



Fraud Enforcement and Recovery Act of 2009 ("FERA"), enacted May 20, 2009.
 Patient Protection and Affordable Care Act ("PPACA") enacted March 2010, as amended by the Health Care and Education Reconciliation Act of 2010, enacted March 2010 ("HCERA").

### FERA signed into law on May 20, 2009 Expands the scope of liability under the False

- Expands the scope of liability under the False Claims Act ("FCA"), which imposes liability for making false statements or claims for reimbursement to the government
- FERA expands definition of "obligation" in the FCA to include the <u>retention</u> of any <u>overpayments</u>
- Tracking mechanisms now key

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#### Prior to FERA, liability existed under the FCA when a person "knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government"

- FCA liability now broadened to include <u>any</u> false or fraudulent claim for government money or property
  - Regardless of whether the claim is presented to a government official or employee (may be claim presented to a contractor, grantee or other recipient if the money/property is to be spent or used on the government's behalf or to advance a government program / interest).
  - Regardless of whether the government has physical custody of the money
  - Does not consider the defendant's intent

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#### PPACA signed into law by President Obama on March 23, 2010

- Focus upon coverage expansion, quality improvement and cost efficiencies → subsidizing Federal healthcare programs
- Reform affecting the health insurance industry and implementation of new consumer protections prohibiting prior practices of health insurers
- Enhanced Medicare & Medicaid Program Integrity provisions
- New requirements for long-term care compliance, transparency, accountability and reporting
- Increased funding for investigation of fraud and abuse

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#### Overpayments from the Medicare and Medicaid programs must be reported and returned within 60 days of the later of: the identification of the overpayment, OR the date any corresponding cost report is due. ► The overpayment must be reported and returned to either CMS, Medicaid, the intermediary, carrier or contractor, with a written explanation of the reason for the overpayment. MAKING A CASE FOR TEAMWORK. Excluded ordering or Inaccurate cost reports servicing person Duplicate payments of the same services Service by unenrolled Payment for nonprovider covered, non-medically Service by person lacking required license necessary services or certification Services not actually rendered (i.e., acuity Service inconsistent with audits) physician order or treatment plan Payment made by a Service not documented primary insurance No order for service as required by regulation MAKING A CASE FOR TEAMWORK ▶ Penalties for Retention of Overpayments: Retention of overpayment $\rightarrow$ "obligation" for the purposes of FCA PPACA also amended the Civil Monetary Penalty ("CMP") Statute to increase CMPs for retention of overpayments May subject the Facility to CMPs of not more than \$10,000 for each item or service, plus not more than three times the amount claimed for each such item or service. The Facility may be excluded from participation in Medicare / Potential liability under New Jersey False Claims Act. MAKING A CASE FOR TEAMWORK

### Open Questions: "Identified" is not defined Intimed is Not detailed. Compare with CMS proposed rule in 2002 (which was never adopted) that required reporting and return of Medicare overpayments within 60 days of identifying of learning of it. The deletion of "learning of" from the PPACA provision may indicate an intent to apply the PPACA provision to situations where a provider has confirmed the existence and scope of the overpayment. However, NY OMIG has taken the position that "identified" means that the fact of an overpayment, not the amount of the overpayment, has been identified. Overpayment is defined to include any funds that a provider receives or retains from Medicare or Medicaid to which the provider, after applicable reconciliation, is not entitled; although "after applicable reconciliation" not defined Potential argument that such reconciliation allows for time to complete an investigation prior to reporting and returning an overpayment. MAKING A CASE FOR TEAMWORK In New Jersey, the New Jersey Office of the State Comptroller - Medicaid Fraud Division (MFD) has developed a self-disclosure protocol to include (but not limited to) the reporting, explanation and return of overpayments within 60 calendar days of identification Available at http://nj.gov/njomig/disclosure Recommends use of Provider Self-Disclosure Form Per the MFD, the benefits to providers who, in good-faith, participate in a self-disclosure, include: Avoidance of FCA penalties if reported within 60 days of identification Forgiveness or reduction of interest payments (for up to two years) Extended repayment terms Waiver of penalties and/or sanctions Timely resolution of the overpayment Decrease in the likelihood of imposition of an MFD Corporate Integrity Program MAKING A CASE FOR TEAMWORK As recognized by the MFD, however, not all overpayments may warrant self-disclosure through the MFD protocol Providers must determine whether the repayment of the overpayment should be through self-disclosure or whether it would be better handled through administrative billing processes (i.e., voiding or adjusting the amounts of claims). Factors to consider include the: • exact issue amount involved any patterns or trends that the problem may demonstrate within the provider's system period of non-compliance circumstances that led to the non-compliance problem organization's history whether or not the organization has a corporate integrity agreement (CIA) in place MAKING A CASE FOR TEAMWORK

### ► Per MFD, issues appropriate for disclosure may include, but are not limited to: Substantial routine errors Systematic errors Patterns of errors Potential violation of fraud and abuse laws ▶ MFD suggests that providers consider obtaining the advice of experienced healthcare legal counsel or consultants in connection with evaluating the proper return of an overpayment. MAKING A CASE FOR TEAMWORK. PPACA required establishment of a Self-Referral Disclosure Protocol for self-disclosure of Stark violations to CMS http://www.cms.gov/PhysicianSelfReferral/65\_Self\_Referral\_Disclosure\_Protocol.asp#TopOfPage ▶ Under the SRDP, CMS may (but is not required to) compromise claims in settlement, based on the following factors: Nature and extent of the improper practice Timeliness of the self-disclosure Cooperation in providing additional information Litigation risk associated with matter disclosed Financial position of the disclosing party Such other factors as HHS/CMS considers appropriate MAKING A CASE FOR TEAMWORK ► A financial relationship exists with a referring physician and no exception applies or a technical violation (i.e. unsigned writing, expired contract) Quantify payments at issue Risk of \$15,000 CMP per claim even if amount of payment is low Large amount may attract whistleblower (increasing trend of physician whistleblowers)

Determine period of disallowance

reimbursement?

When did relationship fall out of compliance? When where claims illegally submitted for

#### PPACA also makes changes to the enforcement of the Federal Anti-kickback Statute ("AKS") by eliminating the intent requirement

- A person may now violate the AKS without actual knowledge of AKS or a specific intent to commit a violation
- ► Claims that include items or services resulting from an AKS violation trigger liability under the FCA
  - These changes will likely result in more aggressive enforcement of AKS violations as primary violations
  - AKS violations risk criminal liability

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#### In addition to existing penalties, PPACA authorizes HHS or the States, in consultation with the OIG, to suspend Medicare and Medicaid reimbursement "pending an investigation of a credible allegation of fraud," effective March 25, 2011.

- Credible allegation of fraud an allegation from any source, including but not limited to the following:
  - Fraud hotline complaints
  - Claims data mining
  - Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.
  - Allegations are considered to be credible when they have indicia of reliability.
- Provided that CMS or the Medicare contractor has consulted with the OIG, and, as appropriate, the Department of Justice ("DOJ"), and determined that a credible allegation of fraud exists.

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#### CMS, in consultation with the OIG, and the DOJ, as appropriate, has discretion as to whether prior notice of the payment suspension is appropriate.

- Provider afforded opportunity to submit rebuttal.
- Suspension of payment may be until resolution of the investigation (legal action is terminated by settlement, judgment, or dismissal or when the case is closed because of insufficient evidence)
  - Unless payment suspension has been in effect for 18 months and investigation is continuing good cause not to continue suspension, except that CMS may extend beyond 18 months if:

    - OIG is considering case for administrative action (or administrative action is pending), OR DOJ submits written request to CMS for continuing suspension of payments.

#### The State Medicaid agency <u>must</u> also suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program & notify the Medicaid Fraud Control <u>Unit</u> Lower standard than current regulation which requires "reliable information that fraud or willful misrepresentation exists." May suspend payments without first notifying the provider of its intention to suspend such payments. Notice only required: To be provided 5 days after payment suspension, however, law enforcement may request delay in notice not to exceed 90 days. To set forth general allegations regarding suspension, not specific information concerning ongoing investigation.

Provider may request, and must be granted, administrative review where State law so requires.

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#### In 2011, the Federal government won or negotiated approximately \$4.1 billion in health care fraud judgments and settlements.

- Department of Justice (DOJ) opened 1,110 new criminal health care fraud investigations involving 2,561 potential
- Office of Inspector General (OIG) excluded 2,662 individuals and entities, including exclusions based upon:
   criminal convictions for crimes related to Medicare and
  - Medicaid (1,015)
  - Criminal convictions for crimes related to other health care programs (233)
  - patient abuse or neglect (206)
    - result of licensure revocations (897)

•	In January 2011, Senior Care Group, Inc. agreed to pay
	\$953,375 to settle allegations of fraud in two SNFs as a
	result of billing for unnecessary services.
	- Pohabilitation contractor processed amplessors to maximize billings

- Rehabilitation contractor pressured employees to maximize billings subsequently submitted to Medicare by Senior. Included OT for Alzheimer's patients who could not expect to return to
- ▶ In April 2011, Genesis Rehabilitation Services agreed to pay \$1.5 million to resolve allegations of submitting claims for services by unlicensed speech therapist.
  - Between October 2006 and June 2010 GRS allegedly employed ST who provided forged licenses and documentation to GRS. GRS failed to verify.

  - Claims submitted were improper as performed by unlicensed individual. MAKING A CASE FOR TEAMWORK.

## In January 2010, five nursing homes operated by Cathedral Rock pled guilty to felony health care fraud related to failure to provide adequate care to Medicare/Medicaid residents. Majority owner entered into a criminal deferred prosecution agreement for 2 years. St million in criminal fines & penalties, as well as \$628,000 to resolve civil FCA allegations that they submitted faise and fraudulent claims to Medicare / Medicaid. Allegations of insufficient staffing levels; residents not receiving medication as prescribed; fallsified medical records (i.e., "charting party" occurred to fill in medical or whether the medication was actually given or not); and submission of fraudulent claims to Medicare / Medicaid for services that were not provided / were worthess. In May 2010, Good Samaritan, a corporation which operates 230 nursing home facilities in virtually every state, agreed to pay \$480,137 to resolve allegations that the corporation employed an excluded RN. As a result, Good Samaritan was required to 60 a compliance review and certification during which the corporation uncovered six additional excluded employees working in other facilities, for which it paid an additional \$200,000. In January 2010, five nursing homes operated by Cathedral Rock MAKING A CASE FOR TEAMWORK In November 2009, Omnicare, Inc., the nation's largest nursing home pharmacy, agreed to pay \$98 million, plus interest, to resolve FCA allegations that Omnicare submitted false claims to federal health care programs as a result of: rams as a result of: Providing consultant pharmacist services to nursing homes at below-cost / below FMV prices as a kickback to induce nursing homes to use Omnicare's dispensing pharmacist services and purchase drugs from Omnicare's Osliciting and receiving \$8 million in kickbacks from defendant IVAX Pharmaceuticals, Inc. in exchange for Omnicare's agreement to purchase \$50 million in drugs from IVAX; Paying a multi-million dollar kickback, disguised as the purchase amount for a business, to defendants Mariner Health Care, Inc. and SavaSeniorCare Administrative Services, LLC in exchange for agreements by Mariner and Sava to continue using Omnicare's pharmacy services for 15 years; and Soliciting and receiving millions of dollars in kickbacks from defendant Johnson & Johnson in exchange for purchasing and recommending the drug Risperdal for use by patients in facilities served by Omnicare. NAX also agreed to pay \$14 million to resolve liability for its role in this scheme. MAKING A CASE FOR TEAMWORK In 2012, OIG has identified the following focus areas for review: Whether payments to SNFs meet Medicare coverage requirements Whether SNFs have addressed certain Federal requirements related to quality of care, including whether SNFs developed plans of care based on assessments of ben planned for beneficiaries' discharges Safety and Quality of Post-Acute Care for Medicare beneficiaries (New) NFs compiliance with assessment and care planning requirements for residents receiving atypical antipsychotic drugs Oversight and enforcement against poorly performing NFs Hospitalizations of residents Nursing homes of processors of the control of the contr Nursing homes' emergency plans and emergency preparedness deficiencies cited by State surveyors $\,$ Medicare Part B Services During Non-Part A Nursing Home Stays (New) Implementation of Nursing Home Compliance Plans in accordance with OIG Guidelines (New) MAKING A CASE FOR TEAMWORK

### Effective March 25, 2011, newly enrolling providers will be categorized into one of three screening levels, based upon risk to the Medicare / Medicaid programs: Limited Moderate High ► Effective March 23, 2012, *currently enrolled providers* will be subject to the same screening requirements in order to maintain enrollment (unless revalidating enrollment, then treated as new provider for purposes of screening requirements) MAKING A CASE FOR TEAMWORK. SNFs have been designated by CMS as "limited risk" Screenings for "<u>limited risk</u>" providers by Medicare contractors will include: Verification that provider meets all applicable Federal regulations and State requirements License verifications, including licensure verifications across State lines for providers that obtain or maintain Medicare billing privileges as a result of State licensure as a result of State licensure Database checks on a pre- and post-enrollment basis to ensure that providers continue to meet the enrollment criteria for their provider type (i.e., SSN/TIN; OIG exclusion; death of owner, delegated official, or supervising physician) Screenings for "limited risk" Medicaid-only providers by Medicaid contractors are the same, however, State Medicaid agency is given discretion to independently designate risk levels to Medicaid-only providers PPACA mandates that state Medicaid agencies <u>must</u> exclude any individual or entity from participating in Medicaid If such individual or entity is terminated from Medicare or another state Medicaid program "for cause" which may include fraud, integrity or quality issues considered to a variety of the state of the s If such individual or entity owns, controls or manages an entity that (or if such entity is owned, controlled or managed by an individual or entity that): Has unpaid overpayments Is suspended, excluded or terminated from participation in Medicaid is suspended, excluded or terminated from participation in Medicaid from participation in Medicaid from participation in Medicaid Facilities must regularly check the online database for the list of providers and employees excluded from participation in the federal health programs and maintain records of all searches. OIG Exclusion List - http://exclusions.oig.hhs.gov/ NJ Exclusion List - http://nj.gov/njomig/disqualified/ MAKING A CASE FOR TEAMWORK

## As of June 29, 2010, the New Jersey Office of the Medicaid Inspector General was transferred to the Office of the State Comptroller – Medicaid Fraud Division. Fraud Division. MFD is comprised of approximately 49 full-time employees (including auditors, claim reviewers, investigators, physician specialists and nurses) → dedicated to fight fraud and abuse in the Medicaid program. Fiscal Integrity Unit consists of four sub-units: Audit - independently conducts audits and oversees state-contracted auditors. Data Mining - reviews anomalous claim reimbursement behavior of providers (submits findings to audit or investigation). Recovery & Exclusions - recovers overpayments and penalties identified by auditors and investigators. Third-Party Liability - recovers reimbursement from private insurers where services were inappropriately reimbursed by Medicaid (as payor of last resort). Investigative Unit investigates providers and recipients Regulatory Unit provides administrative, investigative and rule-making support to other MFD Unit, regotiate and monitor corporate integrity programs; review Medicaid regulations; and issue notices to the provider community. MAKING A CASE FOR TEAMWORK

#### ▶ In 2012, MFD has identified the following focus areas for review:

- Verifying that NFs have appropriately billed Medicare prior to Medicaid and if not, recover the Medicaid payment.
- Pursuing referrals from outside auditors on clinical or financial audits where auditors' work indicates fraud, waste or abuse may have occurred.
- Implementation of Recovery Audit Contractor (RAC) for fee-for-service and managed care providers by providing guidance as to types of audits to be conducted and follow up.

#### PPACA mandates Medicaid recovery audit contractors (RACs) programs to identify & recover overpayments. States must: Contract with RACs on a contingency basis (only from amounts recovered) RACs only paid upon collecting overpayments (or as otherwise designated by the state for identifying underpayments) RACs generally identify improper payments based upon non-covered services, medical necessity, incorrect coding and duplicate services RACs do not replace any existing State program integrity or audit initiatives

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Proposed regulations provide that RACs must report fraud / criminal activity to appropriate law enforcement officials

Risk of whistleblower actions under FCA by RAC contractors

Provide appeal process for adverse Medicaid RAC determinations

### PPACA included the enactment of the Elder Justice Act which establishes a federal elder justice program to prevent, detect, treat, intervene in and prosecute elder abuse, neglect, and exploitation and improve long term care, including:Establishment of the: Elder Justice Coordinating Council Advisory Board on Elder Abuse, Neglect and Exploitation National Training Institute for Federal and State surveyors Authorization of federal grants for: stationary and mobile forensic cer adult protective services improved staffing and staff training long-term care ombudsman program offsetting costs of electronic health record technology for eligible facilities Authorization of HHS study concerning federal nurse aid registry Mandatory reporting of suspected elder abuse crimes and employee protection from retaliation for such reporting. MAKING A CASE FOR TEAMWORK Federal law requires reporting of incidents occurring within facility to administrator and then report in accordance with state law. Now, each individual who is an owner, operator, employee, manager, agent or contractor (a "Covered Individual") of a long-term care facility that receives at least \$10,000 in annual federal funding under the Social Security Act must report any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. The mandatory report must be made to the Department of Health and Senior Services on behalf of the Secretary of HHS and at least one local law enforcement authority: If the suspected crime results in serious bodily injury, the mandatory report must be made immediately and in no event later than 2 hours after forming the suspicion. If the suspected crime does not result in serious bodily injury, the report must be made no later than 24 hours after forming the suspicion. suspicion. MAKING A CASE FOR TEAMWORK ► For the purposes of the Elder Justice Act reporting requirements: Crime is defined by the law of the applicable political subdivision "serious bodily injury" is defined as an injury: involving extreme physical pain involving substantial risk of death involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty requiring medical intervention such as surgery, hospitalization, or physical rehabilitation MAKING A CASE FOR TEAMWORK

#### ► The law does not specify the necessary mechanism for submitting the report to DHSS and law enforcement, nor does it specify the required contents of the report.

► Given the strict time limits for such mandatory reporting, such reports should likely be in the form of a facsimile, including, at a minimum, a description of the suspected crime, names of all covered individuals required to report and confirmation of the report to law enforcement.

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- Requires <u>annual notification</u> to all Covered individuals of the obligation to comply with the mandatory reporting requirements. Requires posting a sign (in a form to be, but not yet, specified by the Secretary) notifying employees that the facility is prohibited from:
  - ibiled from:
    discharging, demoting, suspending, threatening, harassing, or
    denying a promotion or other employment-related benefit to an
    employee, or in any other manner discriminating against an
    employee in the terms and conditions of employment because of
    lawful acts done by the employee; or

  - lawful acts done by the employee, or filing a complaint or a report against a nurse or other employee with the appropriate State professional disciplinary agency because of lawful acts done by the nurse or employee employee notification must also include a statement that an employee may file a complaint with the Secretary of HHS against a long-term care facility that violates the provisions of the Elder Justice Act and information with respect to the manner of filing such a

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#### Penalties for failing to report:

- Civil monetary penalties up to \$200,000 (or \$300,000 if the violation is deemed to exacerbate the harm to the victim)
- Potential exclusion from participation in all Federal health care programs
- Potential ineligibility for Federal funds in the event that a longterm care facility employs an excluded individual during the period of such exclusion.
- Penalties for retaliation:
  - Civil monetary penalties up to \$200,000
  - Possible exclusion from participation in Federal health care programs for a period of 2 years.

# Steps towards compliance: Determine whether facility receives at least \$10,000 in federal funding If applicable, review and revise existing policies, procedures and compliance programs to reflect new mandatory reporting requirements and consider whether to designate a single individual within the facility to be responsible for such reporting Educate all Covered Individuals concerning their mandatory reporting obligation (including consequences of "excluded individual" status for failure to report) and establish a plan for implementing annual notification to all such Covered Individuals Post (in a conspicuous location) a Retaliation Disclosure to Employees Look for future guidance and/or regulations from HHS on these reporting requirements / content of the mandated Retaliation Disclosure to Employees MAKING A CASE FOR TEAMWORK. Buchanan Ingersoll & Rooney PC

# Effective March 25, 2011, PPACA mandates new disclosure requirements for ownership or control interest → all Medicaid providers must disclose, in addition to the prior requirements with respect to ownership / control interest (i.e., name & address of any individual or entity with an ownership or control interest in the provider, as well as related parties): ■ DOB or SSN OR TIN of all individuals / entities with an

- DOB or SSN OR TIN of all individuals / entities with an ownership or control interest in the disclosing entity (or in any subcontractor in which the disclosing entity has a 5% or more interest), as well as the primary & all business addresses of corporate entities
- Name, address, DOB and SSN of any managing employee of the disclosing entity.

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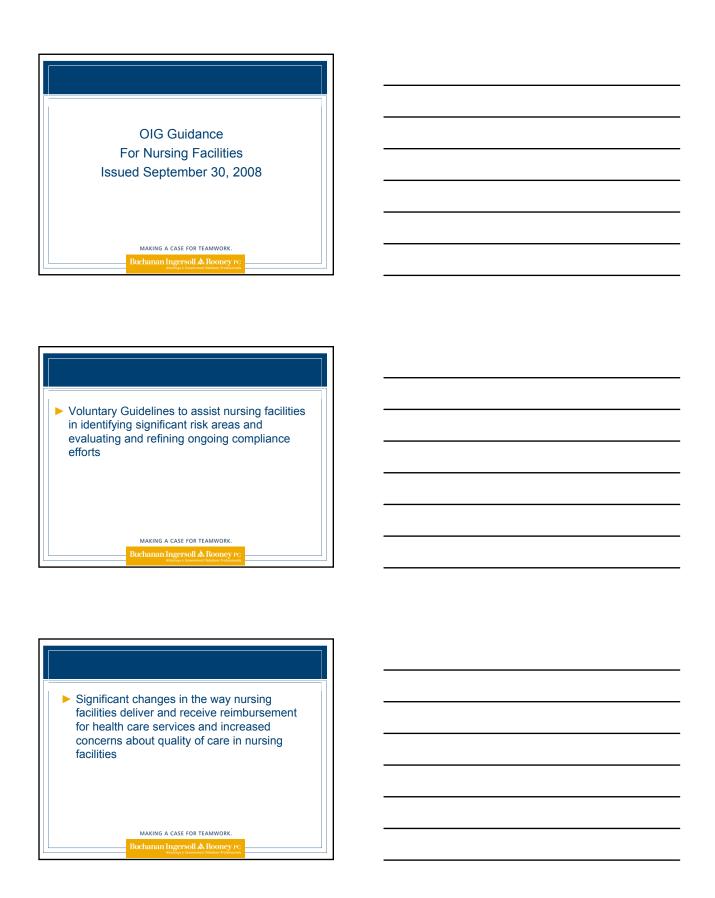
# Disclosures are required: Upon submission of the provider application Upon execution of the provider agreement Upon request of the Medicaid agency during the revalidation of enrollment process Within 35 days after any change in ownership

## PPACA also mandates NFs/SNFs to disclose additional PPACA also mandates NFs/SNFs to disclose additional information on ownership, including a description of the governing body and organizational structure and information regarding additional disclosable parties Pursuant to regulations proposed by CMS on May 6, 2011 (not yet final), an NF/SNF would be required to report upon enrollment and within 30 days of any change, the identity of and information on all of the following: Each member of the governing body of the facility (including name, title, & period of service for each member) Each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility (including name, title, & period of service of each such person or entity) Each additional disclosable party of the facility (including the organizational structure of each additional disclosable party of the facility & a description of the relationship of each such additional disclosable party to the facility and to one another) Finally, NFs/SNFs would also be required to certify as a condition of participation and payment that all of the above is, to the best of the facility's knowledge, accurate and current MAKING A CASE FOR TEAMWORK

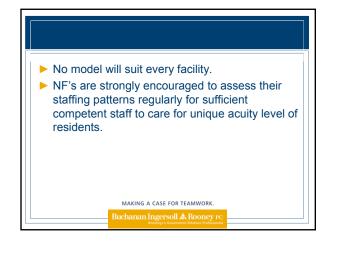
#### For the purposes of these reporting requirements, the following definitions apply: "Additional disclosable party" includes any person or entity who – Exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies / procedures for any of the operations of the facility, or provides financial / cash management services to the facility; Leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5% of the total value of such real property; or Provides management / administrative services, management / clinical consulting services, or accounting / financial services to the facility. "Managing employee" includes any individual, including a general manager, business manager, administrator, director, or consultant, who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

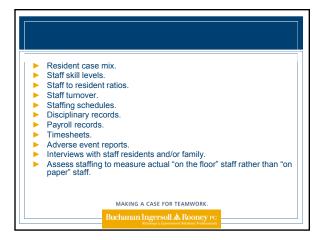
<b>&gt;</b>	For the purposes of these reporting requirements, the following definitions apply (cont.):			
	"Organizational structure" means, in the case of a:			
		•	<u>Corporation</u> – the officers, directors, & shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent	
		•	<u>Limited liability company</u> ("LLC") – the members & managers of the LLC including, as applicable, what percentage each member & manager has of the ownership interest in the LLC	
		•	General partnership – the partners of the general partnership	
		•	<u>Limited partnership</u> ("LP") – the general partners & any limited partners of the LP who have an ownership interest in the LP which is equal to or exceeds 10 percent	
		•	<u>Trust</u> – the trustees of the trust	
		•	Individual - contact information for the individual	
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### PPACA mandates that NFs/SNFs must have a compliance & ethics program in operation that is effective in preventing and detecting criminal, civil, and administrative violations and in promoting quality of care, consistent with regulations developed by HHS and OIG by March 23, 2013, as condition of Medicare / Medicaid enrollment HHS has not yet finalized regulations for mandatory compliance & ethics programs As of February 2011, HHS indicated that it would be issuing a proposed rule concerning the mandatory compliance & ethics program is a later date' Currently, New Jersey does not require Medicaid providers to have a compliance program; yet encourages Medicaid providers to have such a program in place, especially if payments from the Medicaid program exceed \$100,000 per year. Facilities are best served to have compliance & ethics program in place that meet existing OIG guidance and that may be modified to meet the new requirements once issued. Existing Guidance: OIG Compliance Program Guidance for NFs (March 16, 2000) OIG Supplemental Compliance Program Guidance (Sept. 30, 2008) MAKING A CASE FOR TEAMWORK Fundamental Elements of a Compliance Program Written policies and procedures Compliance professionals (i.e., Chief Compliance Officer & Committee) Must use due care not to delegate substantial discretionary authority to individuals whom the facility knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations Effective training of all executives and employees Effective communication process / mechanism for reporting (allowing for anonymous and good faith reporting of potential compliance issues as they are identified) Internal monitoring (internal / external audits) Enforcement of standards / disciplinary policies for failing to report suspected problems; engaging in non-compliant behavior, encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior. Prompt response / corrective actions MAKING A CASE FOR TEAMWORK FERA and PPACA also demand a proactive approach with respect to compliance and ethics programs Diligent contract management Ensure no payments to physicians absent signed writing (unless employee) Capture when agreements expire Documentation of all payments passing between facility and physicians Adequate accounting procedures Adequate accomming processing Adequate monitoring / auditing of billings, payments, medical necessity, quality of care (to promptly identify overpayments) Potential development of specialized compliance committee Involvement of key players: general counsel, compliance officer, administration, accounting and those responsible for physician contracting Ensure standardized process for reporting, investigation and resolution of potential compliance issues Ensure prompt resolution with complete documentation of all measures to resolve issue MAKING A CASE FOR TEAMWORK







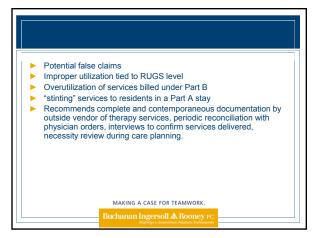


# Interdisciplinary and comprehensive approach. Involving residents and responsible parties. Involvement of attending physicians in meetings or otherwise. Avoid risk of inadequate care, medically unnecessary or medically inappropriate services. MAKING A CASE FOR TEAMWORK. Buchanan Ingersoll & Rooney IC.

## ► Stresses role of consulting pharmacist. Processes to advance resident safety, minimize adverse drug interaction and correct irregularities in resident's drug regimen. MAKING A CASE FOR TEAMWORK. ► Avoid chemical restraint ► Avoid unnecessary drug usage. ► Collaboration between attending physician, medical director and consulting pharmacist to analyze the outcomes MAKING A CASE FOR TEAMWORK. Avoid mistreatment, neglect and abuse of residents Staff to resident Resident to resident Injuries of unknown origin Proper investigation and reporting

Education on confidential reporting opportunities
Encourages specialized training on recognizing abuse and neglect
Staff screening and background checks and proper orientation and
competency evaluation
Goal: Prevent, investigate and respond appropriately



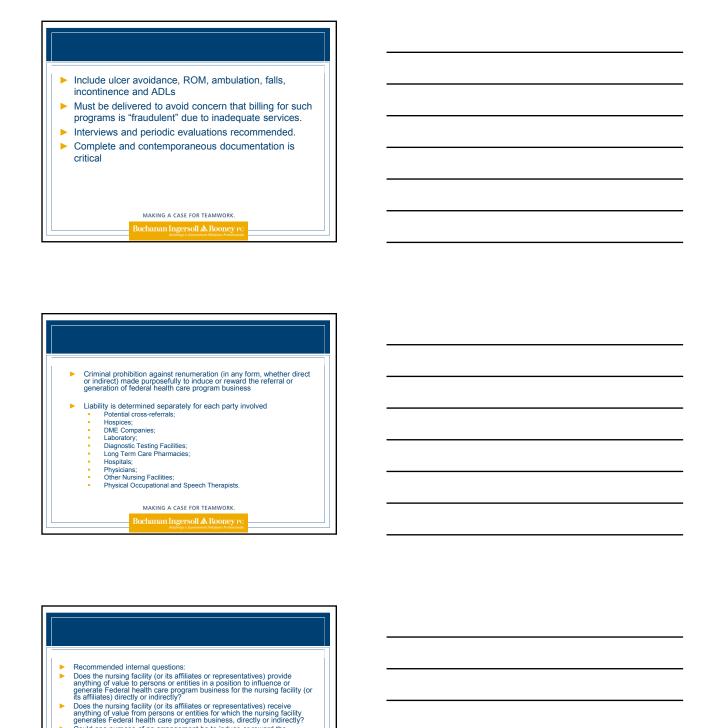


No payment may be made for services or items furnished by an excluded individual or entity

OIG strongly advised NF's screen all owners, officers, directors, employees, contractors and agents against OIG's list of excluded individuals/entities on OIG website and US General Services Administrations excluded parties list system

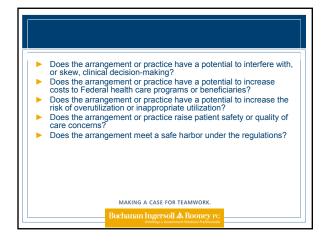
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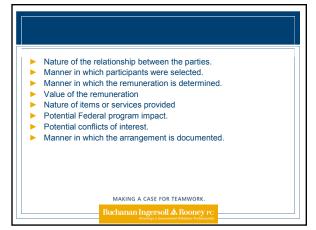
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Could one purpose of an arrangement be to induce or reward the generation of business payable in whole or in part by a Federal health care program?

Importantly, under the anti-kickback statute, neither a legitimate business purpose for an arrangement nor a fair-market value payment will legitimize a payment if there is also an illegal purpose (i.e., inducing Federal health care program business).







# Services contracts for nonphysician services Periodically review contractor and staff arrangements to ensure that: (i) There is a legitimate need for the services or supplies; (ii) the services or supplies are actually provided and adequately documented; (iii) the compensation is at fair-market value in an arm slength transaction; and (iv) the arrangement is not related in any manner to the volume or value of Federal health care program business. Implement policies and procedures to minimize the risk of improper pharmaceutical decisions tainted by kickbacks. Drug switches should only be in best interest of resident. MAKING A CASE FOR TEAMWORK. Buchanal Ingersoll & Rooney PC AMERICA CASE FOR TEAMWORK.

# Physician Services Medical director oversight but no compensation for referrals Fair market value, bona fide services received No excessive number of medical directors Use personal services safe harbor whenever possible MAKING A CASE FOR TEAMWORK. Buchanan Ingersoll & Rooney re

# Discounts Price reductions permitted when in the form of a price reduction, properly documented and disclosed as such on cost report. MAKING A CASE FOR TEAMWORK. Buchanan Ingersoll & Rooney Ro

# No "swapping," i.e. accepting a low price from a supplier or provider on an item or service covered by the nursing facility's Part A per diem payment in exchange for the nursing facility referring to the supplier or provider other Federal health care program business, such as Part B business excluded from consolidated billing, that the supplier or provider can bill directly to a Federal health care program. the supplied to provide can find include to a reducial relatificate program. Appropriate question to ask is whether the discount is tied or linked, directly or indirectly, to referrals of other Federal health care program business. Suspect arrangements include below-cost arrangements or arrangements prices lower than the prices offered by the supplier or provider to other customers with similar volumes of business, but without Federal health care program referrals. Other suspect practices include, but are not limited to, discounts that are coupled with exclusive provider agreements and discounts or other pricing schemes made in conjunction with explicit or implicit agreements to refer other facility business. MAKING A CASE FOR TEAMWORK. Hospice arrangements ce arrangements See new hospice conditions of participation for guidance on hospice interactions with skilled nursing facilities. A hospice offering free goods or goods at below-fairmarket value to induce a nursing facility to refer patients to the hospice: A hospice paying room and board payments to the nursing facility in excess of what the nursing facility would have received directly from Medicaid had the patient not been enrolled in hospice. Any additional payment must represent the fair-market value of additional services actually provided to that patient that are not included in the Medicaid daily rate; A hospice paying amounts to the nursing facility for additional services that Medicaid considers to be included in its room and board payment to the hospice; MAKING A CASE FOR TEAMWORK

- A hospice paying above fair-market value for additional services that Medicaid does not consider to be included in its room and board payment to the nursing facility;
- A hospice referring its patients to a nursing facility to induce the nursing facility to refer its patients to the hospice;
- A hospice providing free (or below fair-market value) care to nursing facility patients, for whom the nursing facility is receiving Medicare payment under the SNF benefit, with the expectation that after the patient exhausts the SNF benefit, the patient will receive hospice services from that hospice;
- A hospice providing staff at its expense to the nursing facility.

