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MEDICAID COMPLIANCE NEWS
Timely News and Practical Strategies for Hospitals, Health Systems and Other Providers

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PERM Rates for '08 States Fall From '07; CMS to Begin Extrapolation Method in 2010

The combined Medicaid error rate for the states measured in fiscal year 2008 by the Payment Error Rate Measurement (PERM) program was 8.7%, and the states measured in FY 2007 had a combined 10.5% rate, HHS Sec. Kathleen Sebelius told Sen. John Cornyn (R-Texas) in a Feb. 25 letter. But rates in some states hover around 20%, and providers in those states should be wary of federal and state auditors when they send requests for information, especially as PERM moves to an extrapolation methodology that could cost providers a lot of money, an industry expert says.

Cornyn asked for the data in a Feb. 18 letter to Sebelius. "I believe you have a responsibility to the American people to provide a detailed justification of the improper payment rates in the Medicaid program. Taxpayers deserve to know if their dollars are being invested in patient care for the Medicaid population or how their dollars are being wasted through inefficient bureaucracies," he says. "Taxpayers deserve to know which states are managing their programs effectively and which ones are not," he adds.

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Some Medicaid Providers, Vendors See State False Claims Acts as Unnecessary

If some hospital associations and pharmaceutical companies get their way, no more states will pass false claims acts (FCAs) that include *qui tam* (i.e., whistleblower) provisions. According to one health care attorney, these laws have the "right goal" but are using the "wrong weapon [and] the risk that it is going to go wrong is not a risk worth taking to protect Medicaid."

There now are 23 states, plus the District of Columbia, with false claims acts (FCAs) that include *qui tam* provisions. Of these 23, 14 meet the requirements of the Deficit Reduction Act. Under Section 6031 of the DRA, states that enact FCAs modeled on the federal FCA will receive an increased percentage — 10% — of any recovery from a state Medicaid judgment or settlement arising out of the FCA or state law.

To be eligible for the extra 10%, a state's FCA must: (1) establish liability that would be applied to the state Medicaid program based on false or fraudulent Medicaid claims, as described in the federal FCA; (2) contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions as those in the federal FCA; (3) provide for filing an action under seal for 60 days with review by the state attorney general; and (4) impose a civil penalty in an amount equal to or greater than the amount authorized by the federal FCA.

The Iowa Hospital Association last month came out against its state's attempt to pass a false claims act that would mirror the federal law, calling it "damaging to hospitals" and "unnecessary." The association claimed the bill "purports to save the state money, when in reality the bill doesn't take into account the increased cost associated with this type of policy change."

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State FCAs Are Seen as Expensive

According to attorney Jonathan Diesenhaus, the concern among hospital associations is that this is just "another variety of private litigation that purports to be about fraud, but is contingency fee driven." Diesenhaus, who is with the Hogan & Hartson law firm, says suits brought under state FCAs are "very expensive" and are "brought by someone who is not a victim."

The question, he tells *MCN,* is "whether states should have redundant *qui tam* actions." Now, citizens can bring actions under the federal FCA. And people can continue litigation even if the federal government or the state drops out of the suit. There is a concern, says Diesenhaus, that there is "too great a risk for abuse of this kind of lawsuit by splitting up the federal and state cases…by hitting a hospital, the majority of which are not-for-profits."

The federal and state governments "can't sue the criminals that are really committing fraud," so they "have to go against the brick and mortar defendant" — pharmaceutical manufacturers and hospitals, he maintains. For pharma, it "doesn't make a tremendous difference," he says, since that industry is already on the hook. But for nonprofit hospitals, these are "very specialized and expensive [lawsuits] to defend and very expensive to settle," he asserts. Under the federal law, a defendant that settles must pay attorney fees for the whistleblower.

Not only do these state laws create opportunity for abuse, they increase the amount of money states must spend to litigate *qui tam* actions. Diesenhaus says the 10% incentive was sold as a "revenue source for the Medicaid program," but in reality states recover less or the same amount after the payment to the whistleblower. The average FCA reward is 20%, he explains. If there is both a federal and a state FCA, the whistleblower doubles his or her recovery, but the state gains only 0.5%. This "won't cover the cost of having to litigate these cases," contends Diesenhaus.

Should States Take Out the *Qui Tam*?

Hospital associations and pharmaceutical companies are "not opposed to enforcement," he says. But there are existing laws already doing a good job catching bad behavior. The cost of implementing the *qui tam* statutes is not worth the risk of abuse, according to Diesenhaus. He suggests that states look to Kansas and Oregon, which have passed FCAs that do not include *qui tam* provisions.

The Maryland Hospital Association also opposes its state's efforts to pass an FCA. One of its legislative priorities for 2010 is to "enact a reasonable False Claims Act statute…to prevent the submission of false claims by health providers…[by using] enhanced tools to prosecute fraud and abuse in the health care system, but eliminate/restrict the *qui tam* (private right of action) provision." The association supports a law requiring proof of intent to submit a false claim, capping the maximum amount of fines imposed and depositing recovered funds into a general fund.

Thomas Russell, the inspector general for the Maryland Department of Health and Mental Hygiene, tells *MCN* that there is only a "small amount of providers (3% to 5% at best)" opposing the proposed legislation. "But they wreak a huge amount of havoc on the state Medicaid program."

The proposed FCA (HB 525) "raises the profile of health care fraud and gives the attorney general and the department of health the best tool in health care fraud to combat a problem causing the Medicaid program to hemorrhage," he contends. The legislation has been passed in the state Senate and is scheduled to be taken up in the House March 10, he says.

Contact Diesenhaus at jldiesenhaus@hhlaw.com and Russell at (410) 767-5862. ✧

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N.M. Health Agency's Practices Said To Hinder State's MFCU Initiatives

CMS is conducting an inquiry into claims that the New Mexico health department's process for referring Medicaid fraud cases is hindering the state Medicaid fraud control unit's efforts to prosecute them, a CMS spokesperson tells *MCN.*

The MFCU, which New Mexico calls the Medicaid Fraud and Elder Abuse Division, is not getting the information and collaboration it needs from staff members in the New Mexico Human Services Department (HSD), the unit says in its June 2009 annual report to OIG. CMS was aware of problems at HSD because it addressed some allegations in a March 2009 program-integrity review, says CMS spokesperson Mary Kahn. CMS became aware last month that some of the problems still exist, she adds.

MFCUs send yearly reports and recertification questionnaires to OIG. In New Mexico's June 2009 report, the MFCU describes its relationship with the HSD as "cordial" and "largely helpful" when there is mutual need. But "it appears that the [HSD] inappropriately filters the information they provide to the division. It appears that both the [HSD] and the New Mexico Department of Health, which has oversight of certain Medicaid programs and is a Medicaid provider, review and, on occasion, redirect the division's data or document requests, instead of allowing a free flow of information as anticipated by Medicaid regulations and the Memorandum of Understanding between the [HSD] and the division," the MFCU's report says.

The MFCU's staff "has reported instances where this sterilization has inhibited our ability to access and prosecute both fraud and abuse claims. For example, the [HSD] has refused our access to records related to the criteria and approvals HSD has implemented/granted for 'approved assistance with medication training programs'.…There are many more examples of this type of interference in the division's requests for information," it says.

Memorandum of Understanding Is Old

The MFCU acknowledges in the report that its Memorandum of Understanding with the HSD is more than five years old and was in the process of being renewed at the time. The new agreement would cover the MFCU's ability to make recommendations to HSD and for staff members to participate in cross-training programs, the report said.

"The [state Medicaid agency] is required under 42 CFR 455.21 to provide any information requested by the MFCU that relates to the MFCU's investigative and prosecutorial responsibilities," CMS's Kahn tells *MCN.* "However, there is no specific regulatory sanction for [a state agency's] alleged violation of this regulation," she notes. "We plan on conducting an inquiry into this situation with the [state agency]."

HSD spokesperson Betina Gonzales McCracken says the state and MFCU are resolving the issues together. "We are working closely with the attorney general's office right now to clear up any confusion or problems that may exist," she tells *MCN.* "We have had several meetings now, and we think we are going in the right direction, and we think we are doing everything that we should be doing."

CMS Found Other Issues at HSD

In its program-integrity review, CMS listed vulnerabilities in the New Mexico HSD's practices. "Although the number of referrals to the MFCU has increased over the past three years, the state's process for determining when to refer a case limits the ability of the MFCU to prosecute fraud cases," it says. The determination to pass a case on to the MFCU is based on (1) the conclusion of the preliminary investigation, (2) the degree to which it violates policy or law, (3) the merits of the case, and (4) a determination of the intent of the party, according to the report.

"Steps 2 through 4 of the above process limit the MFCU's authority to determine the prosecutorial merits of all suspected cases of fraud," CMS says. "While it is true that the definition of 'suspected' fraud is vague, the [state's Quality Assurance Bureau] should not make decisions which are under the purview of the MFCU, such as intent. The MFCU needs to determine if it can prove intent."

HSD and the MFCU should revise the process for referring potential fraud cases, CMS recommends. They need to outline the preliminary investigation process, referral process, and the roles and responsibilities of each party to determine and investigate fraud and abuse, the review says.

At the time of CMS's review, New Mexico Medicaid had more than 400,000 beneficiaries, and about 61% of them were served by managed care entities (MCEs). The MCEs are obligated to report suspected cases of fraud in their quarterly updates to the state. "The MIG review team chose five cases from the quarterly reports that had an allegation code corresponding to fraudulent activity (e.g., services billed but not rendered.) When these cases were checked against the QAB database, none were currently being tracked," the CMS review found. "These discrepancies called into question whether the state was being informed by the MCEs, as contractually required, of all cases of suspected fraud and abuse and was, therefore, able

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to make an informed referral to the MFCU regarding MCE cases."

HSD should strengthen its policies and procedures on MCE program-integrity effort oversight to ensure that all cases are being reported, CMS recommends.

In addition, CMS identified four areas in which the state was not in compliance with federal regulations:

◆ Forms for MCE credentialing did not request ownership and control disclosures, and fee-for-service (FFS) provider enrollment forms don't request disclosure of any parent;

◆ FFS provider enrollment packages and MCE contracts and applications did not require disclosure of business transactions;

◆ MCE credentialing applications and contracts didn't capture criminal conviction information; and

◆ The state did not report the adverse actions it took on MCE provider applications, and MCEs did not always inform the state of adverse actions in MCE provider credentialing.

Despite these vulnerabilities, CMS notes in the review that New Mexico has several effective practices for Medicaid program integrity, including data-mining capability, productive monthly meetings with MFCU staff and background checks on providers.

CMS required that HSD complete a corrective action report to address the areas of noncompliance and vulnerabilities. The report was to address (1) how the state would ensure that the deficiencies would not recur, (2) the time frames for each correction, (3) an explanation if correcting any of the regulatory compliance issues or vulnerabilities would have taken more than 90 days, and (4) any actions already taken to correct compliance deficiencies or vulnerabilities.

According to the corrective action plan, obtained through a Freedom of Information Act request from *MCN,* the state changed contract language with MCEs so that it would be in compliance with federal regulations and forwarded language changes in the Memorandum of Understanding to the MFCU. Also, by April 30, HSD started collaborating with MCEs on reporting suspected provider fraud and revised its policies based on CMS's best practices for Medicaid program-integrity units and state agencies.

CMS Says Communication Is Key

In 2008, CMS released performance standards and best practices for state agencies to follow when referring suspected fraud cases to MFCUs. CMS suggests that state agencies:

◆ ***Meet regularly with the MFCU.*** "Regular meetings between the two entities promote the high level of communication that is integral to the success of both," CMS says. "Perhaps even more importantly, the level of communication established by this close coordination of efforts through regular meetings facilitates the identification of new fraud trends, increases accountability, and generally improves the productivity of the two agencies."

◆ ***Develop and consistently apply one standard for deciding when to refer a matter to the MFCU.*** CMS says it realized this was confusing, so it recommends a standard. "The PIU should make a referral to its MFCU whenever there is *reliable* evidence that overpayments discovered during an audit are the product, in whole or in part, of fraud committed by the provider and/or one or more of the provider's staff or contractors. Reliable evidence is evidence that has been corroborated, that is based upon information from a person whose relationship with the suspected perpetrator is such that the person could reasonably be expected to have knowledge of the misconduct (such as an employee or ex-employee), or that is based on data analysis that reveals aberrant billing practices that appear unjustifiable based upon normal business practices."

◆ ***Include in every referral to the MFCU the information set forth in the referrals performance standard,*** such as subject (name, Medicaid provider ID, address, provider type), source/origin of complaint, date reported to the state, description of suspected intentional misconduct, contact information for the person with practical knowledge of the workings of the relevant programs, and the exposed dollar amount.

◆ ***Update the MFCU on ongoing investigations.***

◆ ***Offer education to the MFCU.*** "Because their primary mission is the investigation and prosecution of fraud in the Medicaid program, MFCU investigators frequently lack programmatic experience," CMS explains. "As a result, they may not be aware of the manner in which program regulations have been interpreted, or know who inside the state Medicaid agency is responsible for various functions, or understand a program's daily operations."

Read CMS's review at www.cms.hhs.gov/FraudAbuseforProfs and click on "Program Integrity Review Reports List." Read CMS's best practices at www.cms.hhs.gov/FraudAbuseforProfs/02_MedicaidGuidance.asp#TopOfPage. ✧

N.Y. State Medicaid Fraud Task Force Gets Off to Slow Start

Senate Republicans in New York state have created a task force on Medicaid fraud, designed to strengthen the state's efforts to fight Medicaid fraud. But despite saying that hearings would begin in February, with recommendations issued before the April 1 state budget deadline, the task force scheduled its first public hearing for March 8.

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According to Sen. Kemp Hannon's office, the task force has taken a back seat to budgetary issues. Hannon is chairman of the task force.

In announcing the task force, Sen. Dean Skelos claimed that the 2006 legislation that created the office of the Medicaid Inspector General and established new procedures for fighting fraud is "not having as much of an impact as we expected." The task force's goal is to find out why and recommend ways to improve fraud prevention, prosecution and recovery, he added. "There is no excuse for tolerating any fraud in a program that is the fastest growing and largest single component of state and county budgets," he said.

Gov. David Paterson's (D) 2010-2011 budget proposes increasing the target for Medicaid fraud-and-abuse recovery and cost avoidance by $300 million to a total of $1.1 billion. Sen. George Winner, a member of the task force, said this isn't nearly enough and asserted that while the state Office of the Medicaid Inspector General (OMIG) has helped the state to step up fraud and abuse recovery efforts, "there haven't been enough of them."

New York state Medicaid Inspector General Jim Sheehan tells *MCN* that "we think we are doing more than any other state" in terms of Medicaid fraud and abuse detection and prevention. "Look at the numbers."

continued

Medicaid Fraud Recovery Rates by State per Federal Grant Dollar Spent

Each fiscal year (FY), states' Medicaid Fraud Control Units receive federal grants from HHS to use in fighting Medicaid fraud and abuse. Below are the rankings of states for FY 2008 based on how much money they recovered per federal grant dollar received. Missouri ranks first with a return rate of $18.81 per grant dollar. The state received a grant of $1,582,000 from HHS and used that funding to recover $29,753,505.

Rank	State	Recovery per Grant Dollar	Rank	State	Recovery per Grant Dollar
1	Missouri	$18.81	26	New York	$6.65
2	North Carolina	$18.38	27	Alabama	$6.54
3	Tennessee	$17.13	28	Virginia	$6.04
4	West Virginia	$15.69	29	Michigan	$5.75
5	Ohio	$15.38	30	California	$5.70
6	Maine	$14.73	31	Illinois	$5.55
7	South Carolina	$14.25	32	South Dakota	$5.51
8	Minnesota	$13.67	33	Mississippi	$5.17
9	Nebraska	$11.36	34	Connecticut	$4.80
10	Georgia	$10.79	35	Utah	$4.56
11	Texas	$10.77	36	Iowa	$3.99
12	Kentucky	$10.13	37	Wisconsin	$3.91
13	Kansas	$9.21	38	District of Columbia	$3.69
14	Massachusetts	$9.18	39	Colorado	$3.66
15	Indiana	$8.92	40	Rhode Island	$3.40
16	Oklahoma	$8.83	41	Arkansas	$2.65
17	Washington	$8.61	42	Nevada	$2.15
18	New Jersey	$8.07	43	Arizona	$2.07
19	Vermont	$8.02	44	Wyoming	$1.96
20	New Hampshire	$7.52	45	Hawaii	$1.15
21	Oregon	$7.34	46	Alaska	$1.02
22	Maryland	$7.27	47	New Mexico	$1.00
23	Pennsylvania	$7.12	48	Montana	$0.92
24	Louisiana	$6.83	49	Delaware	$0.78
25	Florida	$6.76	50	Idaho	$0.06

SOURCE: HHS, SMFCU Statistical Information for FFY 2008, January 2010; http://ago.mo.gov/newsreleases/2010/MO_AG_Medicaid_Fraud_Unit_tops_ranking_in_US/.

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But he says he is "open to suggestions" and that the OMIG keeps "trying to improve."

Sheehan explains that there are two separate recovery goals for OMIG. The first is money required to be recovered under the Federal-State Health Reform Partnership (F-SHRP). The targeted amounts "count only identified recoveries," he explains.

New York has exceeded Medicaid fraud and abuse recoveries as required under the F-SHRP initiative. Under this program, New York agreed to recover a certain amount of overpayments from Medicaid providers and suppliers every fiscal year through 2011. It has exceeded the targeted amounts for 2008, 2009 and 2010 *(MCN 2/10, p. 1).*

F-SHRP does not take into account any cost avoidance, such as if OMIG "kicks a person out of the Medicaid program," notes Sheehan. But Medicaid recovery is more than just fraud and cost avoidance, he says. It also consists of things not considered fraud and abuse, such as recovery of third-party payer tort claims.

In providing evidence of the need for the task force, Skelos cited reports by the state comptroller, HHS and the Government Accountability Office claiming that the state has high Medicaid overpayments and low Medicaid fraud recovery amounts in dollar amounts. A state Comptroller audit released in December indicated that the state had approximately $92 million in Medicaid overpayments and billing errors. In addition, a 2008 state comptroller report determined that approximately 30,000 people in New York city were improperly enrolled in the state's Medicaid system between November 2006 and November 2007, and almost 13,000 former New York city residents should have been investigated for Medicaid fraud, but only 207 cases were investigated.

In January, HHS released a report stating that New York ranked 26th in the nation for Medicaid fraud recovery based on the number of dollars recovered per federal Medicaid dollar spent (see table, p. 5). New York recovered $6.65 per federal grant dollar. According to HHS's report, "SMFCU Statistical Information for FFY 2008," Missouri ranked first, with $18.81 recovered per federal grant dollar.

Moreover, a September 2009 GAO report claimed that New York did not have "a comprehensive fraud prevention framework to prevent fraud and abuse of controlled substances paid for by Medicaid" (GAO-09-1004T).

Contact Hannon's office at (518) 455-2200 and Sheehan through OMIG's public information office at (518) 473-3782. ✧

FCA Suit Targets Providers, Not Drug Firms, in Novel Off-Label Use Case

In an unusual effort to recoup Medicaid dollars and stop a harmful practice, a nonprofit organization in Alaska is suing psychiatrists, the health care organizations that employ them, pharmacies and state officials through the False Claims Act (FCA) for prescribing psychotropic drugs to minors and then billing Medicaid.

The suit was filed by the Law Project for Psychiatric Rights (PsychRights) in April 2009, but was just unsealed last month. PsychRights' mission is to use litigation to stop the use of psychiatric drugging and electroshock therapy on minor patients against their will, the organization's Web site says. The complaint alleges off-label use of some prescription drugs, but does not name drug producers as defendants.

The suit in Alaska names the commissioner of the state's Department of Health and Social Services, and the directors of the Alaska Office of Children's Services, the state Office of Children's Services and the Division of Health Care Services as some of its defendants. In addition, it names 13 psychiatrists and nine providers that employ them. Finally, the suit names three pharmacy chains and a firm that provides continuing medical education credits. The defendants "all have specific responsibilities to prevent false claims from being presented and are liable under the False Claims Act for their role in the submission of false claims," the suit alleges.

PsychRights asks the court to order the defendants to stop violating the FCA; and to charge them triple the damages sustained by the government, plus civil penalties for each violation. The suit also asks that PsychRights be awarded a portion of the settlement, including the cost of the action and attorney fees. The feds declined to join the case, which has not yet been scheduled for trial, in December 2009.

Robert Bundy, an attorney representing three of the defendants (including two pharmacies), says his clients don't believe they did anything wrong. "The speed with which the government declined to intervene is pretty telling," he adds. An attorney representing some of the other defendants could not be reached for comment.

Suits Against Drug Firms Have High Price Tags

Big settlements have come recently from suits against pharmaceutical manufacturers for improper marketing practices and off-label uses of drugs:

In September 2009, a Pfizer Inc. subsidiary agreed to the largest health fraud settlement in U.S. history with a $2.3 billion settlement to resolve criminal and civil liability stemming from the alleged illegal promotion of certain pharmaceutical products. And Eli Lilly and Co. agreed to

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plead guilty and pay $1.415 billion for alleged promotion of unapproved uses of the psychotropic drug Zyprexa in January 2009.

Even though the suit filed by PsychRights includes allegations of off-label and aggressive marketing by drug makers, it seems to name everyone but the companies as defendants. *Why not go after the deep pockets?* Jim Gottstein, who filed the complaint for PsychRights, says the big recent settlements haven't stopped the harmful practice. "The drug companies have already done their dirty work. Doctors continue to prescribe the medications, and drug companies continue to pay [the doctors]. Our objective is to stop that," he says.

"We felt that once the doctors realize that they're inviting financial ruin upon themselves, that they will put the brakes on [the practice]…the same for pharmacies. Are they going to continue to submit claims to Medicaid if they're going to incur liability for each prescription?" he asks.

The case also alleges that children and teenagers on the medications are put at significant risk because "their brains and bodies are developing," PsychRights says. "There is little or no empirical evidence to support the use of drug interventions in traumatized children and youth. Fewer than 10% of psychotropic drugs are FDA-approved for any psychiatric use in children.," the organization asserts.

Most of the children receiving these medications today are Medicaid beneficiaries, the complaint says. "Both because minority and poor children and youth are more likely to be involved in child protection and foster care placements, and because the drugs are paid for by Medicaid and other governmental programs, these children and youth are given more psychotropic drugs than other children and youth," it adds.

The suit explains that Medicaid will pay for "covered outpatient drugs" only if the drug is prescribed for medically accepted indications approved by the FDA or if it is supported by compendia such as the American Hospital Formulary Service Drug Information, the Pharmacopeia-Drug Information (or its successor publications) or DRUGDEX Information System.

States Should Review Prescriptions

"Whether a particular use is supported by a compendium depends on a variety of factors, including the type of drug and indication at issue, the compendium's assessment of the drug's efficacy in treating the indication, the content of the compendium citation, and the scope and outcome of the studies as described in the compendium," the complaint says. "States are required to have a drug use review program to assure that prescriptions are (i) appropriate, (ii) medically necessary, and (iii) not likely to result in adverse medical results. Among other things, such drug review programs, informed by the Compendia, must review each prescription before it is filled to ensure it is properly reimbursable under Medicaid," it adds.

PsychRights alleges that drug companies are aggressively marketing the drugs and are providing perks for physicians, and that the doctors "write prescriptions for pediatric patients for psychotropic drugs that are not for an indication approved by the FDA or supported by one or more of the Compendia, thereby causing claims for such prescriptions to be made to Medicaid and/or CHIP [i.e., Children's Health Insurance Program] for reimbursement."

According to the suit, drug companies pay psychiatrists to induce other psychiatrists to prescribe certain psychotropic drugs for pediatric uses not approved by the FDA, and pay for continuing medical education programs and induce prescribers to prescribe psychotropic drugs to children and youth for unapproved uses. They also give gifts to induce providers to prescribe particular psychotropic drugs to children and youth for unapproved uses, among other things, the complaint alleges.

PsychRights's complaint focuses on three types of drugs:

◆ ***Neuroleptics, which are used to treat autism, bipolar mania and schizophrenia.*** In the late 1990s, neuroleptic use in minors increased "dramatically" in Medicaid populations (61% for preschool children, 93% for children ages six to 12, and 116% for children ages 13 to 18), the suit says.

◆ ***Antidepressants, which are used to treat obsessive compulsive disorder and depression.*** "In 2005, the FDA issued a 'Black Box' warning of suicidality in children and adolescents, that 'antidepressants increased the risk of suicidal thinking and behavior (suicidality),'" the suit says.

◆ ***Anticonvulsants (promoted as "mood stabilizers"), which are used to treat bipolar disorder.*** "A 40-fold increase in the diagnosis of pediatric bipolar disorder over 10 years ensued upon the promotion of these drugs for children and youth given this diagnosis," the complaint says.

Feds Decline to Intervene

The government has already declined to intervene in the case, but that isn't stopping Gottstein. "We can go ahead without them….From my perspective, it's better that they didn't intervene because now we have control over the plaintiff's side of the case. That's not particularly true of most False Claims Act cases, but we have a unique set of objectives."

Gottstein says the potential total amount of improper billings is "mindboggling." According to a memorandum

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Gottstein wrote on the case, the minimum total liability is $5.5 billion, plus triple the cost of the prescriptions.

But there is a chance for a settlement. "Because PsychRights' objective in this litigation is to stop the harm to children and youth caused by the prescribing of psychotropic drugs for non-medically accepted indications presented to Medicaid for reimbursement, as contrasted with obtaining the maximum monetary recovery possible, the defendants in this case have an opportunity to settle on better terms than might otherwise be obtained," the memorandum says.

"At the same time, because this is an action on behalf of the government to recover for the Medicaid fraud perpetrated by the defendants…, the monetary recovery must be, in PsychRights' view, both reasonable and 'meaningful.' What is reasonable and meaningful will depend on the status of each defendant," the document explains. Many of the psychiatrists and providers would be "wiped out financially," it notes, but PsychRights says it would take into account their culpability, net worth, the extent of the false claims and whether the defendant attempts to settle early.

PsychRights has posted a model whistleblower suit on its Web site and encourages organizations and individuals in other states to file their own cases of this kind. The organization points out that parents and mental health workers can bring whistleblower suits. Gottstein says he's working with people on related cases, but there may be more that are still under seal that he isn't aware of. "There are some time bombs out there," he asserts.

Visit http://psychrights.org/index.htm to read the complaint and other documents in the case. Contact Gottstein at jim.gottstein@psychrights.org. ✧

Compliance Resources From HCCA

• **A Supplement to Your Deficit Reduction Act Compliance Training Program**. This 13-page handbook offers an easy way to educate your employees about the basics of Medicare and Medicaid, the Federal False Claims Act, and the whistleblower protections that help health care workers fight fraud.

• **Compliance 101, Second Edition.** This guide offers a comprehensive review of health care compliance fundamentals, including the seven essential elements, the steps needed to set up and maintain an effective program, sample policies and procedures, and more.

• **Health Care Auditing & Monitoring Tools.** This toolkit provides more than 100 sample policies, procedures, guidelines and forms to help establish or enhance your compliance auditing and monitoring efforts. Materials assist with risk assessment and plan development, conducting and reporting audits, evaluating program effectiveness, and more.

Visit the HCCA store at www.hcca-info.org, or call 888-580-8373.

Mich. Executive Order Creates Office to Battle Medicaid Fraud

Michigan becomes at least the ninth state to have an office dedicated to fighting fraud in its Medicaid and other state health care programs with the Feb. 19 executive order to create the Office of Health Services Inspector General (OHSIG).

According to the state, the division will be an "independent and autonomous" entity within the Department of Community Health (DCH). "Although the Department of Community Health has been successful in fighting fraud, waste and abuse, these responsibilities now will be consolidated in the Office of Health Services Inspector General along with an increased focus on specific auditing and fraud prevention goals," Gov. Jennifer Granholm (D) said in a prepared statement. "The inspector general will be an independent watchdog whose top priority will be safeguarding taxpayer dollars."

The office is part of an overall effort to transform Michigan's government, according to the statement. The Health Services Inspector General will be appointed by the governor, according to Executive Order 2010-1. Staff members for the OHSIG will come from the program investigation section in the Bureau of Medicaid Financial Management and Administrative Services within DCH, according to the order.

"This will improve our ability to track down fraud in the Medicaid program or the Children's Special Health Services program and go after improper payments and fraudulent activity," Janet Olszewski, director of the Michigan Department of Community Health, tells *MCN*.

DCH has been "quite vigilant and does a pretty good job, but [Medicaid fraud] seems to be an increasing issue throughout the health care sector," Olszewski says. "There's always room for improvement, and we can centralize the function [of the office], have better coordination and establish a better working relationship with the attorney general's office," she says.

The state has been developing the office for some time and sought CMS's input on its organization, but Olszewski says that the bureau will be "set up to work within [Michigan's] construct. The state's Medicaid program is distributed through managed care plans that handle the utilization of the program, so "this is really

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about bringing extra safeguards to what we're already doing," she says.

According to the executive order, the office will:

◆ ***Solicit, receive and investigate complaints*** related to fraud, waste and abuse;

◆ ***Actively seek out fraudulent billing practices of providers*** and develop techniques and procedures for detecting suspect billing patterns through the use of DCH's database resources and from federal sources;

◆ ***Pursue administrative and civil enforcement actions or collections,*** including (1) referring information and evidence to regulatory agencies and licensure boards, (2) withholding payment of medical assistance funds, (3) excluding providers, vendors and contractors from participating in Medicaid, (4) imposing administrative sanctions and penalties, (5) initiating and maintaining actions for civil recovery and seizure of property or other assets, (6) entering into administrative or civil settlements, and (7) pursuing any other formal or informal enforcement action relating to fraud, waste and abuse under state or federal laws;

◆ ***Provide information on suspected criminal acts*** to the Medicaid Fraud Control Unit, but "a criminal referral does

Mass. Settles Third Case on Lab Tests for Drugs, Alcohol

A clinical laboratory in Springfield, Mass., reached an agreement with the state to repay $450,000 to Medicaid for allegedly improper claims it submitted for drug and alcohol testing, the Massachusetts Attorney General's office said Feb. 11. The settlement is the third for the state, which is conducting an ongoing investigation into urine drug tests billed by independent clinical labs.

System Coordinated Services, Inc., doing business as Life Laboratories, billed Medicaid for tests that were not properly ordered by a physician or other authorized prescriber, and were inappropriately ordered for non-medical purposes (i.e., sobriety monitoring), the attorney general's office says.

State investigators also found that Life Laboratories had failed to give its "best price" for the tests and had thus overcharged Medicaid. "These alleged violations of state law and Medicaid rules and regulations resulted in significant Medicaid overpayments to Life Laboratories," the attorney general's office said in a prepared statement.

Life Laboratories's parent company is an affiliate of the Sisters of Providence Health System, says Mark Fulco, the system's senior vice president for strategy and marketing.

"Life Laboratories always seeks to comply with state and federal statutes, rules and regulations," he says. "We fully complied with [the attorney general's] review, and in 2009 we were notified that certain urine tests were not billed in compliance, so we worked with them to expeditiously resolve that," he tells *MCN.*

Medicaid does not recognize urine testing for sobriety as a valid medical purpose, he explains. And a physician needs to sign for each and every urine test attesting to its medical purpose. "The tests that allegedly failed to meet Medicaid's regulations were actually performed by Life Laboratories on behalf of an outside organization" that Fulco did not identify as part of a contract to test participants in a substance abuse program, he explains. Life Laboratories is no longer providing services to that client, he says.

The settlement does not call for Life Laboratories to hire a compliance monitor or make changes to its compliance program, Fulco says. The state "understands that we have corrected the practice and have a strong compliance program in place, so there is no requirement for any type of change in our practices or policies. I think the fact that we discontinued the relationship with the client for that program demonstrates that we made the necessary changes," he says.

Other settlements to come out of the ongoing investigation of clinical labs include:

◆ ***In 2009, Boston Clinical Laboratories Inc. paid $615,000*** to Medicaid and $14,000 to Medicare to settle false claims allegations *(MCN 8/09, p. 11)*. A 2007 lawsuit against Boston Clini¬cal alleged that from January 2000 through October 2007, the company submitted more than 66,000 claims for urine drug screens to Medicaid and that many, if not all, were not properly ordered by an authorized pre-scriber or were ordered for non-medical purposes.

◆ ***In 2007, Willow Street Medical Laboratory, LLC, paid $8.15 million*** to settle Medicaid fraud allegations. Besides billing inappropriately for tests, investigators found, Willow had made inappropriate payments to obtain Medicaid business from substance abuse treatment programs, halfway houses and shelters. The payments were in the form of free drug screen services, the state said *(MCN 2/08, p. 9)*.

Contact Jill Butterworth in the attorney general's office at jill.butterworth@state.ma.us and Fulco at (413) 748-9704.

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not preclude the office from continuing its investigation, which may lead to administrative or civil sanctions";

◆ ***Develop procedures to collect overpayments,*** restitution amounts and settlement proceeds;

◆ ***Monitor compliance by entities participating in Medicaid*** with requirements to inform their employees, contractors and agents about the details of state and federal false claims statutes; and

◆ ***Prepare an annual report for the governor and the director of DCH*** on the progress of the office, fraud control initiatives, results and recommendations, including the number of audits, investigations, funds recovered, and the number of referrals to other agencies for criminal investigation.

Read the executive order at http://michigan.gov/documents/gov/EO_2010-1_-_Creation_of_health_inspector_general_2-19-10_311840_7.pdf. ✧

High PERM Rates May Hurt Providers

continued from p. 1

PERM, which was mandated by the 2002 Improper Payments Information Act, drives states' pursuit of provider overpayment recoupment through provider audits. The program reviews the fee-for-service, managed care and eligibility components of Medicaid. The higher a state's payment error rate, the more liability the state has to the federal government in terms of its share of Medicaid spending. The error rate, in turn, leads states to collect overpayments from the providers.

PERM measures 17 states each year so that each state is reviewed every three years, the letter explains. The first year that states were measured in all components was 2007, so HHS provided data only on 2007 and 2008 (see tables, p. 11). The remaining one-third of the country was measured in 2009, so the data are not yet available, but HHS reported a Medicaid error rate of 9.6% in its FY 2009 agency financial report, the letter points out.

The rates reflect both underpayments and overpayments and are not necessarily fraudulent, HHS says. Lack of proper documentation could be counted as an error even if a service was medically necessary. And the rates vary across states because of the differences in the way states implement and administer their programs, the agency adds. "The PERM findings should be considered in the context of other policy goals and operational realities. Moreover, because the PERM program is relatively new, and is undergoing modifications…states will need time to adjust to the new reporting initiative," according to HHS. "As states and providers become more familiar with the PERM program requirements, especially with respect to documentation, we expect error rates to decrease in subsequent reviews."

Overall, states' PERM rates are "not too bad," but there are some attention-grabbing outliers such as Indiana, Oregon and Washington, D.C., says Brian Flood, former Texas Medicaid inspector general. States that have lower "population groups" should not have such high percentages, he tells *MCN.* "Why they have such high error rates would be a good question."

Flood points out that Texas had a rate above 13% after PERM's pilot in 2006, but that the state now has a 5% error rate. The state "re-engineered its entire system to more tightly oversee Medicaid spending," he says, by installing new technology; using new data analytics; and recombining audit, regulatory and investigative functions into one office. And Texas increased funding so there were more staff members to review files and do the work necessary to recover the overpayments, he adds.

Georgia's Rate Goes Up Despite Investments

By contrast, Georgia's rate has gone up even though it has taken similar steps, though on a smaller scale, Flood says. "The difference is the materiality of the activity," he says. "In Georgia, they didn't hire as many people, they didn't invest in as much technology and they didn't do the activities on a large enough scale to impact the rate, and you can see that in the numbers," he contends. "This is the barometer of what systems in what states are working and where auditors will go next."

Flood stresses that the high error rates can hurt providers even if they don't see the effects right away. "I try to highlight for folks that this is not a federal problem or a state leadership problem — this comes home to roost." The most frequent case of errors in medical reviews is no documentation or insufficient documentation. So providers need to look out for auditors' requests for documents and submit them in a timely manner, Flood says. One provider could drive the state's error rate way up.

There could be expensive consequences to a high error rate for states and providers if CMS starts using an extrapolation methodology that's scheduled to begin in 2010, says Flood, who now is a managing director at consulting firm KPMG. "In the past, the states were required to recover the identified overpayments for each file reviewed, so there was a one-to-one recovery," he explains. But if CMS takes the rate and extrapolates it across the providers, "that could affect hundreds of thousands of files based on error rates. And the rules say that if [the state has to] pay it back, it has to recover it from the provider." "Imagine the state turning around and dividing that up among the various provider groups that make up the study. It ends up being very big checks that everybody has to share in," he says.

Read more about PERM at www.cms.hhs.gov/PERM. Contact Flood at bgflood@kpmg.com. ✧

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FY 2007 and FY 2008 Medicaid PERM Error Rates

Medicaid Fiscal Year 2007 PERM Rate	Fee-for-Service	Managed Care	Eligibility with Undetermined	Combined Rate	Eligibility without Undetermined	Combined Rate without Undetermined
Rate for Sampled States (weighted average)	8.9%	3.1%	2.9%	10.5%	2.4%	10.0%
Alabama	1.8%	0.0%	2.1%	3.7%	1.6%	3.2%
California	16.4%	8.4%	1.2%	16.1%	1.2%	16.1%
Colorado	5.4%	0.1%	1.2%	6.0%	0.6%	5.5%
Georgia	10.2%	0.0%	5.1%	11.9%	5.0%	11.8%
Kentucky	4.5%	0.0%	0.3%	4.2%	0.3%	4.2%
Massachusetts	3.2%	0.0%	3.9%	6.4%	1.3%	3.8%
Maryland	1.0%	0.0%	7.7%	8.4%	7.7%	8.4%
North Carolina	3.1%	0.3%	1.0%	4.0%	1.0%	4.0%
Nebraska	5.2%	0.0%	0.3%	5.2%	0.3%	5.2%
New Hampshire	3.7%	N/A	0.3%	4.0%	0.3%	3.9%
New Jersey	9.7%	0.0%	2.9%	10.6%	0.0%	8.0%
Rhode Island	9.1%	0.0%	14.3%	21.0%	9.9%	17.0%
South Carolina	4.4%	0.0%	5.3%	9.2%	2.0%	6.1%
Tennessee	1.9%	0.0%	0.0%	1.7%	0.0%	1.7%
Utah	4.0%	0.0%	1.0%	4.5%	0.9%	4.4%
Vermont	4.3%	N/A	2.7%	6.9%	1.0%	5.3%
West Virginia	2.9%	0.0%	2.1%	4.7%	2.1%	4.7%
Medicaid Fiscal Year 2008 PERM Rate	**Fee-for-Service**	**Managed Care**	**Eligibility with Undetermined**	**Combined Rate**	**Eligibility without Undetermined**	**Combined Rate without Undetermined**
Rate for Sampled States (weighted average)	2.6%	0.1%	6.7%	8.7%	3.9%	6.0%
Alaska	0.5%	N/A	0.1%	0.6%	0.1%	0.6%
Arizona	2.7%	0.0%	2.2%	2.6%	2.1%	2.5%
District of Columbia	6.1%	0.2%	16.0%	20.1%	15.1%	19.3%
Florida	7.4%	0.0%	9.2%	14.6%	0.1%	6.1%
Hawaii	5.7%	0.0%	13.4%	16.8%	0.7%	4.6%
Iowa	1.7%	0.0%	3.3%	4.9%	3.3%	4.9%
Indiana	4.4%	0.0%	14.3%	17.2%	12.4%	15.4%
Louisiana	2.5%	0.0%	1.5%	4.0%	1.5%	4.0%
Maine	3.8%	N/A	2.0%	5.7%	0.0%	3.8%
Mississippi	3.3%	N/A	0.1%	3.5%	0.0%	3.3%
Montana	0.9%	N/A	3.6%	4.4%	0.1%	1.0%
Nevada	4.9%	0.1%	3.3%	7.3%	2.5%	6.6%
New York	1.4%	0.0%	6.7%	7.8%	3.1%	4.2%
Oregon	1.7%	0.0%	20.0%	20.8%	19.8%	20.7%
South Dakota	0.8%	N/A	0.0%	0.9%	0.0%	0.9%
Texas	0.4%	0.4%	4.7%	5.1%	4.4%	4.8%
Washington	3.5%	0.9%	3.6%	6.4%	3.4%	6.2%

N/A indicates a component not measured in FY 2007 or FY 2008.
SOURCE: HHS Payment Error Rate Measurement Program, Feb. 25, 2010

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NEWS BRIEFS

◆ **Robert Bourseau, the former co-owner of City of Angels Medical Center, was sentenced Feb. 22 to 37 months in prison for paying illegal kickbacks for referrals of patients recruited from the "Skid Row" area of Los Angeles,** according to the U.S. Attorney's Office for the Central District of California. He also was ordered to pay $4.1 million in restitution for his role in the scheme that defrauded Medi-Cal and Medicare by recruiting homeless persons for unnecessary medical services. Bourseau and co-conspirators were indicted in January 2009 *(MCN 7/09, p. 6).* He pleaded guilty in June and admitted that he schemed to pay co-conspirators to refer homeless Medicare and Medi-Cal beneficiaries to City of Angels for inpatient hospital stays. The hospital entered into sham contracts intended to conceal the illegal kickbacks, and billed federal health care programs for inpatient services to the recruited patients, including those for whom hospitalization was not medically necessary, the feds alleged. Bourseau and business partner Rudra Sabaratnam also agreed to a $10 million consent judgment with the government to resolve the allegations *(MCN 2/10, p. 11).* Visit www.justice.gov/usao/cac.

◆ **Vincent Rubio, the former chief financial officer of Tustin Hospital and Medical Center, has agreed to plead guilty to paying illegal kickbacks for patients who were recruited from the "Skid Row" area of Los Angeles,** the U.S. Attorney's Office for the Central District of California said Feb. 9. Rubio admits in a plea agreement that he paid kickbacks to "marketers" to recruit homeless people from Los Angeles and transport them to the facility to receive unnecessary health services. And the hospital billed Medicare and Medi-Cal for unnecessary inpatient services provided to the recruited beneficiaries, the feds say. In addition to the health care fraud charge, Rubio has admitted that he failed to report the payments he received from one of the marketers on his federal tax returns, the feds say. He faces a 15-year prison sentence. Visit www.justice.gov/usao/cac.

◆ **Two Atlanta-based nursing home chains and their owners have agreed to pay the federal government and several states a total of $14 million to settle allegations that they solicited kickbacks from a company that furnishes prescription drugs to nursing facilities,** the Department of Justice said Feb. 26. In a March 2009 complaint, the feds allege that Mariner Health Care Inc. and SavaSeniorCare Administrative Services LLC conspired to arrange for Omnicare Inc. to pay the firms $50 million in exchange for the right to continue providing pharmacy services to the nursing homes, which together constituted one of Omnicare's largest customers. The parties allegedly attempted to disguise the $50 million kickback as a payment to acquire a small Mariner business unit that had only two employees and was worth far less than $50 million, the feds explain. About $7.84 million of the settlement will go to the federal government, and $6.16 million will be returned to certain Medicaid programs. In November 2009, Omnicare agreed to pay the federal government and numerous states $98 million to resolve civil liability under the False Claims Act for allegedly paying the kickbacks to nursing home companies. According to the settlement, the companies and their owner do not admit liability and deny that they engaged in any wrongful conduct. Visit www.justice.gov.

◆ **A physician and the Illinois clinic he ran both have been sentenced to two years probation for making false statements to a federal health care program,** the U.S. Attorney's Office for the Southern District of Illinois said Feb. 19. James Durham, M.D., and Franklin Rural Health Care Clinic improperly billed Medicaid for more than $145,000 from January 2003 through May 2006 Medicare for about $42,000, the feds say. Federal officials also filed a civil fraud enforcement action against the defendants, which the parties agreed to settle for $360,000. Visit www.justice.gov/usao/ils.

◆ **Hany Iskander, M.D., an Ohio physician, was sentenced to 42 months in prison and will pay nearly $7 million in restitution to the victims of his health care fraud scheme, which include Medicaid and Medicare,** the U.S. Attorney's Office for the Northern District of Ohio said Feb. 4. Iskander will pay $2.8 million to Medicaid and $2.3 million to Medicare, with the remainder of the restitution going to private health insurers. He has also agreed to surrender his medical license and pay another $38,000 for the cost of the investigation. His wife was sentenced to two years of probation. The feds say Iskander ran a pain management business and billed for services that either were not provided or were not medically necessary. He and his wife also were charged with trying to impede the investigation by shredding and mutilating medical records and by trying to hide others in their home. Visit www.justice.gov/usao/ohn.

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