Unique Issues in Medicaid False Claims Act Litigation, Audits and Investigations

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Are Providers' Medicaid Payments Subject to Disallowance if:

- Such payment was not consistent with *federal* Medicaid requirements?
- Such payment was not consistent with *Medicare* requirements?
- Provider failed to comply with conditions of participation or program requirements?

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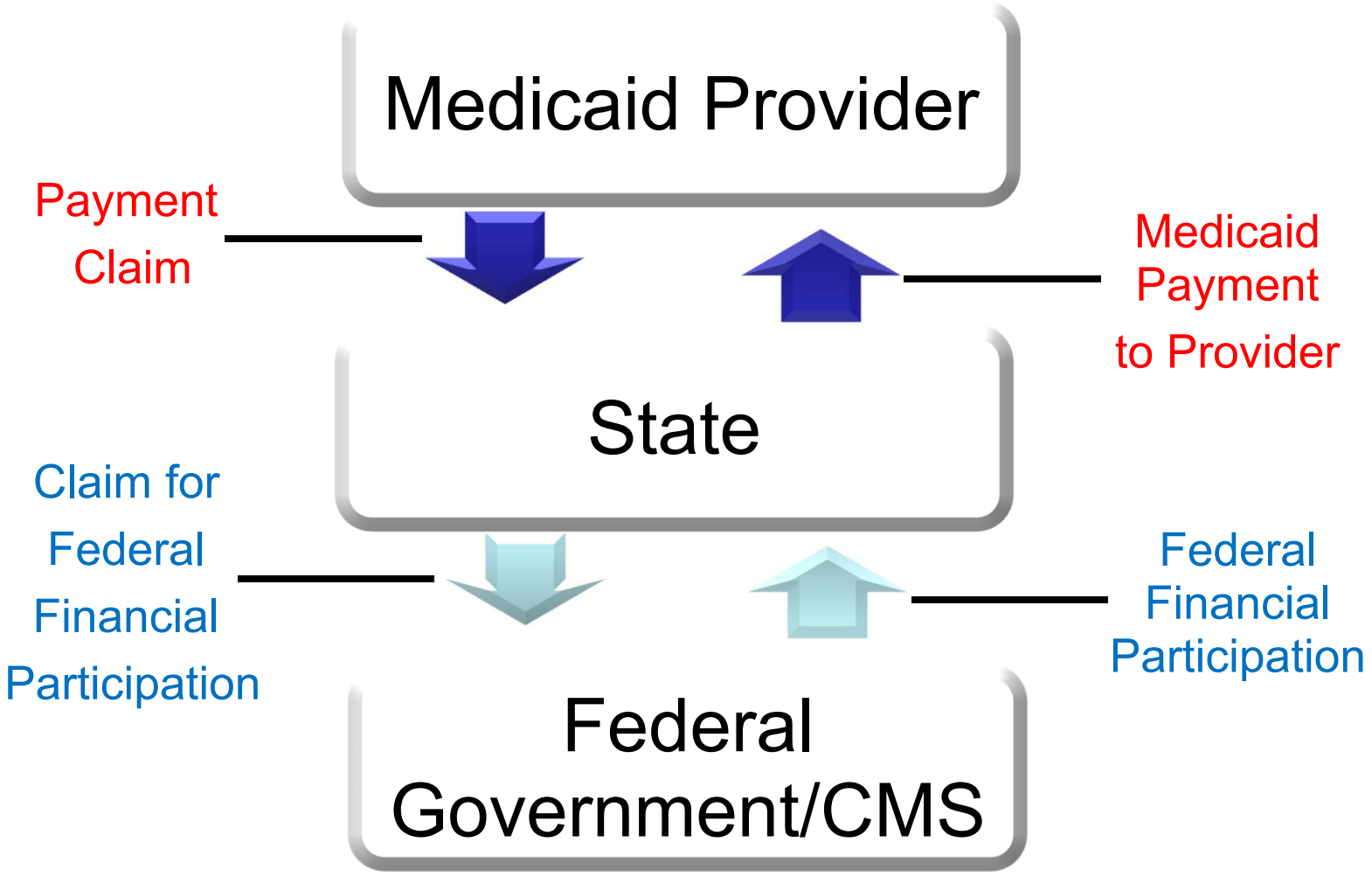
ARE PROVIDERS' MEDICAID PAYMENTS REQUIRED TO BE *DISALLOWED* IF NOT CONSISTENT WITH FEDERAL MEDICAID REQUIREMENTS?

Medicaid


Medicaid Provider
Payment
Claim
Medicaid
Payment
to Provider
State
Claim for
Federal
Financial
Participation
Federal
Financial
Participation
Federal
Government/CMS

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The Federal Medicaid Statute:

42 U.S.C. §§ 1396a(a):

"A **state plan** for medical assistance must –"

(1)

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.

.

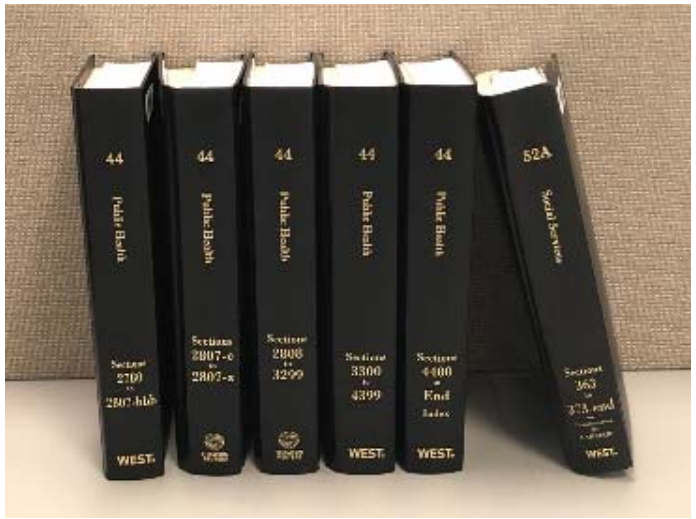
(83).

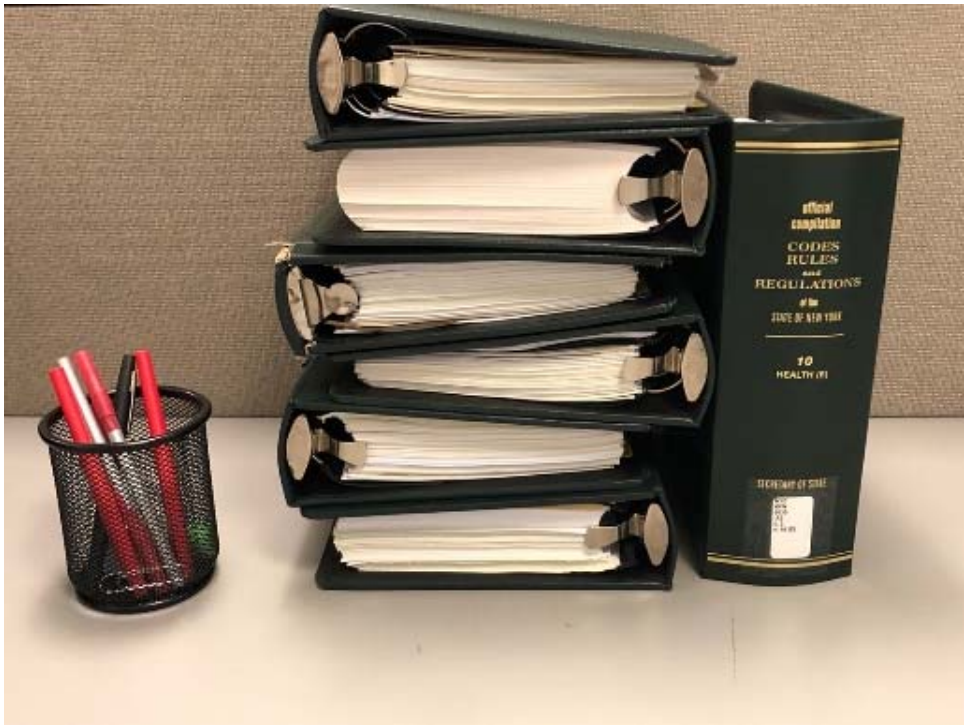
N.Y. Public Health Law,

N.Y. Social Services Law,

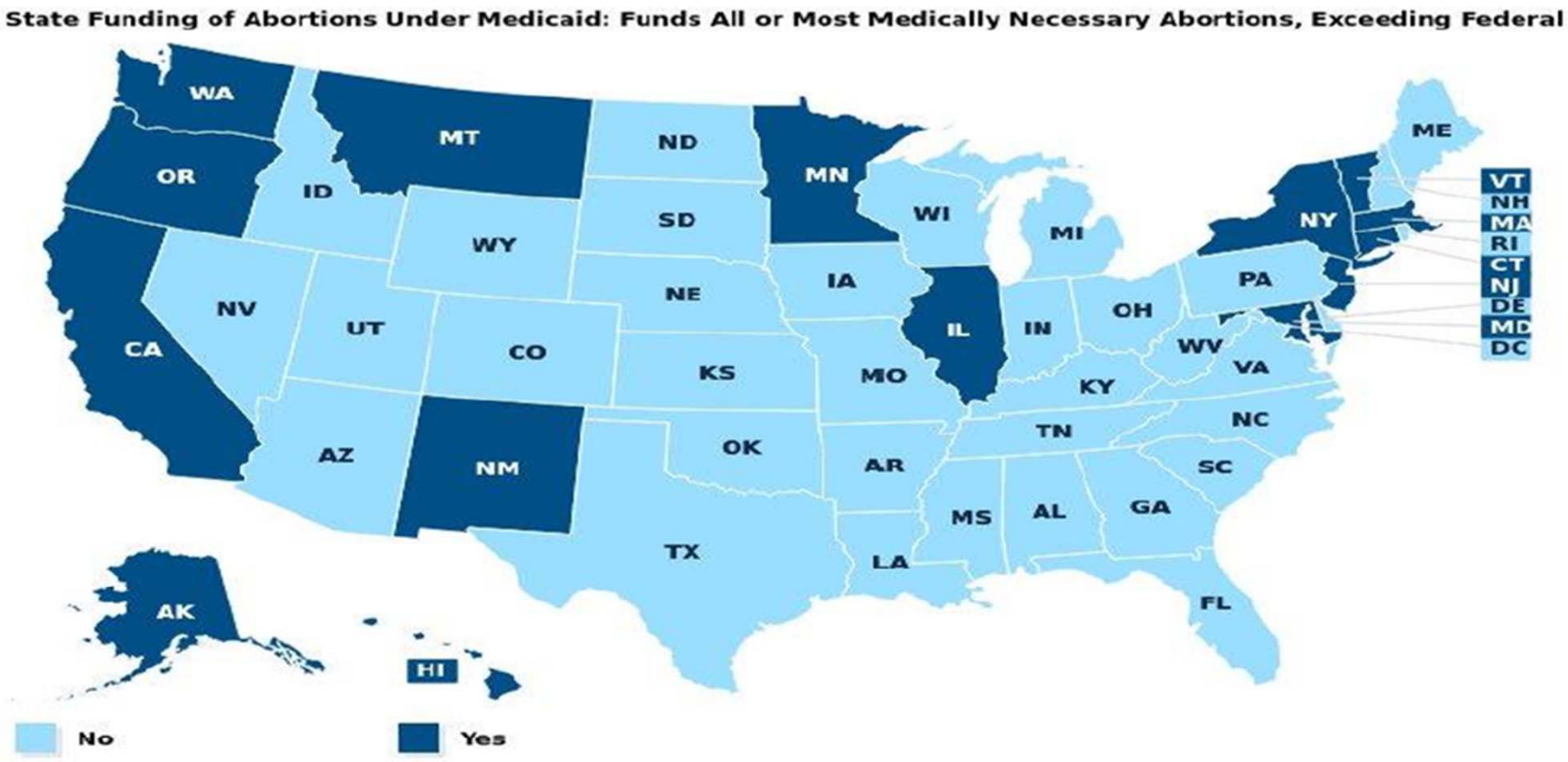
Several thousand pages of administrative agency regulations (Titles 10 and 18 of N.Y.C.R.R.),

Non-regulatory guidance, Monthly Updates, FAQs, etc.





States Sometimes Say They Will Pay Providers Even If FFP Not Available



SOURCE: Kaiser Family Foundation's State Health Facts.

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As one federal district court stated: "States must follow federal Medicaid Law, while [providers] must follow State Medicaid law."

- In *United States ex rel. Doe v. The Taconic Hills Central School District*, et al., 8 F. Supp.3d 339 (S.D.N.Y. 2014), the court held that:
  - Medicaid providers could not be found to have violated the federal False Claims Act when they followed **State guidance**.
  - **Even if** that State guidance may have been inconsistent with federal Medicaid law.

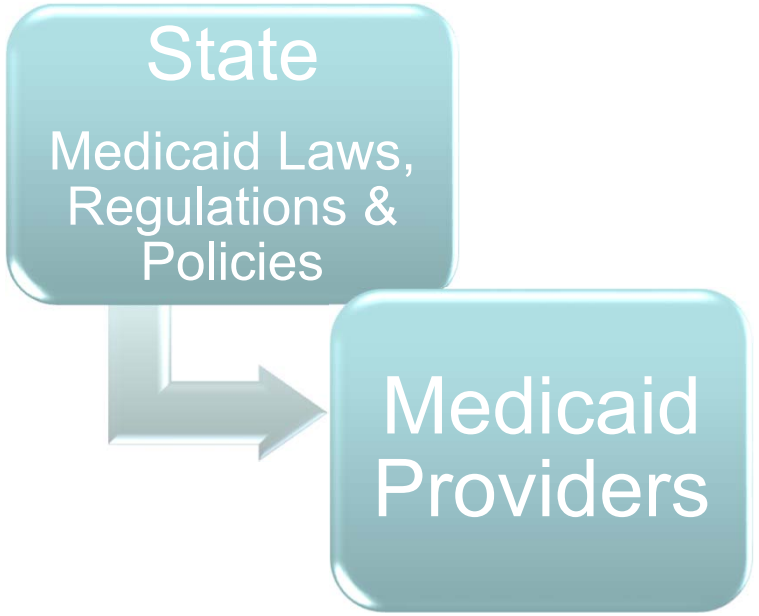
DOJ had commented:

"Compliance with State guidelines does not, in and of itself, preclude a cause of action under the False Claims Act. Such compliance may, however, bear on the *scienter* element of a False Claims Act claim. To establish a violation of the False Claims Act, a relator must establish that the defendant acted 'knowingly'" in presenting or causing the false claim. . . .

If the [providers] complied with State claiming guidelines, "whether the Relators can maintain a cause of action under the False Claims Act would depend on, *e.g.*, *whether such guidelines were consistent with federal requirements* ***and*** *whether the school districts 'knowingly' presented … a claim rendered false by those federal requirements*. Whether a defendant had the requisite *scienter* would depend on the facts and circumstances of the case."

Providers argued,

"The Federal Medicaid Act specifies, in exacting detail, the requirements that States must meet to qualify for Federal funding. See, *e.g.*, … 42 U.S.C. §1396a(a) …. The obligations imposed upon health care **providers**, on the other hand, are mandated by State law. . . ."



Providers argued,
[cont'd]

New York State law explicitly requires Medicaid providers

"to submit claims … in the manner specified by [DOH] in conformance with the standards and procedures for claims submission' and 'comply with the rules, regulations and official directives of [DOH]."

18 N.Y.C.R.R. §§ 504.3(f) & (i)

"Claims for payment [by schools] under this section shall be made in such form and manner, at such times, and for such periods as [DOH] may require."

N.Y. Soc. Serv. Law § 368-d

Providers argued, [cont'd]

"No State's Medicaid providers should be placed between Scylla and Charybdis, requiring them to choose between violating State law directly applicable to them or failing to comply … with Federal requirements that are directly applicable to the State, not to Medicaid providers."

The Court *dismissed* the Complaint:

"States must follow federal Medicaid law, while [providers] must follow state Medicaid law."

Taconic Hills, 8 F. Supp. 3d at 347.

"The appropriate remedy here would be for the Federal government to withhold Medicaid funding from New York State. ...

But it is not appropriate to hold [a provider] liable for submitting a 'false claim' when it complied with all applicable regulations and **therefore did absolutely nothing wrong**."

Taconic Hills, 8 F. Supp. 3d at 347.

ARE PROVIDERS' MEDICAID PAYMENTS REQUIRED TO BE *DISALLOWED* IF PROVIDER FAILED TO COMPLY WITH A CONDITION OF PARTICIPATION OR PROGRAM REQUIREMENT?

Conditions of Participation/ Program Requirements

are not necessarily

Conditions of Payment

conditions of payment =

violations might result in disallowance of Medicaid payment.

program requirements or
conditions of participation =

violations might result in (at worst) the issuance of a plan of correction or other enforcement action

How do we know that failure to comply with program requirements / conditions of participation may not result in disallowance?

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DOH has said so!

- HHS OIG audited State's payments to Continuing Day Treatment (CDT) providers, and wanted to disallow FFP for provider claims that hadn't complied with Title 14 OMH program regulations.
- DOH argued: "It is only when a provider of service does not meet the State's *reimbursement* rules and regulations [in *Title 18*] that OMH would make a referral to [DOH] for the *recovery of an overpayment*."

OIG Audit #A-02-09-01023 http://oig.hhs.gov/oas/reports/region2/20901023 .pdf (n. 2, App. D, p. 3, emph. added.)

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DOH explained that the purpose of program regulations is:

"to require programs, *generally*, to operate in accordance with the [State agency] standards … for how the entire program is operated. . . .

These standards are not intended to be applied as indispensable requirements for each specific individual claim."

http://www.hhs.gov/dab/decisions/dabdecisions/2015/dab2637.pdf (quoting DOH)

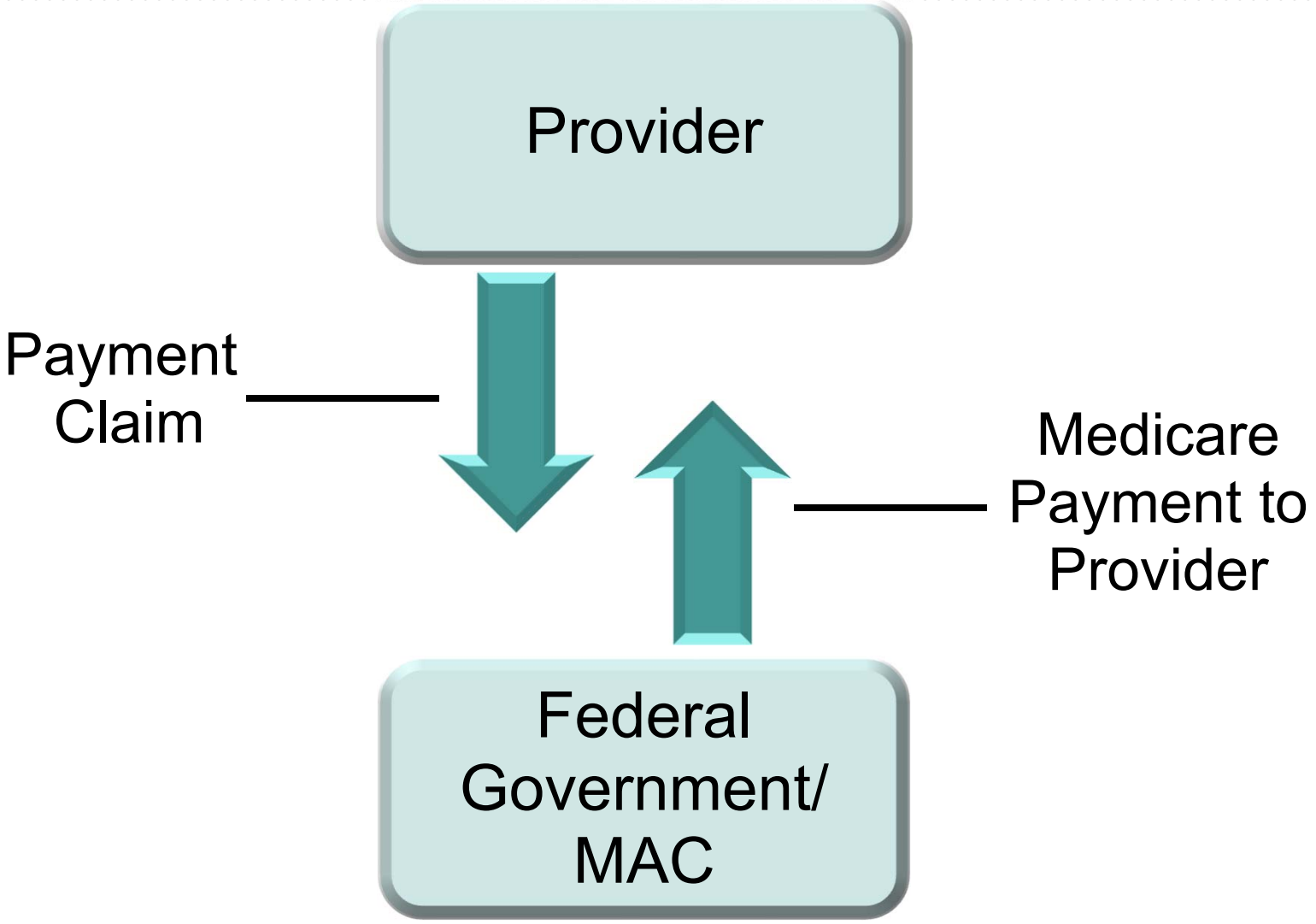
Nevertheless, OMIG Sometimes Applies Program Requirements to Medicaid Payments

OMIG's Audit Protocol – OMH Continuing Day Treatment Services

- Cites to Title 14 OMH regulations and 18 N.Y.C.R.R. § 505.25(d) as authority for payment disallowances.
- But, DOH had told OIG that these regulations were program standards and not payment conditions.

ARE PROVIDERS' MEDICAID PAYMENTS REQUIRED TO BE *DISALLOWED* IF NOT CONSISTENT WITH MEDICARE REQUIREMENTS?

Medicare


Provider
Payment Claim
Medicare Payment to Provider
Federal Government/ MAC

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If Silent, Apply Medicare Requirements? One Instance Specified In State Law…

10 NYCRR Part 86
("Reporting and Rate Certifications for Facilities")
. . .

Section 86-1.6. Allowable costs

(a) To be considered as allowable in determining **reimbursement rates**, costs must be properly chargeable to necessary patient care. Except as otherwise provided in this Part, or in accordance with specific determination by the commissioner, allowable **costs** shall be determined by the **application of** the principles of reimbursement developed for determining payments under the **title XVIII (Medicare) program**. . . .

Example of Medicare Requirements Potentially Being Applied to Medicaid Payments

OMIG Audit Protocol for Long Term Home Health Care Programs:

- Applies Medi*care* regulation to disallow Medicaid claims where practitioner signatures not obtained timely.
- Applicable State Medicaid regulation, 18 N.Y.C.R.R. § 505.21, does not incorporate the Medicare regulation into State regulation.
- Consider challenging application of Medicare regulation to Medicaid?

DEVELOPMENTS / UNIQUE ISSUES UNDER MEDICAID MANAGED CARE

Is enough being done to prevent Medicaid managed care ("MMC") program risks, and to recover overpayments?

GAO & OIG: No.

Administrative agencies are confronting weaknesses in the oversight of MMC program risks related to providers.

Recent Focus on Medicaid Managed Care Program Integrity – Federal

- **CMS** amended regulations to, in part, address "fraud committed by Medicaid managed care plans and fraud by network providers" (81 Fed. Reg. 27600 (May 6, 2016)) and recoupment of overpayments received by MMC providers.
  - 42 C.F.R. Part 438.
- **HHS OIG** found, in part, that Medicaid MCOs must do a better job to identify fraud and abuse by MMC providers using proactive data analysis, inform state agencies of such fraud and abuse, and identify and recover overpayments from MMC providers.
  - *See* HHS OIG, OIE-02-15-00260, *Weaknesses Exist in Medicaid Managed Care Organizations' Efforts to Identify and Address Fraud and Abuse* (July 2018).
- **GAO** identified high levels of risk with respect to "incorrect MCO fee-for-service payments to providers" and gaps and challenges with respect to effective MMC program integrity oversight by federal and state agencies.
  - *See*, e.g., GAO, GAO-18-528, *Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks*, pp. 10, 13 (July 2018).

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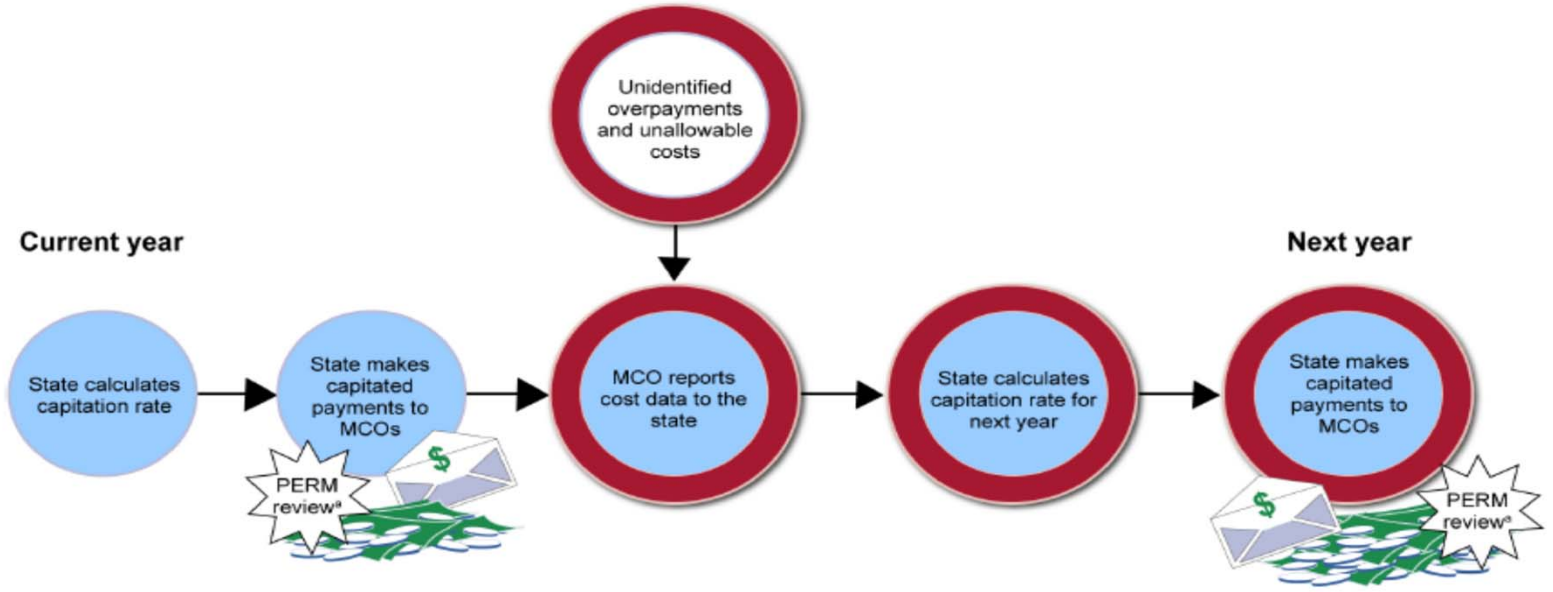
Recent Focus on Medicaid Managed Care Program Integrity – State

- **OMIG** is seeking to adapt FFS audit protocols for MMC providers, recoup inappropriate funds received by MMC providers, validate MCOs' encounter data and confirm that MMC provider records are in regulatory and contractual compliance.
  - *See* SFY 16-17 & 18-19 Work Plans (Network Provider Review Project Team)
- **DOH** is pursuing more state involvement in auditing and investigating MMC providers, and recovering overpayments, penalties, and other damages from MMC providers.
  - *See, e.g.*, October 2015 amendments to DOH Medicaid Managed Care Model Contract (§ § 18.5(a)(vii)(B), 19.9(a) and 22.5(a)(v))
- **Medicaid MCOs** are financially incentivized to refer MMC provider fraud and abuse cases to MFCU, conduct joint audits with OMIG, and collect overpayments from MMC providers on behalf of state agencies.
  - *See, e.g.*, October 2015 amendments to DOH Medicaid Managed Care Model Contract (§§ 22.7(b) & (c) and 23.5)

Why the Focus on Payments to MMC Providers?

Overpayment from MCO to Providers in Current Year
--> Overpayment from State to MCO in Later Year

Figure 1: Effect of Unidentified Overpayments and Unallowable Managed Care Organization Costs on Future Years' Capitation Rates



Source: GAO. | GAO-18-291

[a]The Payment Error Rate Measurement (PERM) reviews the capitated payments states make to managed care organizations (MCO).

DO THE FEDERAL AND STATE OVERPAYMENT LAWS APPLY TO MANAGED CARE PROVIDERS?

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Brief Review of Federal & State Law: Reporting and Returning Overpayments

Federal:

- *SSA § 1128J(d)*: Funds received **under title XIX** to which a person (e.g., **a "provider of services"**) is not entitled, after applicable reconciliation, must be returned.
- *42 C.F.R. § 438.608(d)*: MCOs required to adopt a mechanism for network providers to report and return overpayments to the MCO within 60 calendar days of identification.

State:

- Providers must refund overpayments as part of a comprehensive compliance program. NY SSL § 363-d(2)(g) / 18 N.Y.C.R.R. § 521.3(c)(7).
  - Compliance Programs must address MMC program risks:
  - Effective compliance program required by hospitals that submit claims for "medical assistance" care, services or supplies. 18 N.Y.C.R.R. § 521.1.
  - Medicaid managed care beneficiaries receive "medical assistance" services. NY SSL § 364-j(1)(c).

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Potential Liability For Failure to Return Overpayments

Federal law:

- Federal False Claims Act, 31 U.S.C. § 3729(a)(1)(G): Civil penalties ($5,000 - $10,000) and treble damages
- Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a(10): Civil money penalty of not more than $20,000 + assessment of 3 x amount claimed for each item or service

State law:

- 18 N.Y.C.R.R. Part 515: Sanctions for accepting moneys "in addition to amount . . . payable under the program" (§ 515.2(b)(8)), include repayment of overpayments, censure, exclusion from, or conditional or limited participation in, the Medicaid program (§ 515.3(a) & (b)).
- NY False Claims Act (NY Fin. Law §§ 187, et seq.): Liability for knowingly avoiding the return of an overpayment to the state or a local government include civil penalties (between $6,000 - $12,000), consequential and treble damages.

Participating Provider Agreement:

- Failure to return an overpayment may result in a termination of the Participating Provider Agreement. DOH Medicaid Managed Care Model Contract, § 22.5(a)(viii).

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Unique Issues in Determining Whether an MCO Overpayment Has Been Received

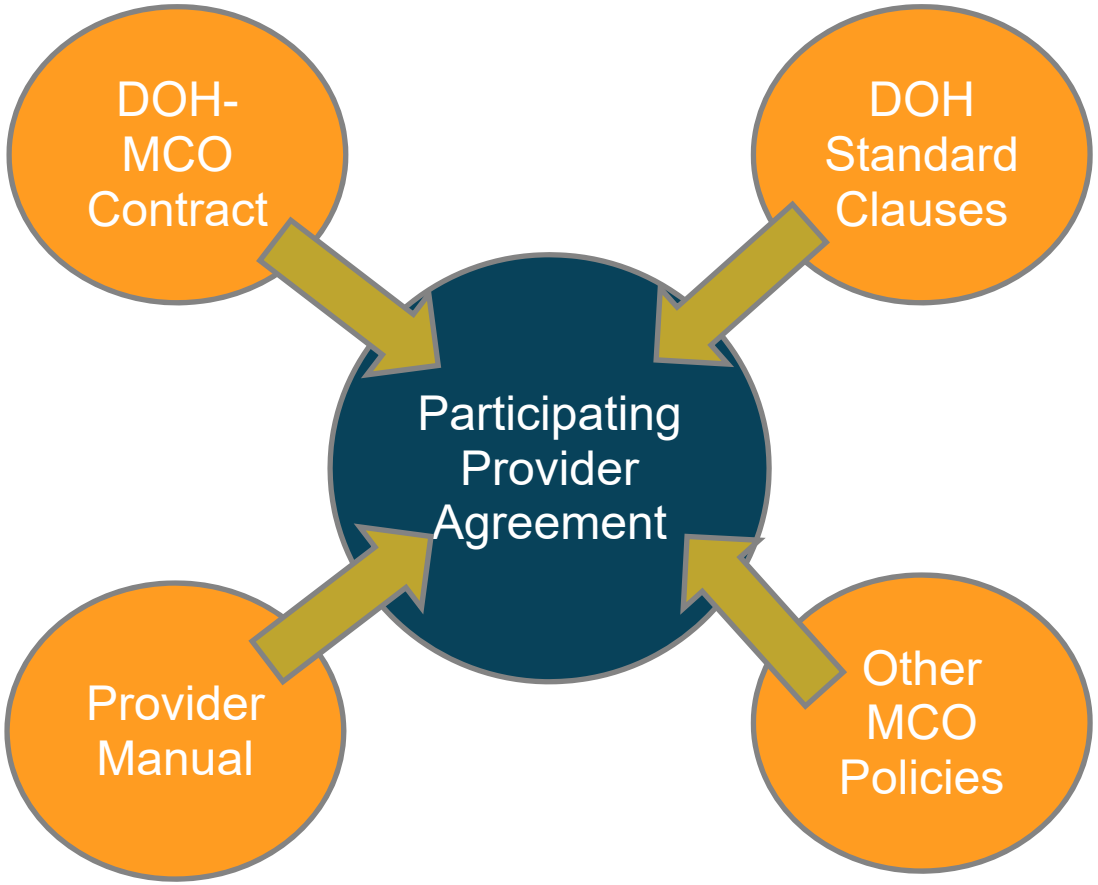
Statutes, and DOH rules & regulations related to rates, fees and claiming instructions:

Do not apply to MMC Providers!
(Model Contract, § 22.5)

For rates, fees and claiming instructions, instead see **Participating Provider Agreement**.

Unique Issues in Determining Whether an MCO Overpayment Has Been Received [cont'd]

Check ALL relevant components of the Participating Provider Agreement.



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What Is the Overpayment Look-Back Period for MMC Providers?

No lookback period in SSA § 1128J(d).

No lookback period in 42 C.F.R. § 438.608.

No lookback period in NY SSL § 363-d(2)(g) or 18 N.Y.C.R.R. § 521.3(c)(7).

However, . . .

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. . . Overpayment Look-Back Period [cont'd]

NY Ins. Law § 3224-b(b)(3):

- MCO-initiated recovery of overpayments limited to a maximum of 24 months, except in cases where "(i) based on a reasonable belief of fraud or other intentional misconduct, or abusive billing, ... or **(iii)** required or authorized by a state or federal government program."

Model Contract (§ 22.7)/ DOH Standard Clauses (§ C.8):

- Specifies a 6-year look-back for MCO-initiated recovery of overpayments per the exception under NY Ins. Law § 3224-b(b)(3)(iii).

  No time limit in cases involving fraud.

NYS Medicaid Update, vol. 26, no. 3 (February 2010):

- "All self-disclosures have an audit period limitation of six years from the date of reporting the disclosure (usually [the] date of the disclosure letter submission). Claims older than six years are not subject to self-disclosure or OMIG audit and therefore not reportable."

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