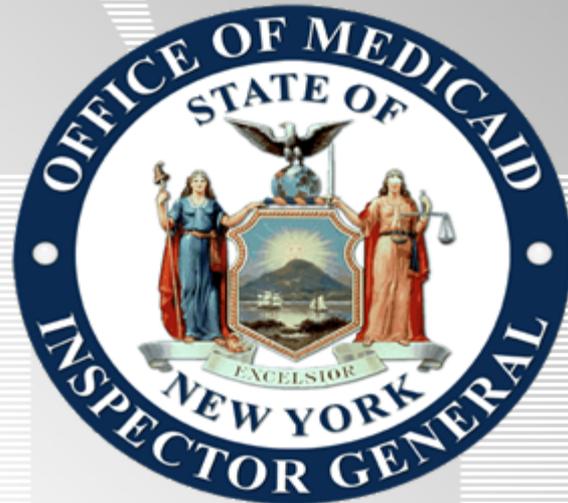


Mandatory Medicaid Compliance Programs

PRESENTED BY:

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- Personal opinions and ideas for collegial discussion
- Acknowledgement-ideas and some materials from many sources-errors my own
- My assumption-usually it's the “good guys” who attend these programs
- If you have a question (unless you are a lawyer) someone else probably wants to know the answer
- If you find these slides useful, please use them

- The majority of HC providers are honest
- Some providers have cut corners or looked the other way
- Criminals have infiltrated the HC system
- Not everything bad is FRAUD

- New York State's Medicaid program (annually):
 - Costs \$46 billion
 - Provides health care to over 4 million recipients through 60,000 active providers
 - Enrolls 10,000 new providers
 - Covers over 160 million eligibility verification and service authorization requests
 - Processes 350 million claims and payments.
 - Is the default state health insurance - increasing efforts to include uninsured

“Putting Patients First”

- Significant increase in health insurance coverage for children and working families
- **Person-centered**, not needs of institutions- money follows patients
- Care coordination, disease management
- **Accountability** and **reporting** for Medicaid funds received, including indigent care
- Major revision of rates and fees to reflect current medical practice

- Audit work/recoveries
- Enforcement of Conditions of Participation and Quality as basis for payment
- Criminal referrals
- Exclusion/penalty authority-individual, entity
- Integrity plans
- Mandatory compliance plans and Compliance Guidance

Illustration by David Harbaugh



"Administering the anesthesia this evening . . ."

Every provider of medical assistance program items and servicesshall adopt and implement an “*effective*” compliance program

- *Social Services Law § 363-d*

Compliance Regulations

- Published January 14th (draft), June 24th (adoption)
→ Effective July 1st → Enforcement October 1st !!!
- Requires:
 - those subject to Articles 28 and 36 of the Public Health Law;
 - those subject to Articles 16 and 31 of the Mental Hygiene Law; and
 - those that order services or supplies or receive reimbursement, directly or indirectly, or submit claims for at least \$500,000 in a year ...

to adopt/implement an “effective” compliance program.

- Annual certification

- MANDATORY COMPLIANCE PROGRAMS-here or coming
- New York Medicaid:18 NYCRR § 521. This rule is effective on July 1, 2009 and covered providers must have compliance programs in place satisfying the requirements of the rule by October 1, 2009.
- Federal contracting-December 2008 (\$5 million and up)
- HHS/OIG –testimony of OIG-considering mandatory compliance program-June 2009

- JUNE 19,2009 HOUSE HEALTH CARE DISCUSSION DRAFT-
 - 10 point mandatory compliance plan for certain health providers and suppliers-similar to New York regulation
 - Section 1641 of discussion draft-Medicare provider must return overpayment, provide statement in writing of reason for overpayment
- “Voluntary” industry codes become mandatory minimum standards-the case of pharmaceutical and device marketing-DC, CA

LEGISLATIVE EXPECTATION:

EFFECTIVE COMPLIANCE PROGRAMS WILL PREVENT AND DETECT FRAUD AND ABUSE

“ . . . to organize provider resources to resolve payment discrepancies and detect inaccurate billings, among other things, as quickly and efficiently as possible, and to impose systemic checks and balances to prevent future recurrences.”

Provider Compliance Programs - Elements

1. Written policies and procedures.
2. An employee vested with responsibility for day-to-day compliance program operation.
3. Training and education of all affected employees and persons.
4. Communication lines to the responsible compliance position.
5. Disciplinary policies to encourage good faith compliance program participation.
6. A system to routinely identify compliance risk areas.
7. A system for responding to compliance issues as they arise.
8. A policy of non-intimidation and non-retaliation for good faith compliance program participation.

Written Policies & Procedures

- Code of Conduct
- Minimum Standards
- Program Implementation
- Employee Guidance
- Investigative Process

Designation of Compliance Officer

- Must be an Employee
- Compliance Officer Responsibilities
- Appropriate Workload
- Reporting Relationships
- Board Interaction

Training & Education

- Who
 - Employee
 - Executives
 - Governance
 - Others

- How much

Open Lines of Communication

- Culture
- Anonymous Hotline
- Reports to Compliance Officer

Disciplinary Policies

- Active Participation
- Mandatory Reporting
- Consistent Enforcement at All Levels in Organization

Identification of Compliance Risk Areas

- Risk Assessments
- Audits
 - Internal
 - External
- Corrective Action

* Heightened expectation for most providers

Responding to Compliance Issues

- Prompt Investigation
- Proper Mandatory Reporting
- Self-Disclosures

Benefits

- Exemplify character of provider
- Demonstrate effectiveness of compliance program
- Possible:
 - Flexibility of provider review
 - Forgiveness of interest for a pre-determined period
 - Extended payback period
 - Avoidance of sanctions and/or operating under a CIA

Non-intimidation and Non-retaliation

- Protect Whistleblowers, Employees and Compliance Officer

It's **NOT** JUST about Recoveries

8 elements plus

- Credentialing
- Mandatory Reporting of Adverse Events
- Governance *
- Quality *

* Raises Compliance visibility/responsibility in both areas.

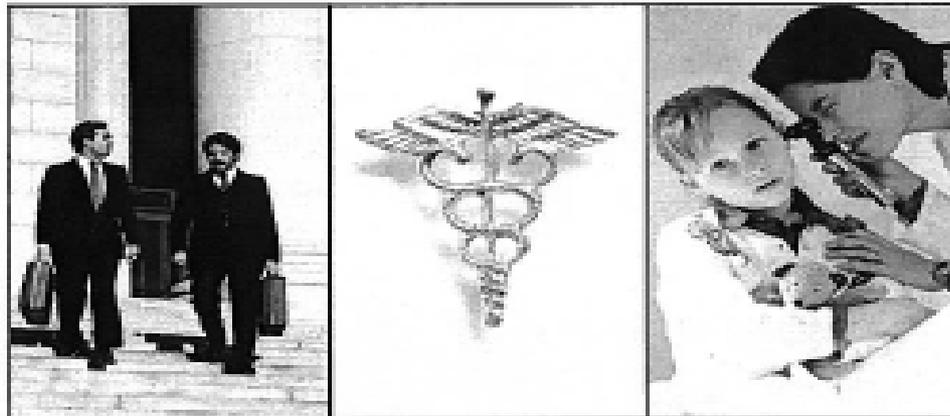
- Mandated as conditions of participation
- Reporting, electronic medical records, and data mining of large-scale databases are going to identify significant outliers on results
- Medicare/ Medicaid exclusion of payments for mistakes will identify participants in mistakes
- Payment for outcomes will identify poorer outcomes

Governance: The Board's Role

- Board = ultimate authority = ACTIVE
- Monitor / restore compliance
- Access to books and records
- Authority to appoint/discharge key management employees
- Board expertise-clinical, quality, fiscal
- Training and Oversight

CORPORATE RESPONSIBILITY AND CORPORATE COMPLIANCE:

*A Resource for Health Care
Boards of Directors*



**THE OFFICE OF INSPECTOR GENERAL OF THE
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

AND

THE AMERICAN HEALTH LAWYERS ASSOCIATION

Corporate Responsibility and Health Care Quality:

A Resource for Health Care Boards of Directors



United States Department of Health and Human Services
Office of Inspector General

American Health Lawyers Association

- ✓ 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 medical 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”)?

Quality and Enforcement

- Has there been a systematic failure by management and the board to address quality issues?
- Has the organization made false reports about quality, or failed to make mandated reports?
- Has the organization profited from ignoring poor quality, or ignoring providers of poor quality?
- Have patients been harmed by poor quality or been given false information?

What are the outcomes we are looking for?

- Senior level commitment on quality, discussion and best practices adoption
- Support for internal quality and reporting efforts
- Accurate information to patients, payors, regulators
- BETTER QUALITY AND PATIENT OUTCOMES
- Program Integrity - getting what we are paying for

What is the Compliance Officer's Role?

- Dialogue with the quality resources within the organization
- Sitting as a member on quality committee (perhaps as a “receiver” of information)
- Monitoring compliance with required mandatory reporting, credentialing, monitoring and auditing internal data (confirming that any adverse events are properly reported and addressed)

- THE PROGRAM MEETS THE STATUTE
 - STRUCTURE
 - Mandatory 8 Elements
- THE PROGRAM WORKS
 - PROCESS-
 - Hot line calls
 - Investigations
 - OUTCOMES
 - Repayments
 - Disclosures
 - Quality issues addressed
 - Performance measures met

- 4Rs OF PREVENTING FRAUD AND ABUSE

- REQUIRE, RECOMMEND, REVIEW, REWARD
EFFECTIVE PROVIDER COMPLIANCE PROGRAMS
- NY-mandatory “effective” compliance programs
- “effective” compliance program requires disclosure to state of overpayments received, when identified
- “effective” compliance program requires risk assessment, audit and data analysis, remedial measures
- “effective” compliance program requires response to issues raised through hotlines, employee issues

Tips to Enhance Compliance Efforts

- Establish culture / tone at the top
- Well-connected compliance officer with access to the “right” meetings and information
- “Active” monitoring & auditing efforts built into department operations
- Conduct employee surveys & exit interviews
- Address issues and track information
 - inquiries/complaints/repayments

www.omig.state.ny.us

- Model compliance programs-hospitals, managed care (coming soon)
- Over 100 provider audit reports, detailing findings in specific industry
- 70 page work plan issued 4/24/09
- Listserv
- New York excluded provider list
- Self-Disclosure protocol

It takes less time to

do a thing right

than it does to **explain why**

you did it wrong

- *Henry Wadsworth Longfellow*