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together

Government Program Integrity Enforcement and Child Behavioral Provider Focus Areas

National Association for Children's Behavioral Health
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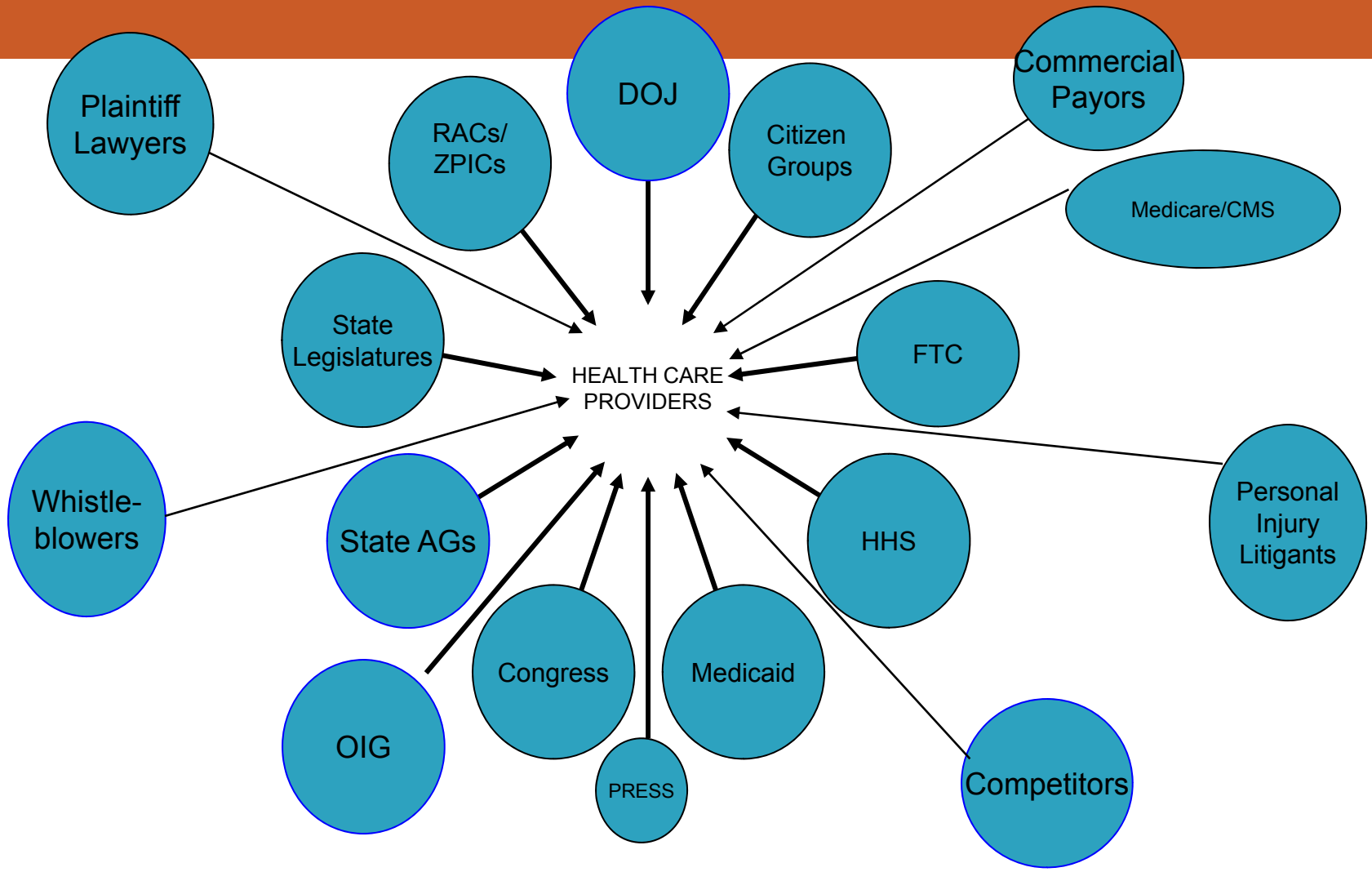
AGENDA

- Government Imperative to Police Federal and State Funds Used for Health Care Programs
- Child Behavioral Health Providers as Audit Targets
- Medicaid Integrity Program Issues
- Detailed Example of Recent Audit
- Federal (OIG and DOJ) Audit and Fraud Enforcement Efforts
- Compliance Program Essentials, including Government Perspective

Political Imperative to Police Expenditure of Federal and State Funds Used in Health Care

- 1970s and 1980's – Anti-Kickback Law, OIG Civil Monetary Penalty and Exclusion Authorities
- 1986 – *Qui Tam* Provisions of FCA strengthened
- 1996 - HIPAA Funding for Program Integrity and expansion of health fraud laws
- 2005 - Deficit Reduction Act ("DRA") and focus on Medicaid program integrity issues
- 2009 – FERA – strengthened FCA
- 2010 – PPACA's Program Integrity Provisions
- 2011 – Ramp up in activity

Many Watchful Eyes



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Variation in Treatment Settings

- Psychiatric Residential Treatment Facilities
- Residential Group Homes
- Institutions for Mental Diseases ≥ 16 beds
  - States self-identify which are IMDs
- Theapeutic Group Homes
- Treatment Foster Care Homes
- State Plans – sometimes unclear on precise residential rehabilitative service and requirement for documentation of claims

Outpatient Programs

- Other licensure schemes
- EPSDT
- Treatment Foster Homes
- School based programs
- No standardized program across all states

IMD Exception for Patients Under 21

- If facilities (with greater than 16 beds) determined to be IMD, no FFP funds available except for inpatient psych
  - IMD - "overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases."
- Confusion on when exception applies
- Inherent contradiction when EPSDT screening shows residential treatment is medically necessary
- Kansas State Medicaid Plan litigation – scope of state plan and PRTF add on rates

Complex Regulatory Scheme Governing RTFs

- Licensure/certification by applicable state regulatory bodies in about half of states
  - State mental health agency, state department of health
- CMS approval of use of PRTFs in Medicaid State Plans
  - PRTFs are optional – must be approved thru state plan
- Accreditation by The Joint Commission, the Council on Accreditation for Children and Family Services, the Commission on Accreditation of Rehabilitation Facilities, and National Committee for Quality Assurance
- Certification by state Medicaid agencies

Why PRTFs may be subject to increased scrutiny?

- Medicaid plays an essential role in funding services for children and youth with mental health and substance abuse disorders
  - High cost of residential care makes PRTFs ripe for audits/reviews based on the presumption that service delivery model vulnerable to fraud and abuse
- Medicaid funding requires accountability for every dollar
- Healthcare civil fraud enforcement is largely about $$$
- Significant misunderstanding about services furnished

Why PRTFs may be subject to increased scrutiny (cont'd)?

- No one size fits all: Diverse RTF and other models
- Service delivery requires coordination across multiple and overlapping systems/disciplines
  - ↑ opportunity for system errors and confusion
- Many employees, medical staff, consultants → if inconsistent standards are applied, will increase likelihood of confusion and inconsistent documentation
- Multiple state or OIG audits can also increase risk of fraud allegations

Residential Treatment Facilities Focus Areas

- Minimum therapy visits per week
- Group therapy hours
- Family therapy sessions
- Staffing ratios
- Face-to-face by supervising practitioner
- Minimum qualification of staff
- Documentation of medical necessity and quality of the healthcare services

State Medicaid Programs are Auditing/Crimping More

- Increased medical necessity and documentation audits of PRTF and other residential treatment claims
- In Kansas, state budget cuts result in fewer children admitted to psychiatric facilities
  - Local mental health centers denying referrals to PRTFs motivated by “savings plan goal” instituted by Medicaid
  - Prior over-utilization? Debate ensues

Other State Children Behavioral Health Audit Activity

- Virginia – State AG has recovered $4.6 million in Medicaid “fraud” for child mental health service providers (in-home counseling/treatment, not inpatient)
- Oregon – Audited about 100 behavioral health organizations in 2008
  - Audits proved expensive for behavioral health programs

Medicaid Program Integrity Oversight Function and Fraud and Abuse Enforcement

- STATE MEDICAID OVERSIGHT
  - Joint Federal and State Program – at least 50% federal funds
  - Federal Social Security Law – minimum "State Plan" requirements – State Plan approval by CMS
  - Inconsistent with federal law – federal funding at risk
  - CMS - Medicaid Program Integrity and Medicare Program Integrity
  - Medicaid contractors (e.g., MICs, RACs)
  - State Inspectors General and Attorneys General
  - State Medicaid Fraud Control Units

Medicaid Integrity Program ("MIP")

- Medicaid Integrity Contractors - Review, Audit and Education
- Recovery Audit Contractors and Contingency Payments
- Types of RAC Audits
- Audit Management Strategy and Preparation
- Post-Audit Considerations and Appeals

MIP Overview

- DRA of 2005
  - Increased Federal $$$ to fight Medicaid fraud, waste, and abuse.
    - *Requires CMS to contract with entities to:*
      - Review provider claims
      - Audit providers and others
      - Identify overpayments
      - Educate providers, MCOs, beneficiaries and others on program/payment integrity and quality of care

Medicaid Integrity Contractors (MICs)

- Three types of MICs:
  - *Audit*
  - *Review*
  - *Education*
- Five jurisdictions:
  - *New York (CMS Regions I & II)*
  - *Atlanta (CMS Regions III & IV)*
  - *Chicago (CMS Regions V & VII)*
  - *Dallas (CMS Regions VI & VIII)*
  - *San Francisco (CMS Regions IX & X)*

Purpose of MICs

- Ensure that paid claims were:
  - For services provided and properly documented
  - For services billed properly, using correct and appropriate procedure codes
  - For covered services
  - Paid according to Federal and State laws, regulations, and policies

Review MICs

- Analyze Medicaid claims data to identify high-risk areas and potential vulnerabilities
- Provide leads to the Audit MICs
- Use data-driven approach to ensure focus on providers with truly aberrant billing practices

Audit MICs

- Conduct post-payment audits
  - Combination field and desk audits
- FFS, cost report, and managed care audits
- Audits will identify overpayments; States will collect overpayments and adjudicate provider appeals

Education MICs

- Use findings from Audit and Review MICs to identify areas for education
- Work closely with Medicaid partners & stakeholders to provide education and training
- Develop training materials, awareness campaigns and conduct provider training
- Highlight value of education in preventing Medicaid fraud, waste, and abuse

Purpose of RACs

- Detect and correct past improper payments
- Allow for implementation of actions that will prevent future improper payments
- Lower CMS error rate
- Protect taxpayers and beneficiaries

Types of RAC Reviews

- Coverage determinations
- Coding determinations
- Medical necessity determinations
- Other determinations
  - *e.g.*, claim priced incorrectly; claim paid twice (duplicate claim)

Medicaid RACs

- ACA section 6411
- Sep. 14, 2011 Final Rule (delayed implementation by states)
- Not all will be the same
- Modeled after Medicare RACs
- States can request exceptions from scope
- Must have Medical Director and other licensed professionals as reviewers
  - Query if they will have child behavioral health experience
- Expected to “save” $2.1 billion in next 5 years

RAC Expansion to Medicaid (cont'd)

- PPACA does not indicate the specific provider types that will be subject to a Medicaid RAC review
- § 6411(a)(1) suggests that it will broadly apply to any entity receiving payments under Medicaid
- States will contract with one or more Medicaid RACs to determine overpayments and underpayments (and recoup overpayments)
- Payments to Medicaid RACs will be made only from amounts "recovered" on a contingent basis
  - CMS will not dictate contingency rate, but will set maximum contingency rate (based on rate paid to Medicare RACs) for which FFP will be available

Detailed Analysis of State Medicaid Audit of Child Behavioral Health Programs

- Virginia DMAS hired outside audit contractor that audited a residential treatment care provider to children
- Contractor determined there was a $1,173,264.06 overpayment and DMAS sought refund
- Failure to properly document 21 treatment interventions each week for each resident
- Failure to provide sufficient progress notes
- Appeal ensued – Provider prevailed before Hearing Officer on Oct. 26, 2011

Hearing Officer Findings

- Provider was governed by a provider agreement with Medicaid and so certain contract law principles apply
  - Regulations – are they clear?
  - Guidance (e.g. Provider Manuals) deserve less deference but are state's attempt to interpret and implement statutes and regulations
- Virginia Regulation:
  - Residential treatment programs shall be 24 hour, supervised, medically necessary, out-of-home programs

VA Hearing (Continued)

- Therapeutic Behavioral Services for Children must be therapeutic services rendered in a residential type setting such as a group home or program that provides structure for daily activities, psychoeducation, therapeutic supervision and mental health care to ensure attainment of mental health goals. Child has significant functional impairments in major life activities
- Active treatment required and services do not include interventions/activities ony designed to meet supportive nonmental health special needs, including but not limited to personal care, habilitation or academic educational needs

VA Hearing (Cont'd)

- VA Medicaid Manual:
  - Minimum of 21 distinct sessions (excluding individual treatment, school attendance and family therapy) of appropriate treatment interventions each week (i.e., group therapy with specific topics focused to patient needs; insight oriented and/or behavior modifying).
    - *One group therapy session per day limit;*
    - *Maximum of 10 individuals per group therapy session*

VA Hearing (Cont'd)

- Medical record documentation must include concurrent documentation of therapeutic interventions (billable and non-billable that meet 21 weekly minimum)
- Progress notes for each session must describe the plan for the next session.
- Did RTC provide 21 sessions per week for each resident?
- Provider relied on a form it had created entitled "Treatment Documentation" that set forth 6 areas (later form had 4 areas of treatment activity)

VA Hearing (Cont'd)

1. Recreation Activity
2. Social Skills Activity
3. Recreation Activity
4. Self-Soothing-Nurturing/Hygiene Activity

- All sessions under "Self-Soothing-Nurturing/Hygiene Activity" were rejected as qualifying for 21 session requirement because determined not to be an intervention

VA Hearing (cont'd)

- But Medicaid Manual indicates that any session with specific topics focused on patients' needs that is insight-oriented or that is behavior modifying may qualify as a session, so long as accompanied by appropriate treatment interventions
  - Socializational, recreational and grooming count.
- VA Medicaid audit contractor accepted recreational and social skill sessions, but not self-soothing, hygiene and manners sessions

VA Hearing (cont'd)

- "Patients were extremely troubled, dysfunctional and damaged human beings" who "needed assistance in nearly all aspects of life."
- Manners session – taught children not to be verbally/physically abusive at meal table, follow directions
- Bathing and bed time – therapy required because many children had been abused during these activities
  - Needed therapy in these areas or would not bathe or want to go to bed

VA Hearing (cont'd)

- Auditor had not inquired beyond the provider documentation as to what occurred during these "grooming/self-soothing" sessions – had it done so, probably would have approved of them.
  - Dangers of "desk audits"
- Other basis for denials – Plans of Care – next session planning
  - The Treatment Documentation form did not include a "Plan for Next Session"

VA Hearing (cont'd)

- "Staff Plans for the Next Session" introduced on revised Treatment Documentation form in July 2008
  - Auditors only denied claims for sessions prior to that date
  - Provider claimed there were other documents available to determine plan for next session
- Hearing Officer sided with Provider – other documentation existed and Provider was in "substantial compliance" – no "material breach" to justify denial of all payment for those patients because of lack of "column" on form

VA Hearing (cont'd)

- VA Medicaid had audited Provider in 2006 and noted lack of "Plan for Next Session" – demanded $800k but rescinded finding after additional materials were submitted for review.
- Hearing Officer found VA Medicaid was bound by that determination
- Failure to show on a form what was planned for next day is a "de minimis matter" and Provider substantially complied with its contract with Medicaid
- Rejected State's arguments on safety and welfare of patients – state never removed any residents – an"old canard"

BREAK

Federal Enforcement Agencies and Interplay with Medicaid Providers

- HHS Office of Inspector General
- U.S. Department of Justice

HHS Office of Inspector General

- All HHS Programs, including HHS grant funds
- Oversight over how federal HHS funds are spent on Medicaid programs
- Will audit state Medicaid programs
- Will also audit Medicaid providers
- Annual OIG Work Plan
- Compliance Guidance and CIAs (OCIG)
- Exclusion and civil penalties
  - Exclusion screening!

HHS OIG Audits and Inspections on Behavioral Health Providers

- Not a new focus area
  - Long focused on adult psychiatric facilities and PHP
- Starting in 2001, OIG began auditing States' FFP claims for children in IMDs
- "Review of Medicaid Claims for Beneficiaries under the Age of 21 Who Reside in Institutions for Mental Diseases in Virginia" – March 17, 2004 (IMD exclusion focus, 17 beds or more, inpatient psych)
  - Recommended disallowance for all such FFP claims except inpatient psychiatric claims
  - NY, VA and TX appealed and lost

OIG Audits (cont'd)

- "Review of Medicaid Residential Rehabilitation Services for Children in Maryland" – Aug. 24, 2011
  - Per diem payment rates
  - Documentation of daily services and specify services?
  - State disagrees with OIG interpretation

Review of OIG Reports

- States often trying to avoid refund of significant FFP dollars disagree with OIG's interpretation of state plan and documentation requirements
- Nonetheless, instruction to review because other auditors (MICs, RACs, etc.) are likely to take similar positions in absence of clear documentation standards in Medicaid manuals, state plans, etc.
- Minimum therapy requirements = minimum

U.S. Department of Justice

- Criminal and Civil Fraud Prosecutions
  - Civil fraud under False Claims Act – knew or should have known standard
- 94 United States Attorneys Offices
- "Main Justice" – Washington DC
- FBI
- Work with OIG and State AGs
-  coordination and data sharing

Anatomy of a Fraud Investigation

- Whistleblower (qui tam) investigation under False Claims Act
- Involvement of government investigators and Department of Justice attorneys
- Involvement of HHS OIG and/or State AG or state agency
- Billing but also poor quality of care investigations

False Claims Act Settlements

- Over 90% of cases, if DOJ takes over lawsuit, settlement follows
  - No admission of liability
  - Usually double "damages" to avoid litigation risk ($5,500 to $11,000 per false claim, treble damages)
- May result in Corporate Integrity Agreement with HHS-OIG or (increasingly) state AGs or IGs to avoid exclusion

2009 Settlement Involving Psychiatric Residential Treatment Facility

- Alleged False Claims Act violations involving Youth Family Centered Services, Inc./ Southwood Psychiatric Hospital (Pennsylvania)
- Allegations: Failure of care – insufficient levels and methods of staffing, inadequate staff training, deficient facilities, deficient safety procedures, and deficient medical/psychological treatment
- Involved whistleblower – psychiatrist/medical consultant who had worked for PA Medical Assistance – Program Integrity

2009 Settlement Involving Psychiatric Residential Treatment Facility (cont'd)

- Requirements under settlement agreement:
  - Reimburse Medicaid $150,000
  - Retain Independent Review Organization to evaluate quality of programs (3 years) and accuracy of billings (1 year)
  - Create Office of Corporate Compliance, Compliance Director and Deputy positions, Regional compliance committees in each region, Local Compliance Director at each facility
  - Commit to other systemic improvements beyond what is required by law

Other RTF Investigations

- Whistleblower action in Virginia – State and DOJ have brought suit under FCA
- Allegation of false treatment plans to make it seem that youth center was operating as RTF providing inpatient psychiatric care when actually just a juvenile detention facility with a physician prescribing meds
- Also allegations of insufficient treatment – short or non-existent group therapy sessions but documented as full sessions

Audit Readiness

- Prepare your organization for what may come
- Documentation self-audits
  - Is your documentation sufficient, clear, organized?
  - Does it exist?
  - Does it show minimum levels of care?
  - Train/educate on importance of adequate documentation
    - *Large "take backs" puts organization's mission at risk*
- Implement procedures to promptly respond to RAC requests for medical records

Post-Audit Considerations and Appeals

- If disagree with the RAC determination, file appeal before the 120-day deadline
- Keep track of denied claims and correct previous errors
- Determine corrective actions that need to be taken to ensure compliance with Medicaid and other regulatory requirements
- Avoid submitting incorrect claims

Audit Management Strategy and Preparation

- Consultant/Law Firm Assistance
  - AHA survey reports average of $91,000 in such costs
- Medicare RACs by Region:
  - Region A: Diversified Collection Services
  - Region B: CGI
  - Region C: Connolly, Inc.
  - Region D: HealthDataInsights
- June 18 CMS Program Update – Providers prevailed on 64% of RAC appeals

Prepare Your Organization and Board

- Invest in enhanced processes and controls on billing, documentation, credentialing, etc.
- Ensure clinicians, therapists are on board – sometimes fervor to provide treatment coupled with lackadaisical attitude on documentation is a bad combination
- Ensure the Board knows what's at stake
  - Lack of adequate compliance controls may turn mere overpayments into allegations of "false claims" that the organization "should have known" (knowingly) were being submitted. (Standard under FCA)

Compliance Program Essentials

- Seven federal "core elements"
- Importance for False Claims Act liability mitigation
- Importance for 60 day mandatory refund obligations
- “Going Bare” also raises risks for Board Members

Compliance Program Checkup

- PPACA – Mandatory Compliance Programs
- Weak Compliance Program = ↑ Risk

Mandatory Compliance Programs

- No established timeframe for regulations
- CMS/OIG joint initiative
- Focus on establishment of “core elements”
- Condition of enrollment, so will have teeth other than increased FCA exposure
- Wait for regulations or assess/develop current programs now?

State Medicaid Requirements

- DRA of 2005 required:
  - Five million dollar threshold
  - Establish written policies annually about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws
    - *Applies to all of the entity's employees (including management), and employees of contractors or agents*
  - Written policies (and the employee handbook) must also address policies and procedures for detecting and preventing fraud, waste and abuse, as well as the rights of whistleblowers

Mandatory Repayment of Medicare and Medicaid Overpayments

- § 6402(a) of PPACA (effective Mar. 23, 2010)
- For first time, disclosure and repayment is express legal requirement
- 60 days after "identifying" an overpayment
- Must include written explanation for overpayment
- Overpayment retained after 60 days is subject to False Claims Act liability
- Also CMP for knowing failure to report and permissive exclusion

Mandatory Repayment of Medicare, Medicaid and CHIP Overpayments (cont'd)

Significant uncertainty remains

- When is an overpayment considered "identified"
- When does the 60-day countdown begin
- Whose knowledge of overpayment binds the entity

TAKE AWAYS:

- Enforcement is increasing
- Pressure to control costs can impact internal control environments
- Assess your compliance controls – proactively

QUESTIONS?

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