MODERN HEALTHCARE Webcast

Welcome...

During today's discussion, feel free to submit questions at any time by using the questions box. A follow-up e-mail will be sent to all attendees with links to the presentation materials online.

Today's topic

Staying compliant: Provider strategies for meeting regulatory rules in the wake of the Affordable Care Act

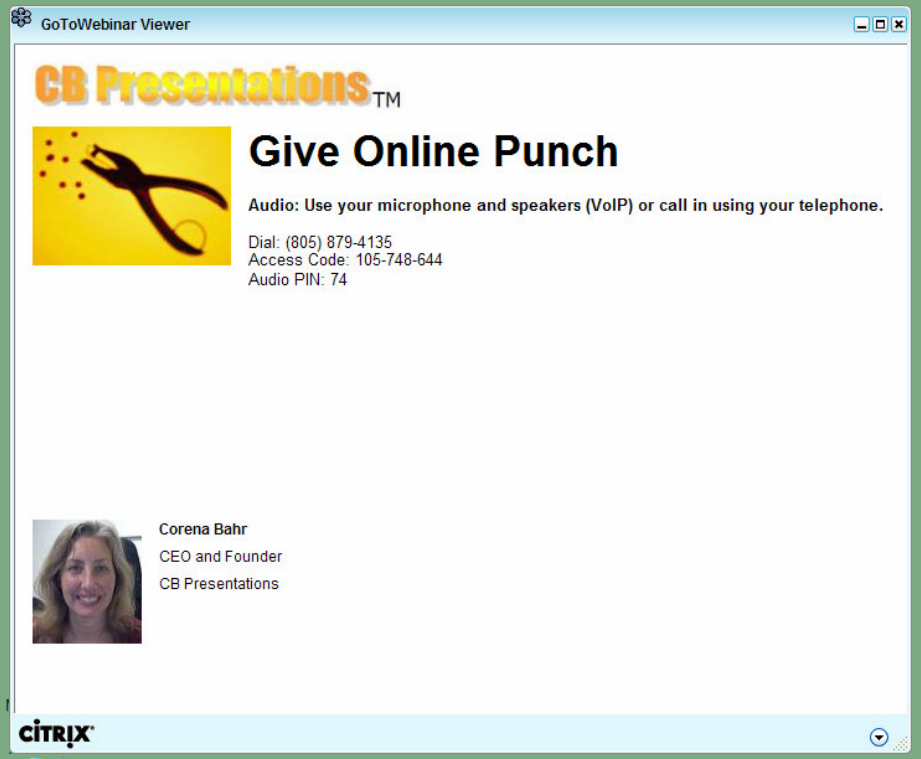
Marti Arvin
Chief compliance officer,
UCLA Health and the
David Geffen School
of Medicine

David Matyas
Healthcare compliance
attorney,
Epstein Becker & Green

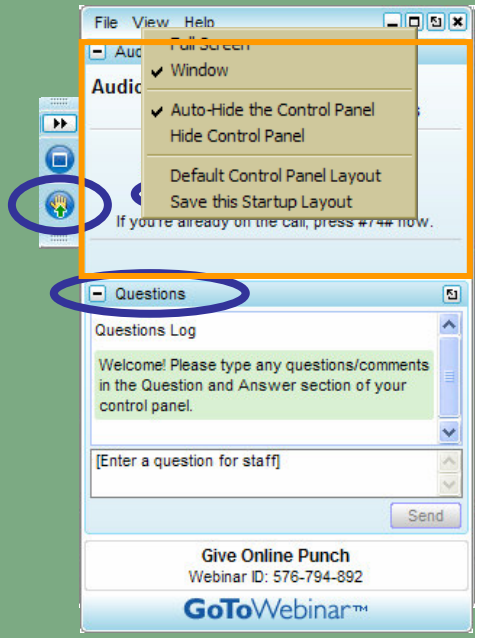
James Sheehan
Former Medicaid
inspector general,
State of New York

Housekeeping

1. Viewer Window



2. Control Panel



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Now presenting...

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Marti Arvin
Chief compliance officer, UCLA Health and the David Geffen School of Medicine

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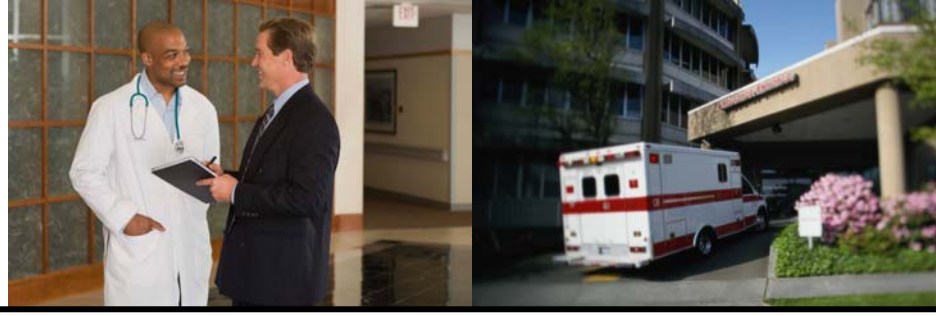

HEALTH REFORM, COMPLIANCE and INSOMNIA

Presented by Marti Arvin, Chief Compliance Officer
UCLA Health System and
David Geffen School of Medicine

DISCLAIMER: The views I express here are my own views and not those of the UCLA Health System, the David Geffen School of Medicine, UCLA or the University of California system.

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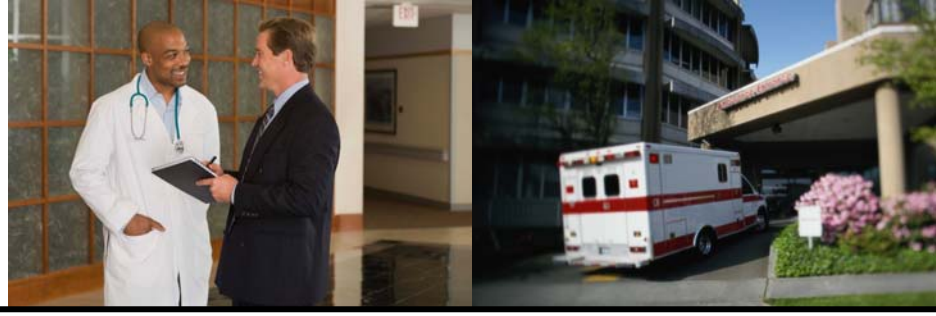

AGENDA

- Things that keep me up at night
  - EHR compliance issues
  - Privacy and information security compliance issues
  - Decreasing reimbursement – will it lead to decreased compliance

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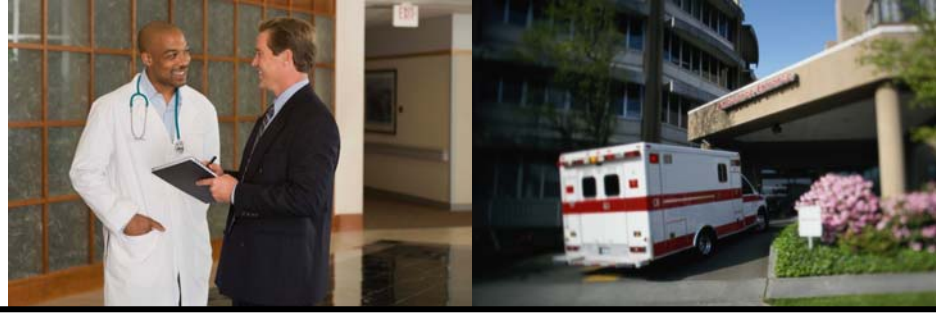

EHR Compliance Issues

- Access Issues
  - Internal
  - External
- Research Issues
- Meaningful use
  - What documentation will be sufficient to demonstrate compliance?
- Accounting for TPO disclosures

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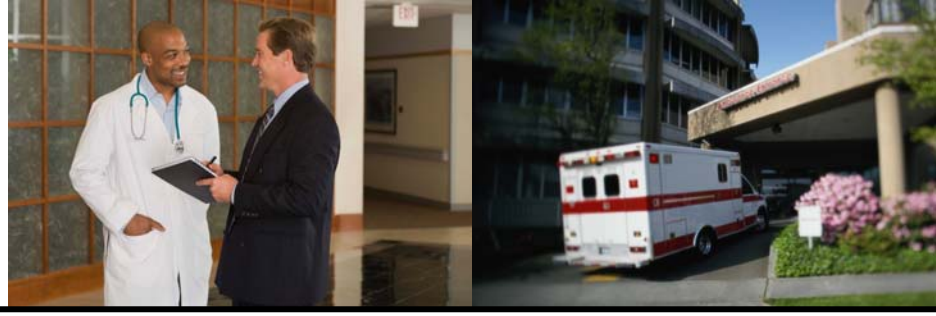

Privacy and Information Security Compliance Issues

- Information breaches
  - Where is data stored?
  - How is it stored?
- Increased auditing by the Office for Civil Rights
- Increases enforcement action by OCR
  - Use of resolution agreement/corrective action plans
  - Civil Monetary Penalties

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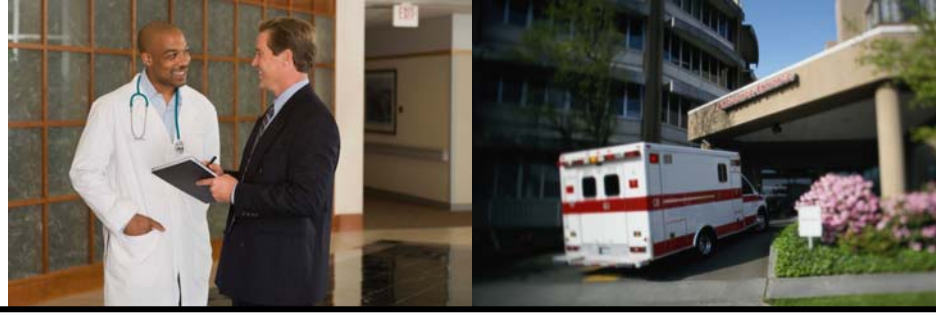

Decreased Reimbursement

- Will this lead to decreases compliance as employees are pushed to operate in a leaner and leaner environment?
- How do we keep improving our compliant culture in these times?
- Mandatory compliance programs
  - What is an effective compliance program?
  - How do you demonstrate it?

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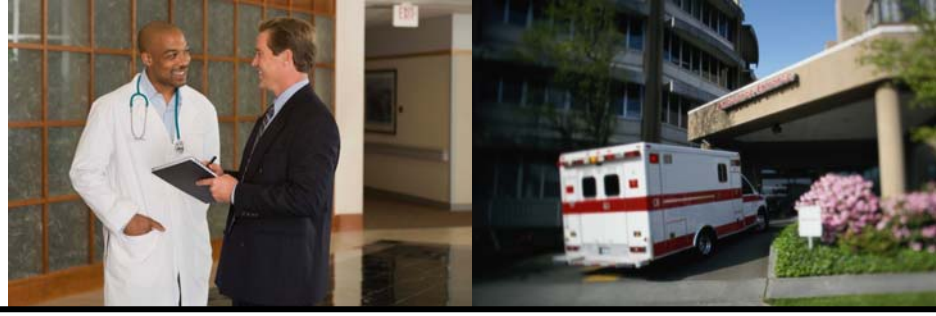
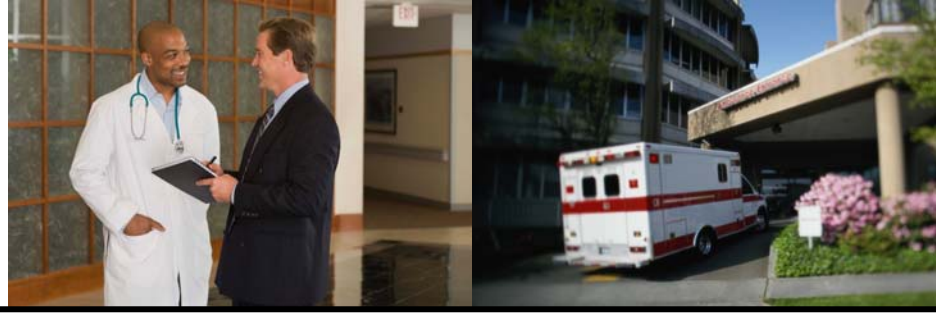
Healthcare compliance attorney,
Epstein Becker & Green

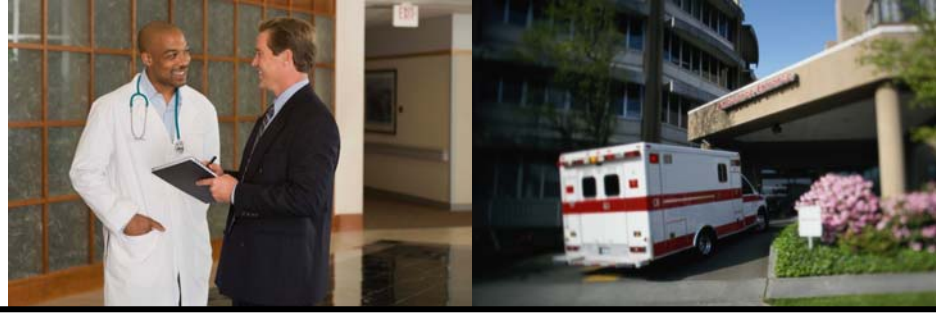


Overview of Certain Fraud Provisions Added As Part of the Affordable Care Act



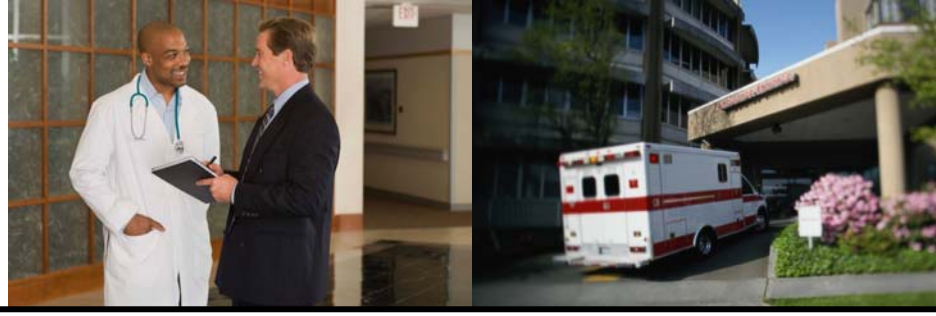
Reverse False Claims

- ACA requires any person who has received "an overpayment" to return it, and report the reason for the overpayment, to the payor within 60 days after the overpayment was "identified" or the date the any corresponding cost report is due, whichever is later.
- Overpayment is defined as "any funds that a person receives or retains ... to which the person, after applicable reconciliation, is not entitled."
- Overpayments must be reported and returned to the Secretary, State, Intermediary, Carrier or Contractor.



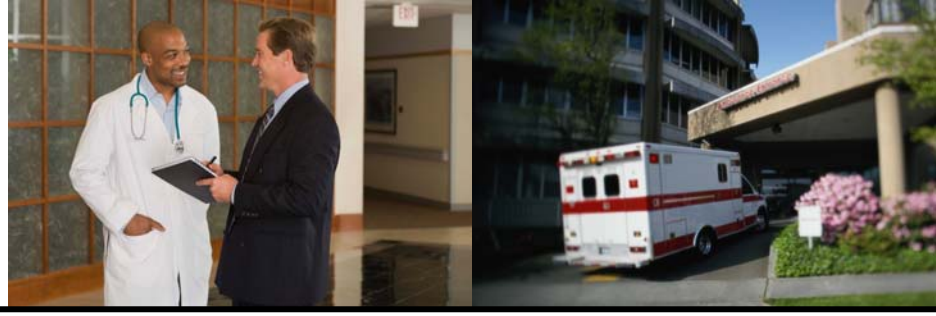
New Civil Money Penalties

- For ordering or prescribing “a medical or other item or service during a period in which that person was excluded”, if the person knows or should know that a claim would be made under a Federal Health Care Program.
- For knowing of an overpayment and failing to return and report such overpayment
- For knowingly making or causing to be made a false statement, omission or misrepresentation of a material fact in a Federal health care program application, agreement, bid or contract



Suspension of Payments

- Medicare and Medicaid payments may be suspended "pending an investigation of a *credible* allegation of fraud against the provider of services or supplier" unless the Secretary determines there is good cause not to suspend.
- Secretary shall consult with OIG to determine if there is a credible allegation of fraud.
- There is no definition of "credible allegation of fraud."



Mandatory Adoption of a Compliance Program

- ACA provides that the OIG and HHS Secretary can require, as a condition of participation in Medicare, that providers and suppliers establish a compliance program that contains the "core elements"

- One court has held that a health care provider's lack of an *effective* compliance program constitutes "reckless disregard" for purposes of the FCA's scienter requirement.

  United States v. Merck-Medco Managed Care LLC, 336 F.Supp.2d 430, 440-41 (E.D.Pa. 2004).

Attorney Client Privilege and Compliance

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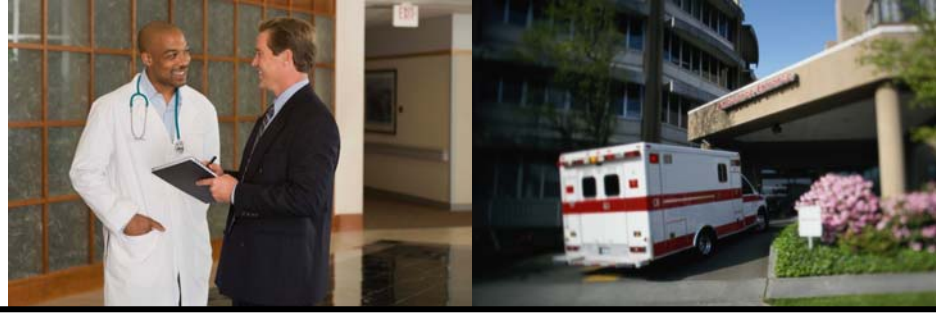
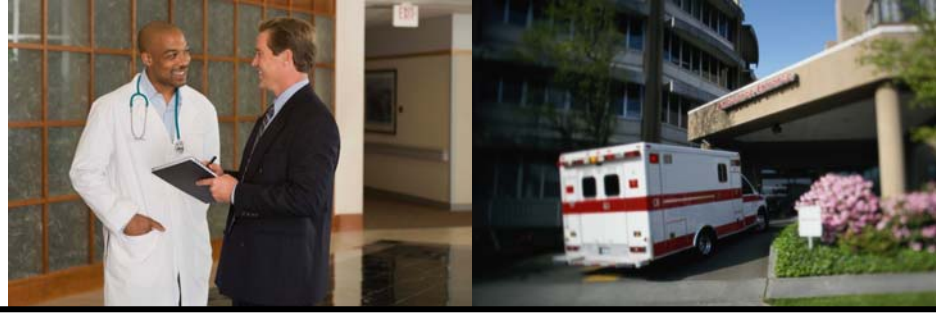


General Issues

- Keep legal and compliance files separate
- Label all documents that are in fact
  - Remember, just because the document is labeled does NOT mean it is in fact privileged – must be seeking or giving legal advice or prepared in anticipation of litigation.
- Waiver Pitfalls
  - Forwarding privileged emails
  - Conversations with attorneys in the presence of non-attorney consultants or other attorneys engaged for separate representation



Conducting Internal/External Audits

- Is legal counsel engaged?
  - In-House counsel
  - Outside Law Firm
- If done internally, are audits conducted by compliance department or at the direction of legal?
  - *Remember, just because the document is labeled does NOT mean it is in fact privileged – must be seeking or giving legal advice or prepared in anticipation of litigation.*
- Is the Chief Compliance Officer an Attorney? Does it Matter

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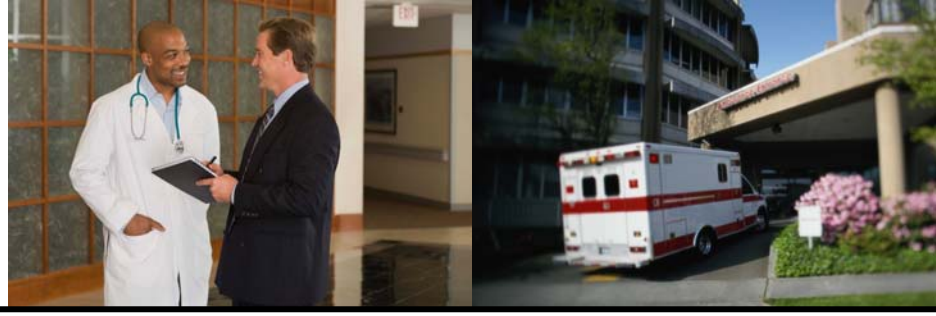

Board of Director/Senior Management Team Responsibility

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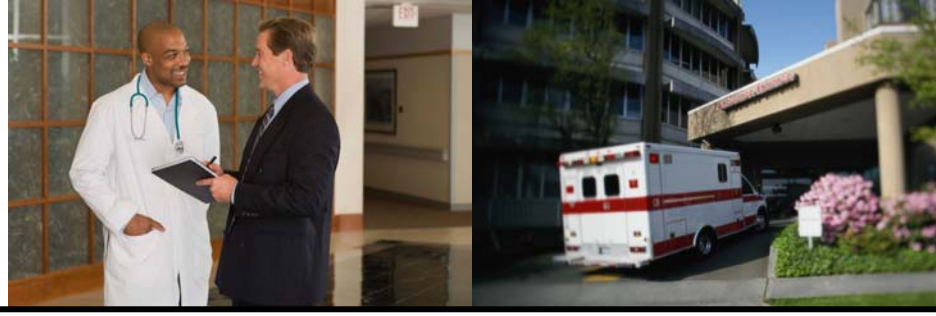

As a Board Member or a Senior Member of the Management Team, you are NOT expected to be a lawyer or an expert on laws BUT, you need to:

- Generally understand the application of the laws that affect your business
- Ask questions of management
- Be an ambassador to educate others and lead from the top down

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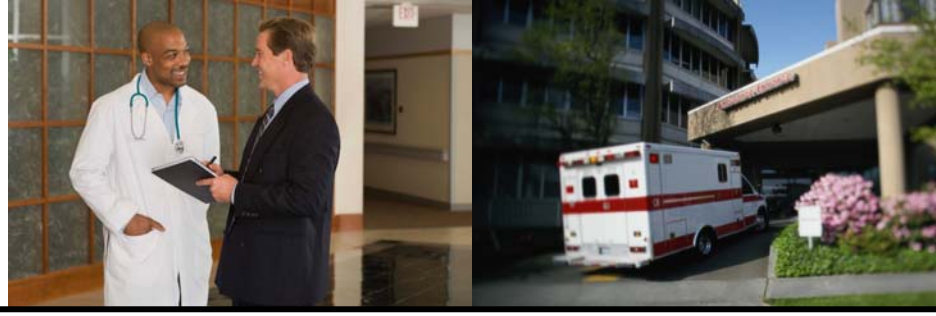

Ensuring Effectiveness of an Organization's Compliance Program

- Dynamic and evolves over time
- Remember one size does not fit all
- Ask questions re: **structure** and **operation** of the program
- For government views on what is necessary, look to:
  - Recent CIAs
  - OIG Guidance
  - Federal Sentencing Guidelines

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Now speaking...

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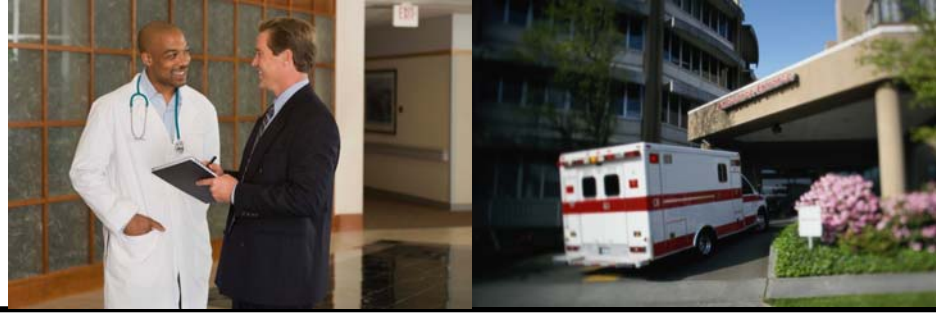
James Sheehan
Former Medicaid inspector general,
State of New York



Provider strategies for meeting regulatory rules in wake of the Affordable Care Act

Jim Sheehan
Executive Deputy Commissioner and Chief Integrity Officer,
New York City Human Resources Administration
212-274-5600
Sheehanj@hra.nyc.gov

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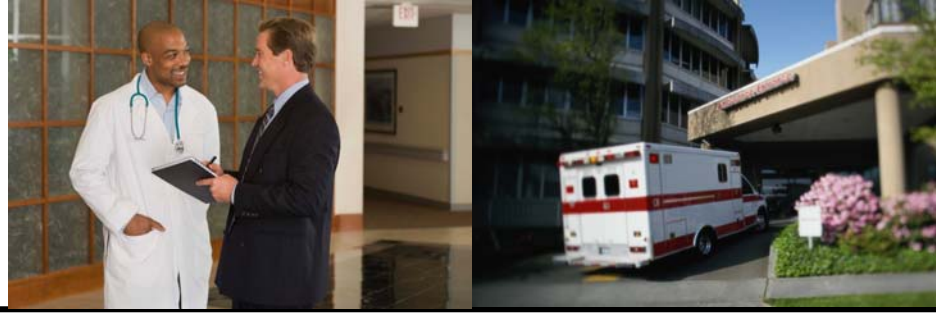

WHAT YOU NEED TO KNOW FROM THIS PRESENTATION

- Significant changes in government approaches to compliance and audits
- Requires changes in your business practices and compliance program
- Awareness of current enforcement and whistleblower actions
- Growth in Medicaid enforcement-use of ACA 6402

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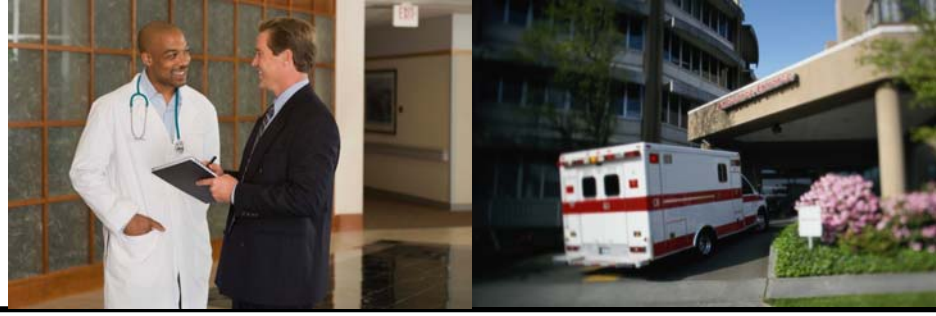

THE COMPLEXITY OF THE MEDICAID WORLD

- Existing state agencies and contractors – NY OMIG, NJ Controller, Pa. DPW, UMass
- HHS-OIG
- Law enforcement agencies (Medicaid Fraud Control Units, U.S. Attorney Offices)
- Medicaid Integrity Contractors (2008)
- Medicaid RACs (2011-12)

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THE COMPLEXITY OF THE MEDICAID WORLD

- New players in “audit”-media and public
- South Carolina-put provider data on line
- Wall Street Journal November 5, 2011
- “In Medicare’s data trove, clues to curing cost crisis”
- WSJ sued to obtain access to provider specific records-case pending in Fl.
- New York Times November 6,2011
- Causes of 1,200 deaths in facilities for persons with disabilities, run by or paid for by state

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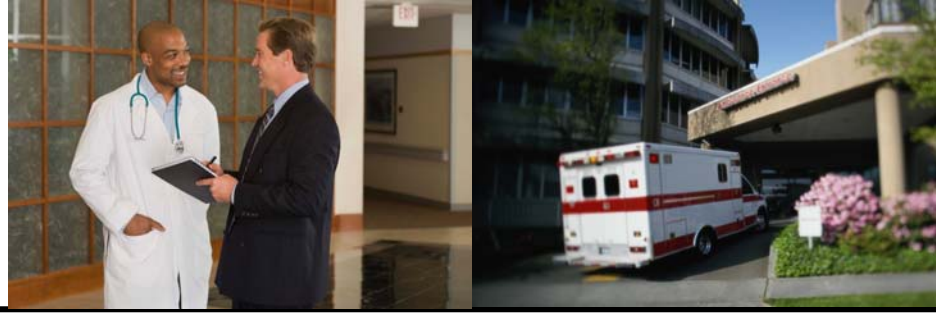

MEDICAID – NEW PLAYERS

- Mandatory reporting and refund of overpayments-Section 6402 of ACA
  - Mandatory Compliance programs in business partners
  - HOSPITALS/PHYSICIANS (Stark)
  - PHARMA/DEVICE COMPANIES WITH PHYSICIANS (Sunshine Act)
  - BILLING COMPANIES AND PROVIDERS
  - MANAGED CARE AND PROVIDERS
  - IRS 990 review for non-profits

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A STORY OF A 2011 MEDICAID CASE

- Dr. Howard Goldstein, Missouri psychiatrist

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DR. GOLDSTEIN'S DEFENSE

• Dr. Howard Goldstein was a "workhorse" who saw dozens of patients in a room at a time but "does not write well," defense lawyer Albert Watkins explained.

• Watkins said that caused Goldstein's employer, SSM St. Charles Clinic Medical Group Inc., to question his billings and led Dr. Goldstein to use computerized records whose repetitive entries became the subject of a federal probe.

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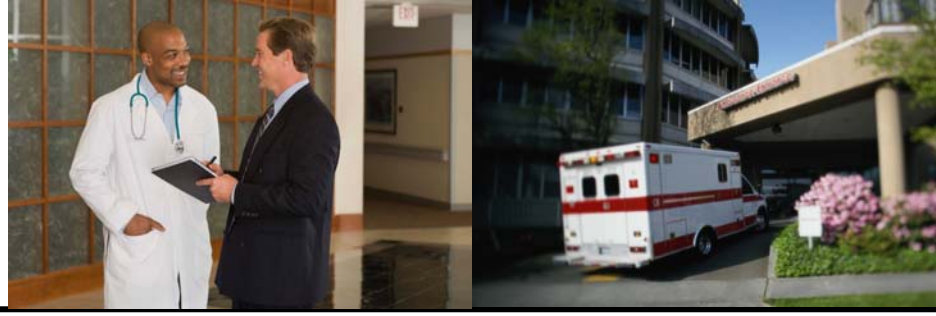
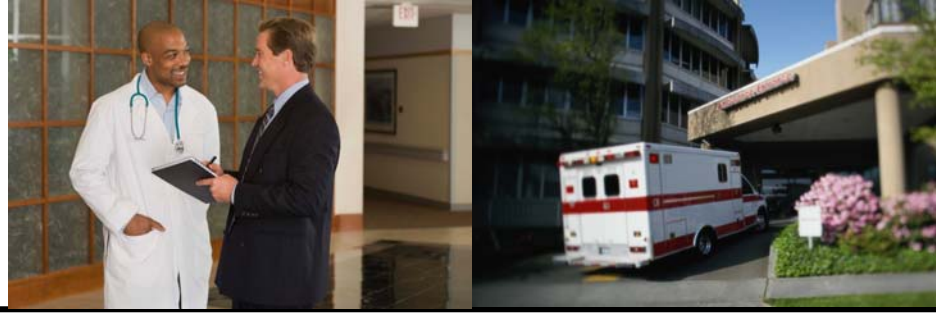


SSM St. Charles Medical Group

- 2007-Audited Dr. Goldstein -records “scant and illegible”
- Considered firing, but sent him to coding education classes
- 2009-routine peer review identifies continued record issues-reported to compliance officer, who reported to DOJ
- SSM to pay $865,812



SSM St. Charles Medical Group

- Repaid $870,000 to federal and state governments
- No CIA
- No monitor
- Commendation by US Attorney's Office

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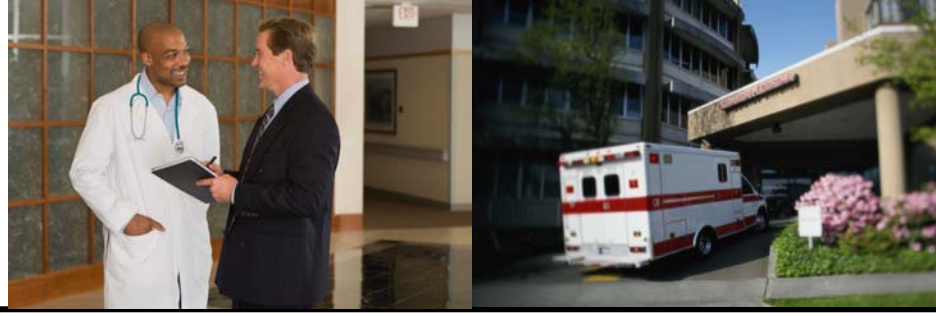

Lessons from Dr. Goldstein case

- What routine monitoring do you undertake?
- What actions do you take when physicians records do not support billing?
- What records do you make of findings?
- What records do you make of corrective actions?
- What do you do to monitor current actions of non-compliant physicians?
- You are responsible for employee bills

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A STORY OF A 2011 MEDICAID CASE

- Maxim Health, a Medicaid home health agency doing business in multiple states
- No or minimal records supported billings for services
- Evidence of obstruction (destruction of records, discouraging testimony)

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RICHARD WEST-PATIENT - MAXIM WHISTLEBLOWER

- "I'm on oxygen,I wasn't getting the nursing care I needed and services were being cut back because of me being over the so-called spending limit. There were times I thought I would die."
- After checking his own medical records, he discovered the company providing him with nursing care appeared to have overbilled Medicaid for hundreds of hours for people who were never there.

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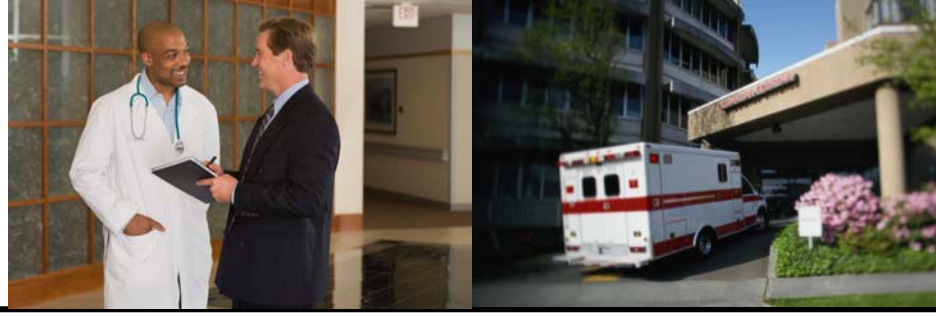

MAXIM HOME HEALTH-2011-THE NEW MODEL HEALTH CASE

- Maxim Healthcare Services, company with 360 offices nationwide offering home health care services, agrees to pay about $150 million to settle civil and criminal charges -false billings to Medicaid and the Department of Veterans Affairs (no Medicare)
- Nine current and former Maxim employees have pleaded guilty since 2009 to felony charges

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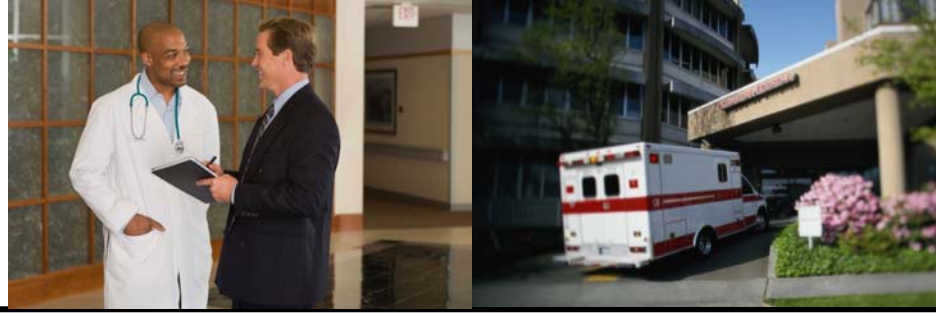

MAXIM CONSPIRACY TO DEFRAUD-criminal information

- "Maxim emphasized sales goals at the expense of clinical and compliance responsibilities"
- During the relevant time period, Maxim did not have in place "appropriate training and compliance programs to prevent and identify fraudulent conduct."
- "Relevant time period" before ACA.

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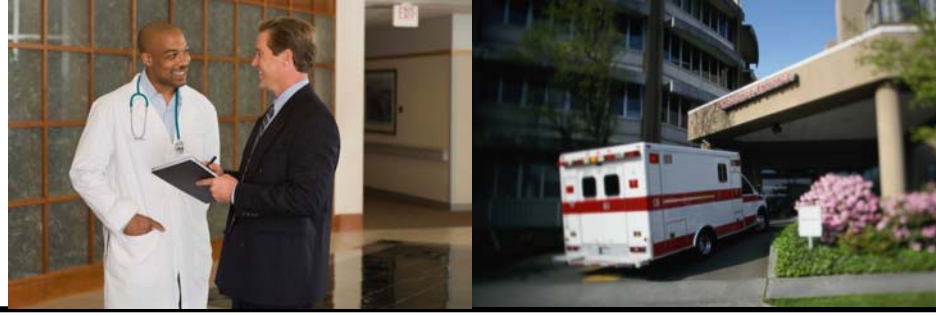
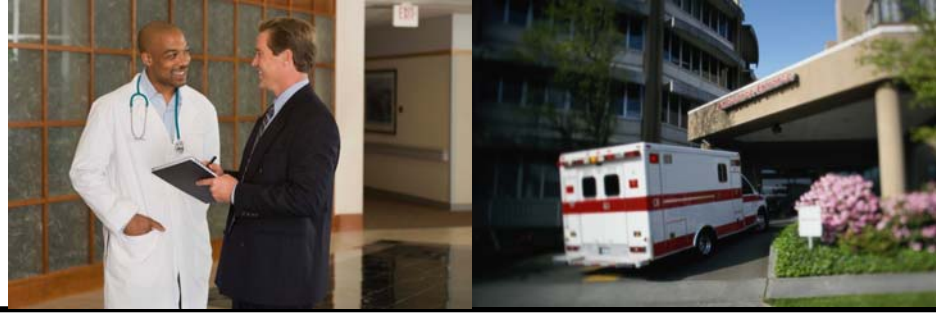


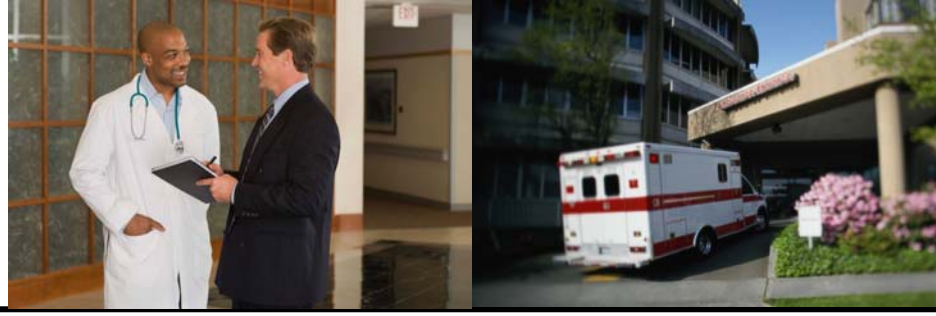
MAXIM PROSECUTION

- Criminal Information
  - False documents re training
  - False documents re evaluations by supervisors
  - Billing through licensed offices other than the unlicensed office where care was actually supervised
  - Documents certified that mandated training had been received when it had not been
  - CONDITIONS OF PARTICIPATION VIOLATIONS AS BASIS FOR CRIMINAL PROSECUTION



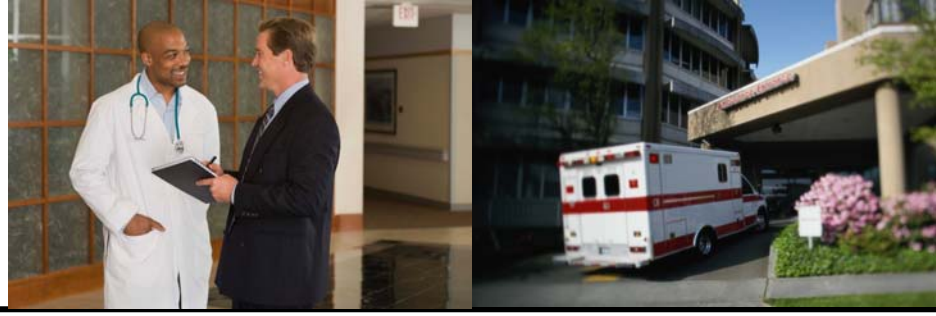
MAXIM CIVIL FALSE CLAIMS RELEASE

- "submitting or causing to be submitted false claims to state Medicaid programs and the VA, for services not reimbursable by state Medicaid programs or the VA because Maxim lacked adequate documentation to support the services purported to have been performed"



MAXIM CIVIL FALSE CLAIMS RELEASE

- “for the fo!lowing offices, during the following periods, submitting or causing to be submitted false or fraudulent claims to state Medicaid programs for services not reimbursable by state Medicaid programs because the offices were unlicensed:”



MAXIM DEFERRED PROSECUTION AGREEMENT

- "The company has identified and disclosed to law enforcement the misconduct of former Maxim employees, including providing information which has been critical in obtaining the convictions of some of the individuals who have pleaded guilty to date. The company has also significantly increased the resources allocated to its compliance program." DOJ press release 9/12/2011

MAXIM DEFERRED PROSECUTION AGREEMENT

- "reforms and remedial actions the company has taken – beginning in May 2009-establishing and filling of positions of chief executive officer, chief compliance officer, chief operations officer/chief clinical officer, chief quality officer/chief medical officer, chief culture officer, chief financial and strategy officer, and vice president of human resources; hiring a new general counsel"

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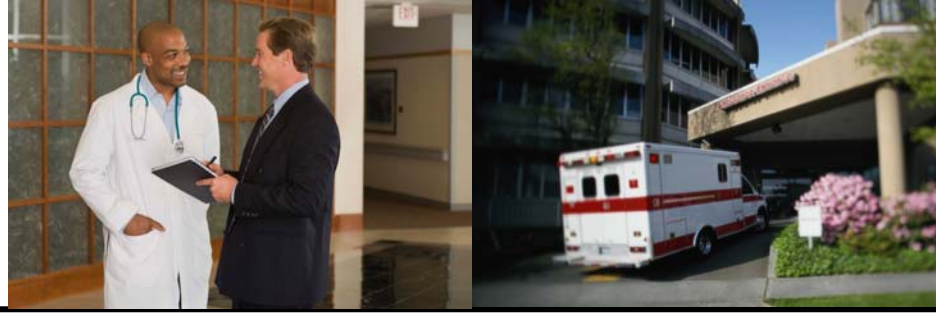

MAXIM RESOLUTION

- Eight former Maxim employees, including three senior managers, have pleaded guilty to felony charges in federal court in Trenton, N.J.
- DEFERRED PROSECUTION AGREEMENT-INCLUDING ADMISSION OF CHARGES IN INFORMATION
- CORPORATE INTEGRITY AGREEMENT
- $150 million in FCA damages and criminal penalties
- Monitor

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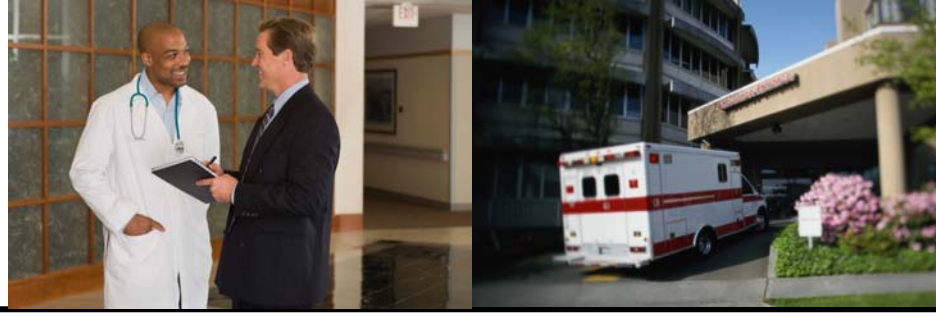

MAXIM

- No Medicare-but federal prosecution
- Cooperation against senior executives
- Medicaid home health-traditionally considered difficult investigative subject area
- Patient as whistleblower
- This is a 2004 case-if filed now, states would be required by CMS to suspend payment during “an investigation of credible allegation of fraud.”

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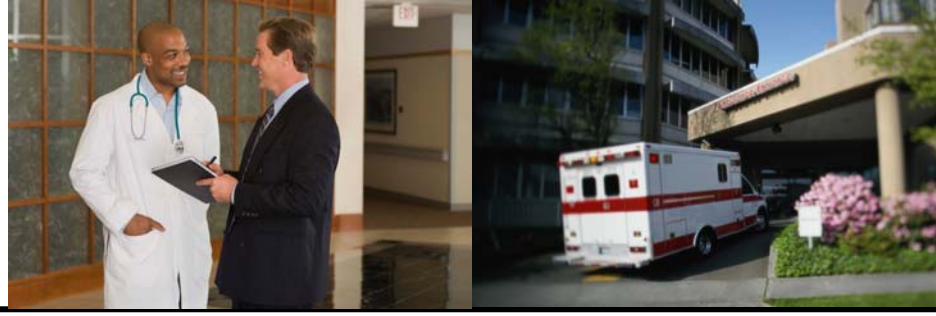

OIG 2012 MEDICAID WORKPLAN

- THREE MAJOR AREAS
- Pharmacy
- Home, Community, and Personal Care Services
- Other

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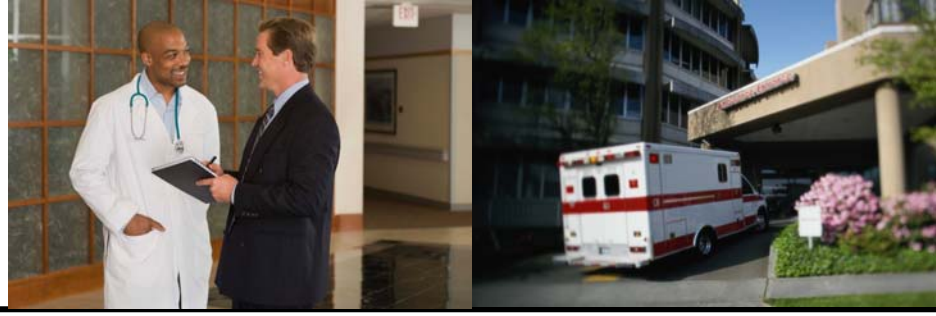
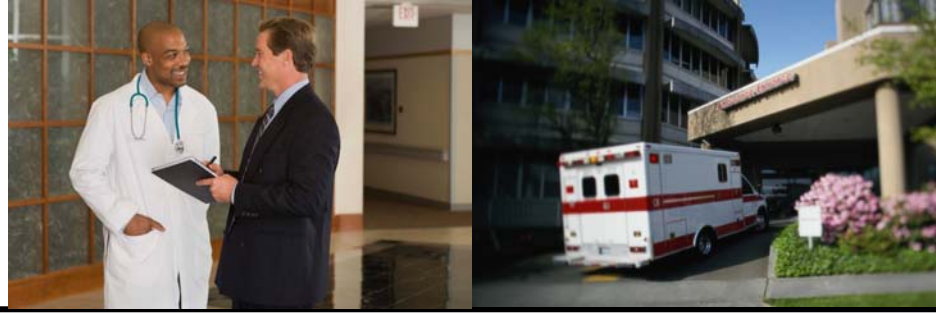


OIG 2012 MEDICAID WORKPLAN

- Claims With Inactive or Invalid Physician Identifier Numbers
- Beneficiaries With Multiple Medicaid Identification Numbers
- Federally Excluded Providers and Suppliers
- Overpayments: Medicaid Credit Balances
- States' Efforts To Improve Third-Party Liability Payment Collections in Medicaid

Staying compliant: Provider strategies for meeting regulatory rules in wake of the Affordable Care Act



OIG 2012 WORKPLAN-MCOs

- Completeness and Accuracy of Managed Care Encounter Data
- Managed Care Entities' Marketing Practices
- Excluded Individuals Employed by in Managed Care Networks
- Managed Care Organizations' Use of Prepayment Review To Detect and Deter Fraud and Abuse.

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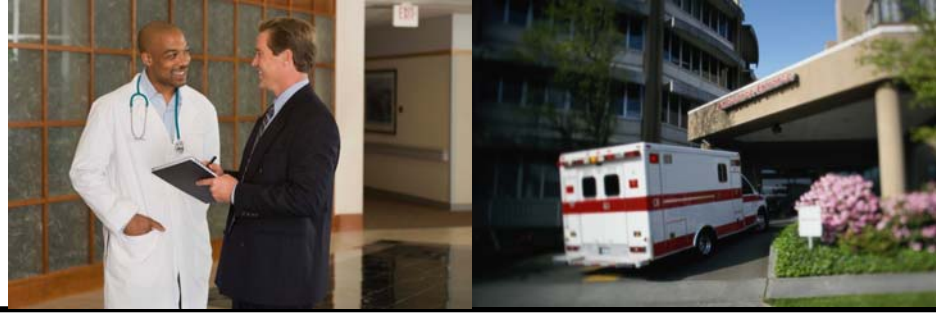

NEW CMS REVIEWS

"Predictive modeling technology (is being applied) to Medicare fee-for-service claims nationwide July 1, 2011. All claims across the country are now being screened before they are paid. The ones with the highest risk scores will receive immediate attention and additional review by our analysts through our new rapid response strategy." Dr. Peter Budetti, Director, CMS Center for Program Integrity

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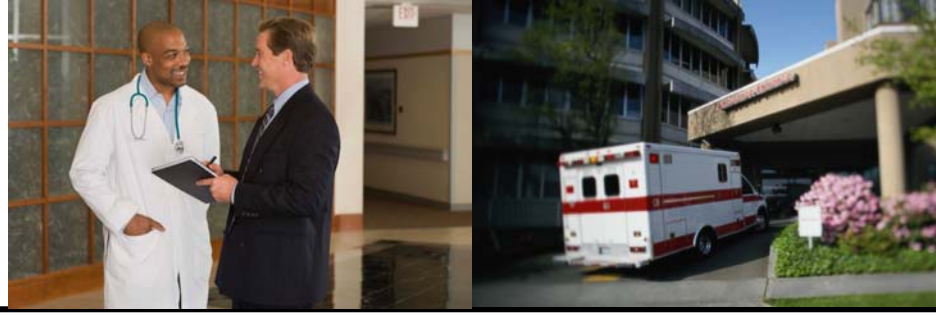

PREDICTIVE MODELING

•The Small Business Jobs Act of 2010, signed Sept. 27,2010 requires the Center for Medicare & Medicaid Services (CMS) to "adopt predictive modeling and other analytics technologies to identify improper claims for reimbursement and to prevent the payment of such claims under the Medicare fee-for-service program."

•two year predictive modeling contest for hospital admissions. WSJ 3/16/11

•GAO Report GAO-11-409T 3/9/2011-5 steps to reduce M/M fraud, waste, abuse, including data mining,better predictive modeling, followup to RAC findings on providers

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ACA SECTION 6402 MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

"(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***.*

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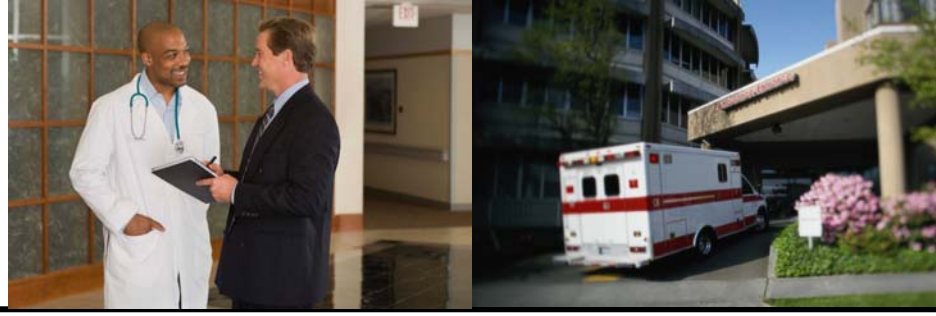

SEC. 6402 (d)MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

‘‘(2) DEADLINE FOR REPORTING AND RETURNING OVERPAYMENTS.—An overpayment must be reported and returned under paragraph (1) by the later of—

‘‘(A) the date which is 60 days after the date on which the overpayment was **identified;** *or*

‘‘(B) the date any corresponding cost report is due, if applicable.

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PROVIDER MUST REPORT AND RETURN THE OVERPAYMENT AND STATE THE REASON, IN WRITING FOR THE PAYMENT

•NO CMS REGULATION OR GUIDANCE;NO PLANS FOR REGULATION OR GUIDANCE

• PA 2010 self-audit protocol: Medical Assistance Bulletin 99-02-13, http://www.dpw.state.pa.us

•NJ Self-Disclosure Process www.nj.state.us/njomig

•NY OMIG's Disclosure Protocol, available on the OMIG website, www.OMIG@.ny.gov

• Mass., Ct. Do not yet have disclosure protocols

•COMPARE WITH federal OIG self-disclosure protocol http://oig.hhs.gov/authorities/docs/selfdisclosure.pdf.

•COMPARE WITH "unsolicited/voluntary refunds" to Medicare contractors (last checked July 2, 2010)

•See, e.g., http://www.wpsmedicare.com

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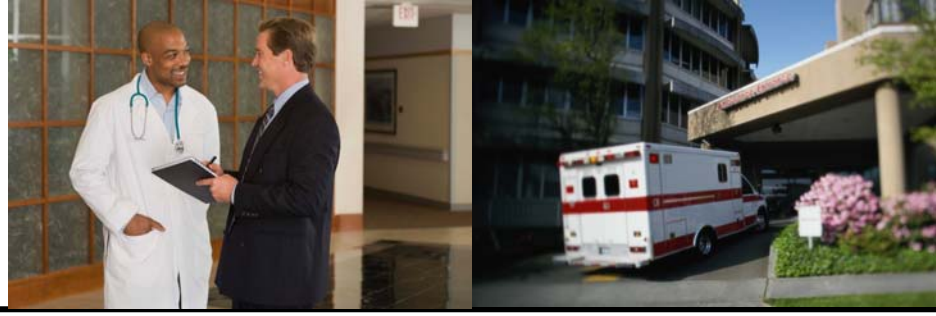

WHO IS MOST LIKELY TO USE THE FERA FCA PROVISIONS TO ENFORCE THE 6402 ACA DUTY?

- WHISTLEBLOWERS AND THEIR COUNSEL
  - Data analysis for whistleblower case evaluation, supporting whistleblower allegation
    - Using your data and benchmarks
    - Matching exclusion lists against employee/contractor lists
    - Publicly available data on outliers
    - Discovery and access to govt. data and documents
    - Publicly available data on provider behavior
    - Best practices research

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FREE STUFF FROM THE NY MEDICAID IG

www.omig.ny.gov

- Model compliance programs-hospitals (coming soon) and Compliance Alerts
- Over 3000 provider audit reports, detailing findings in specific industry
- Annual work plans for 2009, 2010, and 2011
- New York excluded provider list
- Self-Disclosure protocol
- Corporate Integrity Agreements
- Listserv
- Link to sites for all 18 states which currently publish their state exclusion lists

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Webcast

Q&A

Please use the questions box on your webcast dashboard to submit comments to our moderator

Joe Carlson
Reporter,
Modern Healthcare

MODERN HEALTHCARE Webcast

Thank you...

... for attending today's editorial webcast on compliance issues. We also thank our panelists, Marti Arvin, chief compliance officer with UCLA Health and the David Geffen School of Medicine; David Matyas, healthcare compliance attorney with Epstein Becker & Green; and James Sheehan, former Medicaid inspector general, state of New York.

Expect a follow-up e-mail within two weeks. For more information send an e-mail to webcasts@modernhealthcare.com

Our next editorial webcast—on the latest tools, techniques and strategies providers can use to ensure that patient care is as safe as can be—is set for 10 a.m. CT on Dec. 21.
For more information and to register, visit modernhealthcare.com/webcasts