inadequate, deficient and substandard as to constitute worthless services.”
- [Http://www.usdoj.gov/usao/moe](http://www.usdoj.gov/usao/moe)



# Approaching Issues For Hospitals, Health Plans?

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- State health officials fined nine California hospitals Thursday for infractions that put patients at imminent risk of injury or death, including a notorious case at Martin Luther King Jr.-Harbor Hospital in May in which a woman died after writhing unattended on the floor of the emergency room lobby. Each fine is for \$25,000, the most allowed under the first phase of a law that went into effect Jan. 1. The fines are the first the state has levied against hospitals.



What to do next??

# Planning for 2008

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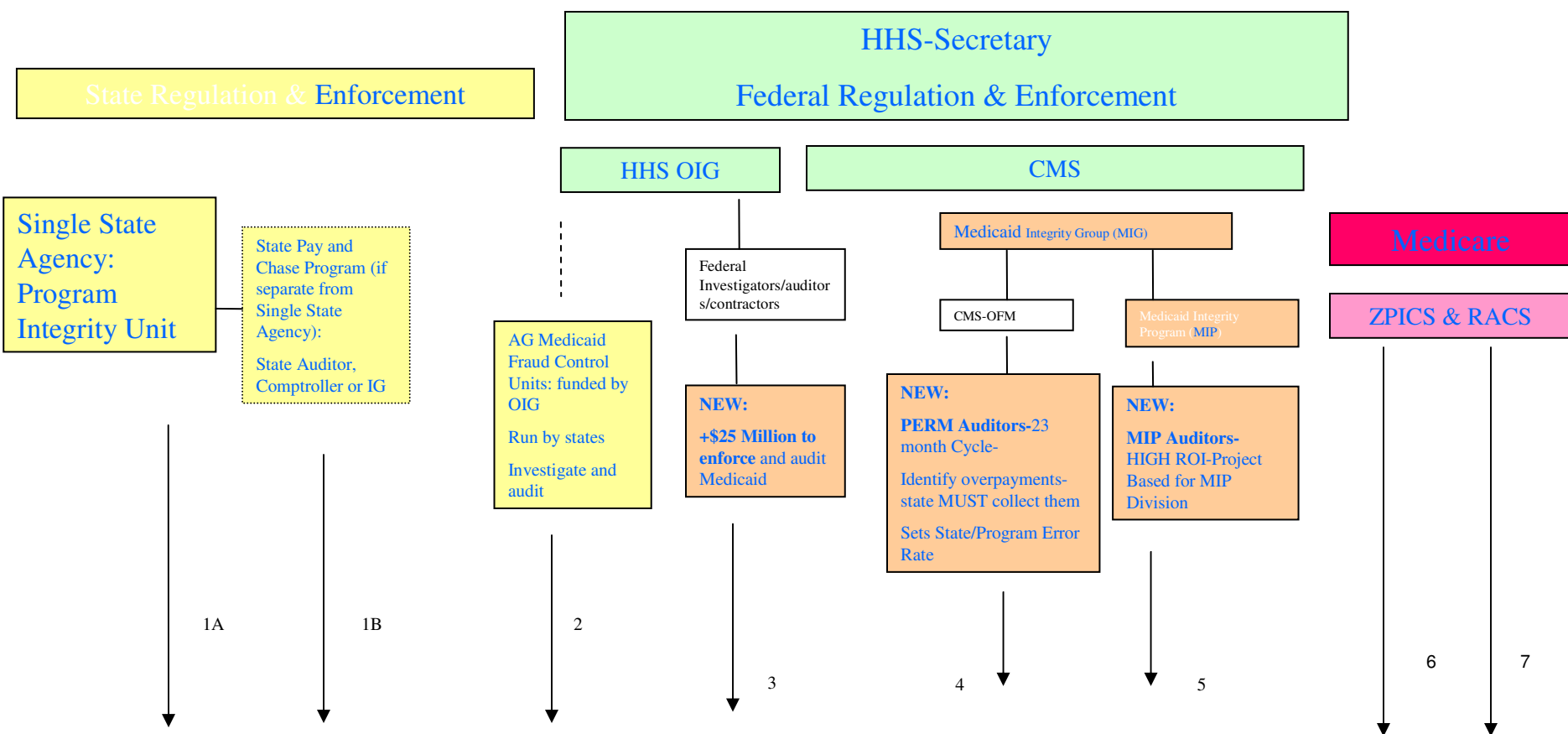
# Significant Changes In The Environment For 2008

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The current environment, taken as a whole, is challenging to provider stability and increases the risk of unexpected losses or expenses caused by regulatory actions. The environment will likely increase overhead expenses to meet the new regulatory requirements. However, failure to mitigate risks will have higher consequences in the new regulatory schema.



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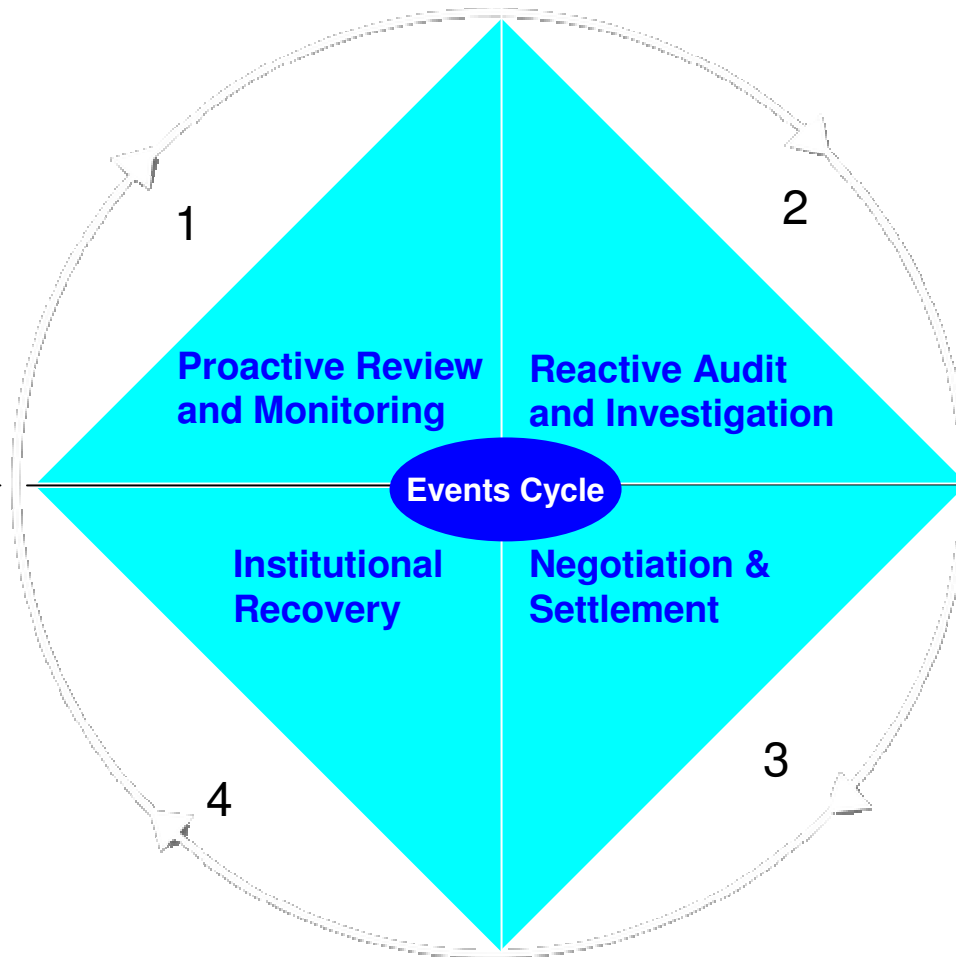
**Medicaid & Medicare Providers**

State MPI & AG PLUS NEW DRA/CMS:PERM/MIP/ZPIC and RACS

**Here is the Provider's Future**

# Healthcare Regulatory Compliance Services Cycle of Compliance

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# Potential Proactive plan for FY 2008

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- Next Steps: Proactive, Reactive, Settlements, Stabilization
- Proactive Integrity Actions include:
  - Compliance Risk and Process that Management should consider:
    - Compliance Risk and Infrastructure Assessments
    - Compliance Gap Analysis
    - Establish Data Analysis equal to government analytical capability
    - Establish Data Analytics to identify trends for monitoring or auditing activity within the corporation
    - Provide an active tool for the BOD and C management for active due diligence



# Potential Reactive plan for FY 2008

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## Reactive Integrity Actions to Consider:

- Providers should consider how to manage the government audit or investigation:
  - Parallel the reviews of ongoing government activity.
  - Run data analysis to forecast government focus or inquiry issues
  - Run data analytics to identify trends for monitoring or auditing activity within the corporation
  - Create or maintain a feedback loop to the internal stakeholders

# Protecting the Entity-- Plan for FY 2008

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## Negotiation and Settlement Actions to Consider:

- Providers should consider how to manage the negotiations with the government:
  - Run data analysis to compare the government focus or inquiry issues with internal data
  - Run data analytics to identify trends requiring negotiation, auditing or confirmation activity within the governments case against the corporation
  - Create or maintain a feedback loop to the internal stakeholders
  - Develop negotiation models
  - Develop settlement strategies
  - Protect the institution: property, integrity and market.



# Surviving FY 2008

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## Institutional Recovery and Stabilization Actions to Consider:

- Providers should consider how to manage the negotiations with the government:
  - Look at the feedback loop used in the action and review it with internal stakeholders
  - Develop lessons learned documentation and process models
  - Develop improvement or redesign strategies
  - Ensure data infrastructure and analytics integrity and capability
  - Protect the institution: internal controls, process mapping, monitoring plan, public messaging and market face



# Surviving FY 2008

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- Potential To-Do-List:
- Compliance program review
  - Review to what extent the 7 elements are present (plus risk assessment and integrity/culture assessments).
- Compliance effectiveness assessment
  - Review to what extent the compliance program is effective
  - Interview employees
  - Review documents
  - Validate certain program components
- Compliance risk assessment
  - Interview employees
  - Review documents
  - Identify risk
  - Assist with prioritizing
- Infrastructure review
  - Review certain program components
  - Perform the above mentioned review steps on a more focused program component
- Specific risk review
  - Perform compliance audit of agreed upon risk area



# Summary of Integrity 2008

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- Develop sound practices to help the organization assess its risks for strategic planning and coordinated tactical responses to risks or threats.
- Proactively mitigate the strategic risks facing the organization and quickly respond and assess tactical risks or threats facing the corporation.



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# ***The Legal Issues***

# Consult Your Attorney Regarding:

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- Statute of limitations and “relation back”
- Original source rule
- Public disclosures
- Quality failures as false claims
- Lack of medical necessity as false claims
- Non-compliance with CIA as “causing to be submitted” false claims
- Express and implied certifications
- Materiality
- Knowledge
- Grassley’s proposed amendments to vitiate providers’ common defenses and recent decisions, including Rockwell



## Key Trends:

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- Measurement through PERM
- Extrapolation with loose tolerances
- Excessive services and charges
- Unacceptable recordkeeping
- Quality failures as false claims
- “Worthless services” and errors as basis for criminal indictment
- Unbelievable utilization: data mining and Medi-Medi
- Use of exclusion authority



# Key Trends: Areas of Interest

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- Large providers
- Hospitals
- LTC, Mental health, substance abuse, disabilities remain targets
- Quality of care
- “Data Prospecting” for outliers in performance and cost
- Overlap with state tax and 990 issues
- Anti-Kickback and Stark
- Managed care programs
- Mandatory data reporting and data accuracy



# Questions?

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