



Healthcare Association  
of New York State

## **EXECUTIVE SUMMARY**

### **HANYS' RECOMMENDATIONS TO PREVENT MEDICAID FRAUD, WASTE, AND ABUSE**

#### **BLUEPRINT FOR ACTION**

Recent reports about Medicaid fraud and abuse have garnered much attention among the public, elected officials, and the media. To address the issue, HANYS formed a multi-disciplinary Ad Hoc Medicaid Work Group and Legal Subcommittee to develop recommendations on ways to prevent fraud and abuse and to advise on proposals under consideration in the State Legislature. The recommendations included in this report are guided by five major principles:

- ◆ HANYS' members are committed to acting honestly and support government's role in preventing, uncovering, and eliminating Medicaid fraud and abuse.
- ◆ HANYS' members aim to combat fraud, minimize billing errors, and comply with thousands of pages of Medicaid and Medicare rules and guidance.
- ◆ Efforts to combat fraud must not confuse mistakes for fraud. HANYS' members take seriously both fraud and billing mistakes, but mistakes and fraud are not the same.
- ◆ Providers have an obligation to self-disclose if either fraud or billing errors are found.
- ◆ Efforts to combat fraud must not lose sight of the importance of New York's Medicaid program of ensuring access to care for our most vulnerable populations.

HANYS' recommendations fall within the following major categories:

- ◆ **Need for corporate compliance programs**—Providers have a responsibility to understand the law and strive to carry out operations within legal parameters. Corporate compliance programs specify corporate expectations and are a blueprint to guide employees, executives, boards, and others to carry out duties in conformance with the law. Compliance programs provide a framework for proactive corporate self-examination and remediation to reduce the incidence of problems and are critical in the battle against Medicaid fraud and abuse.

**Recommendation: Support legislation to require all providers to implement a corporate compliance program as a condition of participation in Medicaid.**

- ◆ **Better self-disclosure protocols**—A clear, efficient and “user-friendly” system for making self-disclosure needs to be established, as well as mechanisms for the state to accommodate these disclosure by accepting repayments promptly.

**Recommendation: Support a legislative or regulatory provision that requires the Department of Health (DOH), in consultation with the provider community and the Attorney General’s office, to establish appropriate systems and protocols for provider self-disclosure.**

- ◆ **Clearer guidance to providers**—The Medicaid payment system is exhaustively complex. To remain compliant, providers often find it necessary to seek agency guidance on the application of certain rules for specific instances. The informality of the current system provides value and should be maintained; however, DOH should be required to provide binding guidance when asked, Medicaid Fraud Control Unit (MCFU) should publish an annual workplan similar to those of comparable federal agencies, and the Medicaid billing process should be streamlined.

**Recommendation: Support legislation to provide for written guidance, rules for reliance on such guidance, and requirements for publication of MFCU workplans. Additionally, HANYS recommends that the Medicaid billing process be simplified.**

- ◆ **Enforcement of current laws**—The state already has numerous comprehensive laws and regulations to fight Medicaid fraud. Health-related enforcement agencies have many legal tools to maximize fraud detection and prosecution efforts, including whistleblower protections and a variety of civil and criminal sanctions.
- ◆ **Adequate resources for enforcement**—A major priority should be the commitment of additional resources to DOH for audit and investigation activities. Resources should also be committed to significantly improve claims processing and related information systems, and provider education. Systems between and among state agencies and state and local entities must be improved and mutually compatible.

**Recommendation: HANYS recommends a state budget appropriation to provide additional staffing and/or infrastructure resources to DOH, as well as funding for provider education.**

- ◆ **Concerns about Qui Tam and False Claims Act proposals**—“Qui tam” is the phrase used to mean a law that allows private citizens to act as government prosecutors and bring lawsuits as if they were the government. These laws provide that if the lawsuit ends in dollars being recovered by the government, the person originally bringing the case, the “qui tam,” is awarded a percentage of the recovery. A qui tam provision continues to be objectionable because of conflicts with existing law and protocols, motives, tactics, litigation procedures, and other issues.

**Recommendation: HANYS urges the State Legislature to resist the temptation of enacting qui tam provisions.**

Medicaid funds lost to fraud, waste, and abuse are funds lost by low-income, elderly, and disabled individuals in New York State who need and deserve access to the health care that Medicaid provides for them. Beneficiaries, providers, and government have an obligation to ensure that Medicaid dollars are used for their intended purposes.



## **HANY'S' RECOMMENDATIONS TO PREVENT MEDICAID FRAUD, WASTE, AND ABUSE**

### **BLUEPRINT FOR ACTION**

#### **INTRODUCTION**

Recent reports on the issue of Medicaid fraud and abuse have garnered much attention among the public, elected officials, and the media. New York Governor George E. Pataki announced the creation of a Medicaid Inspector General. The State Senate and Assembly have each held hearings on Medicaid fraud. The Attorney General is advocating for enactment of his proposal to create a state version of the controversial federal False Claims Act and has asked hospitals and nursing homes for certain reserve account information.

In the legislative hearings, state officials were unable to pinpoint the amount of fraud and abuse, but all agreed that any fraudulent loss of Medicaid dollars was too high.

New York State's health care providers have a legacy of ethical behavior and caring. HANY'S' members are involved in numerous initiatives to combat fraud, minimize billing errors, and comply with the thousands of pages of Medicaid and Medicare laws, regulations, and instructions. HANY'S maintains that any Medicaid dollars lost to fraud and abuse are diverted from patient care, and all stakeholders must be diligent in fraud prevention.

To address Medicaid fraud, HANY'S formed a multi-disciplinary Ad Hoc Medicaid Work Group to develop recommendations on preventing fraud and abuse and to advise on proposals under consideration in the State Legislature. The Work Group was comprised of HANY'S' member chief executive officers, chief financial officers, compliance officers, trustees, and others. HANY'S also created a legal subcommittee to provide input and analysis.

The recommendations included in this report were guided by five major principles:

- ◆ HANY'S' members are committed to acting honestly and support government's role in preventing, uncovering, and eliminating Medicaid fraud and abuse. Fraud is unacceptable and takes necessary funding for medical care away from the poor, elderly, and disabled who need it.
- ◆ HANY'S' members aim to combat fraud, minimize billing errors, and comply with thousands of pages of Medicaid and Medicare rules and guidance.
- ◆ Mistakes must not be confused with fraud. HANY'S' members take seriously both fraud and billing mistakes, but mistakes and fraud are not the same. Mistakes happen and are unintentional.

- ◆ Providers are obligated to self-disclose both fraud and billing errors.
- ◆ Actions to combat fraud must not lose sight of the importance of New York’s Medicaid program at ensuring access to care for our most vulnerable populations—the very young, the elderly, the working poor, and the disabled individuals who can receive the health care they need because of this valuable program.

It is important to prevent, uncover, and eliminate fraud. However, the real faces of Medicaid are the honest providers and beneficiaries who appropriately participate in the Medicaid program, and live and work in our communities. These faces include children who get a healthier start in life, pregnant women who would not otherwise have access to vital prenatal care, parents who would have to choose between health care or other family needs, and the elderly and disabled who have access to critical long-term care services because of Medicaid.

### **WHAT DOES HANYS RECOMMEND TO ADDRESS MEDICAID FRAUD, WASTE, AND ABUSE?**

HANYS has a series of recommendations to help address Medicaid fraud. These recommendations fall within the following major categories:

- ◆ need for corporate compliance programs;
- ◆ better self-disclosure protocols;
- ◆ clearer guidance to providers;
- ◆ enforcement of current laws;
- ◆ adequate resources for enforcement; and
- ◆ concerns about “qui tam” and False Claims Act proposals.

### **CORPORATE COMPLIANCE PROGRAMS**

Health care providers recognize that participating in government-sponsored programs carries certain opportunities and obligations. One of the fundamental principles guiding providers’ behavior is that compliance with myriad state and federal laws, rules, and regulations must remain a corporate priority. Providers have a responsibility to understand the law and strive to carry out operations within legal parameters.

To promote compliant behavior, health care providers have implemented corporate compliance programs that specify corporate expectations and credos. A corporate compliance program is a blueprint that guides employees, executives, boards, and others to carry out their duties in conformance with the law. It provides a framework for proactive corporate self-examination and remediation to reduce the incidence of noncompliant activities. An effective compliance program identifies problem areas and corrects them as soon as possible. The detection and prevention features of a compliance program are critically important in the battle against Medicaid fraud and abuse.

While each provider develops its own compliance program in harmony with its own culture, size, complexity, and resources, all compliance programs include seven essential elements:

- ◆ written policies and procedures that articulate corporate standards of conduct and spell out procedures to identify compliance risk areas such as the claims submission process;
- ◆ a designated person in charge of the compliance program with senior-level authority, including direct reporting to the board or a committee of the board—the person, often called the compliance officer, should have authority over and responsibility for the compliance program operation;
- ◆ effectively train and educate staff on the importance of compliance, including the expectation that all employees are expected to adhere to the compliance program;
- ◆ effective lines of communication to corporate compliance officials with a means of communicating concerns confidentially and anonymously, without retaliation or retribution;
- ◆ well-publicized and enforced disciplinary standards that address any individuals engaging in behavior that undermines the facility’s status as a reliable and honest provider, and fails to abide by facility policies and procedures;
- ◆ an active auditing and self-monitoring process that incorporates the proactive self-examination of identified risk areas and other matters as they arise; and
- ◆ an effective method for responding to detected problems and initiating meaningful corrective action in order to foreclose their recurrence.

The overarching goal is to promote healthy corporate behavior non-punitively and to encourage active employee participation to identify issues and rectify them rather than allow them to fester. Corporate compliance programs are a powerful and efficient tool for uncovering billing mistakes and occasional fraud. **Because of the effectiveness of corporate compliance program performance, HANYS believes that the state, as a condition of participation in the Medicaid program, should require all providers to implement such a program, including the elements described above.**

### **SELF-DISCLOSURE PROTOCOLS**

A source of systemic waste in the Medicaid program is inaccurate payment to providers. Using current corporate compliance mechanisms, providers may discover an improper payment from Medicaid. However, there is no uniform way for providers to bring the matter to official attention—most communication is somewhat informal. More formal routes, such as the filing of “negative rate appeals,” are cumbersome and do not provide an efficient way for the state to recover funds.

More disconcerting is that if an overpayment is identified, the Medicaid system often is unable to accommodate swift repayment. Instead, inaccurate payments continue, the amount of wrongly paid dollars increases, and the provider mistakenly appears to reap unwarranted funds. This

situation shortchanges the state, misleadingly raises the specter that fraud is occurring, and is unfair to the provider.

**HANYS suggests that the state establish a clear, efficient, and “user-friendly” system for making self-disclosures and to accommodate these disclosures by accepting repayments promptly.**

Specifically, HANYS proposes:

- ◆ Development by the Department of Health (DOH), in consultation with the provider community and the Attorney General’s office, of a clear, efficient, and non-punitive system for self-disclosing overpayments and making repayments.
- ◆ Clearly spell out the mechanics of the disclosure and repayment process and avoid undue complexity.
- ◆ Improve DOH information systems so they are able to accommodate repayments more efficiently than currently is the case.
- ◆ Include, in the amounts to be repaid through a self-disclosure protocol, mathematical errors, rate miscalculations, negligence, and the like.
- ◆ Provide immunity from civil liability unless the self-disclosure is in response to an investigation that the provider knows about or should reasonably be expected to know about.
- ◆ Do not shield the provider entity from referrals by DOH to the Attorney General for possible action to recover penalties or damages due to criminal activity or intentional misconduct.
- ◆ In the event the Attorney General commences an action, the self-disclosure must be a mitigating factor, among other things, for determining the amount of penalties and damages.

## **GUIDANCE TO PROVIDERS**

The Medicaid payment system is exhaustively complex. To remain compliant, providers often find it necessary to seek agency guidance on the application of certain rules to specific instances.

Great judicial deference is accorded an agency’s interpretations of its own rules; the same level of deference should be applied by the agency itself and by other agencies as well. Providers rely on advice from DOH in their efforts to comply with billing rules.

- ◆ The informality of the current system provides value to the Medicaid system and should be maintained. **However, to improve the overall accuracy of Medicaid provider payments, DOH should provide a timely, written response to written inquiries on the application of a rule, billing code, or rate calculation.**
- ◆ Currently, when guidance is provided, it unfortunately does not hold the provider harmless in the event of a subsequent audit or investigation. **HANYS proposes that if the provider in**

**good faith relies on DOH guidance, the provider should be shielded from Medicaid liability exposure.**

- ◆ Current audit protocols limit opportunities for providers to challenge or raise issues with a subcomponent within a proposed audit adjustment. **There is a need for fair and equitable audit appeals rules that allow a provider to challenge, in whole or in part, audit findings.**
- ◆ At the beginning of each federal fiscal year, the Health and Human Services' Office of Inspector General (OIG) publishes an Annual Workplan that describes subject areas on which OIG expects to focus in the upcoming year. The Workplan is an excellent tool for providers to use to concentrate on areas that may be overlooked, conduct self-audits, and focus ongoing compliance activities. By contrast, the Annual Report of the Medicaid Fraud Control Unit (MFCU) provides no such guidance. While it includes a "Future Activities" section, it does not refer to any particular issue. **Legislation should require that the MFCU prepare and publish an annual Workplan using the federal template as a model.**
- ◆ Given the complexity of the Medicaid system and the difficulty in navigating (without error or confusion) the many pages of rules, billing codes, and rates, efforts should be undertaken to simplify and streamline the process for Medicaid as both a primary and secondary payer.

### **ENFORCEMENT OF CURRENT LAWS**

The state already has numerous laws and regulations on the books to fight Medicaid fraud, including:

- ◆ provisions in the Social Services Law for the improper submission of false or fraudulent claims; these provisions carry sanctions including tripling the amount of actual damages and per-violation penalties of \$2,000-\$7,000;
- ◆ many sections in the Penal Law that make filing false claims a crime, including:
  - ✓ several crimes regarding the filing of false instruments;
  - ✓ many larceny and grand larceny laws; and
  - ✓ specific laws criminalizing "insurance fraud," which includes submitting false claims for payment to a public program such as Medicaid;
- ◆ protections for whistleblowers who report suspected fraud;
- ◆ sweeping investigative and prosecutorial powers of the Attorney General as granted by the State Constitution and the Executive Law;
- ◆ enabling prosecution of prescription drug diversion activity under the state's organized crime and wiretapping laws; and
- ◆ a category of criminal offense sanctioning providers and non-providers that participate in illegal kickback schemes.

This existing body of comprehensive state laws and regulations gives health-related enforcement agencies the tools necessary to maximize fraud detection and prosecution efforts.

## **RESOURCE COMMITMENTS**

DOH officials have also highlighted fraud detection efforts through the Medicaid Fraud Hotline, data mining, forge-proof prescriptions, establishing a preferred drug list, and collaborating with medical professionals on the appropriate delivery of health care services. DOH said its studies of the state's payment accuracy demonstrate a 98% accuracy rate in Medicaid payments. In addition, the state contracts with IPRO for Medicaid claims review compliance. These reviews generate approximately \$150 million per year in Medicaid payment recoupments.

- ◆ A major priority should be the commitment of additional resources to DOH for audit and investigation activities. Resources should also be committed to significantly improving claims processing and related information systems. Systems between and among state agencies and state and local entities must be improved, be mutually compatible, and avoid duplication.
- ◆ Provider education activities should be a priority. Adequate funding should be made available to DOH to allow for periodic provider education.

## **FALSE CLAIMS ACT, QUI TAM, AND WHISTLEBLOWER**

HANYS has historically opposed state legislation to create a state False Claims Act (FCA) modeled after the misused federal FCA. Generally, such proposals would create a private right of action against persons or entities accused of defrauding the state and specifically provide that “**no proof** of specific intent to defraud is required” for a legal action. These laws provide an incentive for private parties to sue, since they are rewarded with a percentage of any amounts recovered from the defendant.

During the 1990s, hospitals and health care providers nationwide faced unprecedented, overzealous federal government investigations. Federal officials embarked on an anti-fraud campaign that threatened hospitals with prosecution under the federal FCA unless they consented to settlements and paid large fines for making unintentional mistakes. In doing so, it was alleged in many cases that errors and billing mistakes—that are often unavoidable in complex and contradictory billing systems—were actually fraud. The result was that millions of dollars were diverted from patient care as hospitals tried to defend themselves against unwarranted charges. The “guilty until proven innocent” mentality of prosecutors abusing the federal FCA led to considerable criticism by members of Congress and providers.

The widespread misuse of the federal FCA provides the backdrop for the issues and concerns about any legislation that could replicate that nightmare. New York State should not adopt the “guilty until proven innocent” approach that discredited federal anti-fraud efforts. In short:

- ◆ HANYS has historically opposed legislation modeled after the federal FCA, which was widely misused.

- ◆ A state FCA would be redundant. There are adequate provisions in the state Social Services Law and Penal Law to fight real fraud.
- ◆ The proposed FCA provides incentives to sue and invites the potential for abuse.
- ◆ Existing whistleblower laws provide employee protections without “bounty hunter” provisions.

## **QUI TAM PROVISIONS**

“Qui tam” is a law that allows private citizens to act as government prosecutors and bring lawsuits as if they were the government. These laws provide that if the lawsuit ends in dollars being recovered by the government, the person originally bringing the case, the “qui tam,” is awarded a percentage of the recovery. A qui tam provision in state law, whether in a new “False Claims Act” or as an addition to existing law, is objectionable for the following reasons.

- ◆ Qui tam provisions undermine effective corporate compliance programs by encouraging employees to put personal reward ahead of rapid, internal correction. The federal OIG protocols for a corporate compliance program require that issues first be reported “up the ranks” to be resolved internally before becoming significant problems.
- ◆ Rather than a weapon to fight fraud, qui tam laws provide incentives for employees and competitors to act out of retribution.
- ◆ Since qui tam actions are commenced without informing the provider and the papers are sealed except to the government, there is no opportunity for a provider to address the issues presented until they arise in a full-blown fraud lawsuit once the government decides to act.
- ◆ Since qui tam provisions encourage the filing of lawsuits to obtain recoveries, they trigger a wasteful expenditure of scarce dollars intended to provide needed health services. Instead, these dollars are diverted to compensate attorneys, accountants, and others in defense of claims, regardless of their merits.
- ◆ By their nature, qui tam laws amount to privatizing a government prosecutorial function. Laws are generally enforced by government agencies that act on behalf of citizens at large—qui tam cases are brought by private individuals in the name of the government to enrich themselves. The government gives up a portion of its share of recoveries to one individual, hardly benefiting society as a whole.
- ◆ Currently under sections 740 and 741 of the Labor Law, employees who report violations of law to public officials are protected from employer retribution for doing so; thus, “whistleblowers” who are on the “inside” of a provider’s operations are protected if they report wrongdoing. A qui tam law provides no further protection to the whistleblower—it provides a monetary reward. Its effectiveness can only be measured by employees’ interest in recoveries, not employees’ protection from retaliation or desire to fight fraud.
- ◆ Qui tam laws reward plaintiffs who have participated in the fraudulent scheme, or who are aware of the scheme and do nothing to stop it, and who may have reaped monetary or other

rewards for doing so. The net effect of a qui tam statute is to financially reward wrongdoing or intentional inactivity at the expense of providers and the government. For example, with qui tam, some wrongdoers may intentionally allow the fraud to continue, knowing that their reward will grow as the fraud grows.

- ◆ It is commonplace for qui tam plaintiffs to obtain documents by whatever means they deem necessary to bring and prove a case. Instances of document theft by plaintiffs happen frequently to build cases. Such actions do not diminish the reward due to the plaintiff, nor do they disqualify the plaintiff from receiving any reward.

## **CONCLUSION**

Medicaid funds lost to fraud, waste, and abuse are funds lost by low-income, elderly, and disabled individuals in New York State who need and deserve access to the health care that Medicaid provides for them. Beneficiaries, providers, and government are obligated to ensure that Medicaid dollars are used for their intended purposes.

The Medicaid system is very complex. In the course of rooting out illegal and wasteful activity in the Medicaid payment system, it is important that the state not be overzealous and criminally prosecute innocently made billing errors or technical mistakes. It is important that the state and prosecutors differentiate between unintentional mistakes and fraud—an intentional misrepresentation used to get undeserved funds.

The Medicaid program is vital to those who depend on it to meet their health care needs. The taxpayer funds invested in the program are valuable and contribute to our overall community health. Fraud and abuse divert precious dollars that are needed to provide care for our most vulnerable populations. Working together, all stakeholders can identify ways to prevent and eliminate Medicaid fraud and protect this valuable program for the people it serves.

## **ATTACHMENT I**

### **MEDICAID FACTS**

- ◆ The Medicaid program is essential in promoting community health and helps drive the state's overall well-being, helping children to learn better, adults to work better, and providing a safety net for those who would otherwise fall through the cracks.
- ◆ New York's Medicaid program provides needed health care for 4.2 million children, parents, working poor, elderly, blind, and disabled individuals—about one in every five New York State residents.
- ◆ Many of these people have jobs that do not provide insurance, or who make a living by working several part-time jobs.
- ◆ Approximately 24% of Medicaid recipients are elderly or disabled, yet these populations account for nearly two-thirds (65.4%) of Medicaid spending.
- ◆ Medicaid spending on prescription drugs grew by 88% from state fiscal year (SFY) 2000-01 to SFY 2004-05. During that same period, Medicaid spending on hospitals and nursing home services grew by only 27% and 21% respectively.
- ◆ Medicaid enrollment grew 54% from 2000-2005.
- ◆ Medicaid is a publicly funded program, with the federal, state, and local governments all contributing to fund it. In New York State, the total cost of the Medicaid program in 2005 was \$44 billion, of which the federal government contributed one-half, and the state and localities share the remaining one-half.
- ◆ For most services, including hospital care, the state and counties each pay 25%. For long-term care, the state contributes 40% and counties pay 10%. Over the past two years, the state has been taking over the local share of the Family Health Plus program and, starting in 2006, the county share of the overall Medicaid program will be capped.