Hot Topics in Compliance
Recent Developments and What to Expect in the Year Ahead

New Jersey HFMA
March 8, 2016

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Overview

• Current regulatory and enforcement environment

• Hot topics
  – Physician Risk Areas
  – Recent Settlements
  – OIG Work Plan
  – Provider-based Status
  – Payment Models and Compliance Risks
  – Fair Market Value and Implications

• A Look at What’s Coming

• Meaningful Use

• RAC Updates
Current Regulatory Environment
Top 10 Health Care Fraud Issues in 2016
BNA’s Health Care Fraud Report

According to BNA’s Health Care Fraud Report, the following are the top issues to watch in 2016:

1. Increase in False Claims Act cases related to the Stark law and anti-kickback statute.
2. Increased enforcement against corporate executives and management.
3. The release of the 60-day final rule.
4. The release of new regulations revising fraud and abuse laws.
5. Increased civil monetary penalty enforcement.
6. Focus on specialty pharmacy fraud.
7. Aligning alternate payment models with the Stark law and the anti-kickback statute.
8. Use of statistical sampling to support False Claims Act cases.
9. Kickbacks to pharmaceutical and medical device manufacturers.
10. Attention on defective medical devices.

Sources: http://www.bna.com/outlook-2016-false-n57982066278/
HCCA Compliance and Ethics Hot Topics Survey

“What are the hot topics in compliance you will be focusing on in 2016?”

Cyber
Leveraging Compliance Practices with Business Practices
Ethical Culture
Effective Internal Investigations
Third Party Risk
Increasing the Compliance Team Skillset
Social Media
Small Media
International Compliance Risk

HCCA Compliance and Ethics Hot Topics for 2016
Federal Enforcement Initiatives
Fiscal Year (FY) 2015 in review

Medicare questionable claims and payments

- Medicare inappropriately paid $20 million for chiropractic services that lacked a primary diagnosis covered by Medicare
- OIG identified questionable billing by 1,400 pharmacies that may indicate fraudulent activity
- 1,726 providers billed $768 million for ophthalmology services in 2012, of which $171 million was for services associated with measures on which these providers have demonstrated questionable billing

Rise in OIG Criminal and Civil Actions

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Whistleblower Activity Continues

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Fraud Prevention System

The Fraud Prevention System applies predictive analytic technology to claims prior to payment to identify aberrant and suspicious billing patterns

- In its third year of implementation, the Fraud Prevention System:
  - Recorded $133.2 million of actual and projected savings
  - Results are a $2.84 to $1 return on investment
  - Additional $454 million in unadjusted savings that the FPS identified.

Federal Enforcement Initiatives
Fiscal Year (FY) 2015 in review
HEAT (Healthcare Fraud Prevention and Enforcement Action Team)

During FY 2015, Strike Force efforts resulted in the filing of charges against 232 individuals or entities, 225 criminal actions, and over $357.8 million in investigative receivables.

June 2015: A nationwide takedown led by the Medicare Fraud Strike Force resulted in charges against 243 defendants, including doctors, nurses, and other licensed medical professionals which potentially involved over $700 million in false claims. More than 44 of the defendants were charged with fraud related to the Medicare part D.

June 2015: Southern Texas Strike Force team efforts led to conviction of former president of Riverside General Hospital, his son and co-conspirators sentenced to a combined 117 years of incarceration for their roles in a $158 million Medicare fraud scheme. The scheme involved false claims to Medicare for partial hospitalization program (PHP) services that were medically unnecessary, not eligible for reimbursement, and were not provided.
# New Corporate Integrity Agreements

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<td>Columbus Regional Healthcare System, Inc.</td>
<td>09/03/2015</td>
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Hot Off the Press
Physician Risk Areas and Recent Activity
Health care organizations must ensure professional services agreements are in compliance with applicable laws.

Laws are broad in reach and complex in nature, requiring consistent policies and procedures to address risks.


Stark, Anti-kickback, Civil Monetary Penalties, and False Claims Act may all apply.
Doctors must be careful when entering into payment agreements such as medical directorships and their compensation must reflect fair market value for services provided.

Federal Agencies increasingly pursuing allegations against individual doctors, as opposed to just hospitals and organizations that pay them.

Reminds physicians that they are also accountable for arrangements that violate anti-kickback and STARK laws.

Third fraud alert in three years.
In 2013: OIG issued a fraud alert about physician-owned device distributorships
In 2014: issued a fraud alert about lab payments to physicians
Implications for Provider Arrangements with Healthcare Professionals (HCPs)

- If a violation of Stark or AKS occurs, referrals are inappropriate and therefore should not have been billed (FCA violation).
- If the claims were billed and payment was made for them, then it falls under FCA related to overpayment.
- If an individual or entity presents or causes to be presented a claim to a Federal Healthcare program that the person knows or should know is for an item or service that was not provided as claimed or is false or fraudulent, they are liable and subject to a CMP.
Compliance Risk Areas for Physician Financial Arrangements

**Process & Policy Issues**
- Lack of formalized written policies and procedures
- Policies not current, updated, or comprehensive
- Fragmented processes throughout the system
- Technical violations such as lack of signature
- No documentation of review and approval according to hospital policy

**Payment Issues**
- Payment made for a service not described or included in the contract
- Payment is made to a party other than the actual contract party
- Payment is not reviewed and approved, or is made without a written agreement
- Payment is made after contract has expired

**Database Issues**
- No means to monitor or control physician arrangements
- Systems do not integrate with workflow
- Multiple databases and systems
- Incomplete, inaccurate database
- Missing supportive documentation
Deeper Dive on Some Recent Settlements
Physician Arrangements
Adventist Health System, $118.7 Million settlement (Sept ‘15)

- Federal whistle-blower lawsuit that claimed its clinics provided excessive compensation to physicians for referrals
- Whistleblower were three former hospital employees including a risk manager and a compliance officer
- Case centered upon incentives paid to physicians for referrals
- Adventist was not required by OIG to enter a CIA as it believes that the provider’s current compliance program already is effective enough that it would prevent such issues from arising in the future.
Physician Arrangements and False Claims

North Broward Hospital District, $69.5 Million settlement (Sept ‘15)

• Whistle-blower lawsuit that claimed that doctors were employed at levels beyond fair market value based in part on referrals to Broward Health Systems and Clinics

• Whistle-blower also alleged that this lead to submission of false claims to government in violation of False Claims Act

• Whistleblower was a physician (2010) and received $12M as reward

• Signed Corporate Integrity Agreement
  http://oig.hhs.gov/fraud/cia/agreements/North_Broward_Hospital_District_08312015.pdf
    – Repayment of overpayments
    – Establish a Compliance Program
    – 5 year commitment
Physician Arrangements in the Headlines (cont.)

“Tuomey will pay U.S. $72.4 million to duck $237 million False Claims verdict”

• Tuomey Healthcare System has agreed to settle with the government for $72.4 million—less than a third of the $237 million that a federal appeals court said it would have to pay for illegal compensation arrangements with doctors.

• The sum required by the verdict would otherwise have been the largest levied against a community hospital and would have exceeded the Sumter, S.C., system’s annual revenue.

• In 2013, a federal jury concluded that Tuomey violated the False Claims Act by submitting tens of thousands of illegal claims to Medicare. The jury found that Tuomey paid doctors in ways that rewarded them financially for referring patients to the hospital in violation of the Stark law, tainting the Medicare claims. A federal appeals court upheld that decision in July.

• Before agreeing to settle the case, Tuomey had already lost three times in federal court.

Source: http://www.modernhealthcare.com/article/20151016/NEWS/151019923
Physician Arrangements in the Headlines (cont.)

“Manhattan U.S. Attorney Settles Civil Fraud Claims Against Westchester Medical Center Arising From Its Violations Of The Anti-Kickback Statute And The Stark Law”

- Department of Justice, Thursday, May 14, 2015

• Westchester Medical Center has agreed to pay the federal government $18.8 million for its alleged violation of the Anti-Kickback Statute and Stark Law

• The government alleged WMC advanced funds to Cardiology Consultants of Westchester, a cardiology practice formerly operating on WMC's campus. The funds were allegedly used to open a cardiology practice for the purpose of generating referrals to the hospital. The complaint further alleged WMC allowed the cardiology practice to use WMC's fellows in its office free of charge, according to the DOJ.

• Dan Bisk, WMC's former compliance officer, originally brought the lawsuit under the qui tam, or whistle-blower, provision of the False Claims Act

Physician Arrangements in the Headlines (cont.)

“California Hospital to Pay More Than $3.2 Million to Settle Allegations That It Violated the Physician Self-Referral Law”

- Department of Justice, Friday, January 15, 2016

- Tri-City Medical Center, a 397-bed hospital in Oceanside, Calif., has agreed to pay the federal government more than $3.2 million to resolve allegations it violated Stark Law and the False Claims Act.

- The settlement resolves allegations that Tri-City Medical Center entered into 97 financial arrangements with physicians and physician groups that did not comply with Stark Law. Five of the arrangements were with the hospital's former chief of staff and were entered into between 2008 and 2011. Ninety-two of the arrangements, which were entered into from 2009 until 2010, were with community-based physicians and practice groups.

- The health system also allegedly compensated individual physicians based on their referrals of diagnostic tests to these clinics.

- "Patient referrals should be based on a physician's medical judgment and a patient's medical needs, not on a physician's financial interests or a hospital's business goals."
  - U.S. Attorney Laura E. Duffy

OIG Work Plan

FY 2016
OIG 2016 Work Plan

OIG added several new compliance risk areas to the FY 2015 plan:

- **Medicare payments during MS-DRG payment window**
  OIG will review Medicare payments to acute care hospitals to determine whether certain outpatient claims billed to Medicare Part B for services provided during inpatient stays were allowable and in accordance with the Inpatient Prospective Payment System.

- **Hospitals’ use of outpatient and inpatient stays under Medicare’s two-midnight rule**
  OIG will determine how hospitals’ use of outpatient and inpatient stays changed under Medicare’s two-midnight rule, as well as how Medicare and beneficiary payments for these stays changed, by comparing claims for hospital stays in the year prior to the effective date of the two-midnight rule to stays in the year following the effective date of that rule.

- **Medicare oversight of provider-based status**
  OIG will determine the number of provider-based facilities that hospitals own and the extent to which CMS has methods to overseer provider-based billing. OIG will also determine the extent to which provider-based facilities meet requirements described in 42 CFR § 413.65 and CMS Transmittal A-03-030 and whether there were any challenges associated with the provider-based attestation review process.
Some hospital audit activities to highlight that are continuing to be examined following the FY 2015 plan are:

1. **Reconciliations of outlier payments**
   Medicare outlier payments to hospitals will be reviewed to determine whether CMS performed necessary reconciliations in a timely manner to enable Medicare contractors to perform final settlement of the hospitals’ associated cost reports.

2. **CMS validation of hospital-submitted quality reporting data**
   OIG will determine the extent to which CMS validated hospital inpatient quality reporting data. Accuracy and completeness of this data is important because CMS uses it for the Hospital Value-Based Purchasing Program and the Hospital-Acquired Condition Reduction Program.

3. **Comparison of provider-based and freestanding clinics**
   OIG will review and compare Medicare payments for physician office visits in provider-based clinics and freestanding clinics to determine the difference in payments made to the clinics for similar procedures and assess the potential impact on Medicare of hospitals’ claiming provider-based status for such facilities.

Source: Fiscal Year 2016 HHS OIG Work Plan
OIG 2016 Work Plan (cont.)

OIG will continue to examine other Medicare Hospital Audit compliance risk areas that were the focus of earlier plans, which include:

- Medicare costs associated with defective medical devices
- Analysis of salaries included in hospital cost reports
- Inpatient claims for mechanical ventilation
- Duplicate graduate medical education payments
- Indirect medical education payments
- Outpatient dental claims
- Nationwide review of cardiac catheterizations and endomyocardial biopsies;
- Long-term care hospitals - adverse events in post-acute care for Medicare beneficiaries
- Hospitals' electronic health record system contingency plans

Source: Fiscal Year 2016 HHS OIG Work Plan
Other Provider and Supplier Compliance Risk Areas:

- Histocompatibility laboratories - supplier compliance with payment requirements
- National Background Check Program for long-term care employees;
- Home health prospective payment system requirements;
- Competitive bidding for medical equipment items and services
- Ambulatory surgical centers - payment system
- End-stage renal disease facilities-payment system for renal dialysis services and drugs
- Ambulance services - questionable billing, medical necessity and level of transport
- Anesthesia services - payments for personally performed services
- Imaging services - payments for practice expenses
- Selected independent clinical laboratory billing requirements
- Annual analysis of Medicare clinical laboratory payments
- Physical therapists - high use of outpatient physical therapy services

Source: Fiscal Year 2016 HHS OIG Work Plan
Provider Based Status
What is provider-based status and how does it impact my facility?

• Provider-based status signifies a relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility
• Provider-based status affects the manner in which services are billed to Medicare and Medicaid
  • The location bills as part of the main provider to which it is provider-based:
    • The professional claim (for physician services) is billed on CMS 1500 with the appropriate site of service (21 for hospital inpatient or 22 for hospital outpatient)
    • The technical claim (for hospital services) is billed on UB-04
Bipartisan Budget Act of 2015

No new off campus hospital outpatient departments?

• Signed into law by President Obama on November 2, 2015

• Beginning January 1, 2017, established a prohibition on *newly* created off-campus hospital outpatient departments from receiving provider-based Medicare reimbursement for non-emergency services

• Revises the hospital Outpatient Prospective Payment System (OPPS)
  o Off campus facilities prohibited from reimbursement under the OPPS
  o Services provided by off campus facilities will be reimbursed under Medicare physician fee schedule or other applicable reimbursement methodology

• **Exemptions:** “dedicated emergency departments” and existing off campus hospital departments
  o Existing off campus hospital departments defined as “billing under [the hospital OPPS] with respect to covered [outpatient department] services furnished prior to the date of the enactment of this paragraph.”
## Provider Based Status in the News

### Newer Developments

- On Friday, February 5, 2016, members of Congress from the House Energy & Commerce Committee, and the Energy & Commerce Health Subcommittee, issued a letter requesting formal feedback on policies related to the enactment of the PBD HOPD provision and recommendations for how the House Energy & Commerce Committee should approach site-neutral payments going forward.

- Letter highlighted recommendations from the Medicare Payment Advisory Commission (MedPAC) and findings from a Government Accountability Office (GAO) report in favor of site-neutral payments.
  - Equalizing Medicare payment rates across settings for Evaluation and Management (E&M) office visits;
  - Aligning payment rates between Hospital Outpatient Departments (OPDs) and physicians' offices for other types of ambulatory services;
  - Aligning payment rates between OPDs and physicians' offices for cardiac imaging services; and,
  - Equalizing payment rates between OPDs and Ambulatory Surgery Centers for certain ambulatory procedures.
Provider Based Status in the News

Newer Developments

- On the same day, the American Hospital Association (AHA) sent a letter to Andy Slavitt, Acting Administrator of the Centers for Medicare and Medicaid Services (CMS), urging the agency to implement policy so that:

  - Items and services provided in the same facility as a dedicated emergency department would fall under the exception to the site-neutral payment
  
  - HOPDs that rebuild or relocate to a new facility would be exempt from the change in policy so long as they were billing the OPPS prior to November 2, 2015
  
  - HOPDs that change or expand the type of outpatient services they offer would still be eligible for reimbursement through OPPS
  
  - A change in ownership of an HOPD would not nullify the facility’s grandfather status
  
  - Medicare payment for facilities affected by the change in policy would include both a facility fee and a professional fee
  
  - There would be minimal disruption to billing and payment for all providers and payment systems involved
Payment Models and Compliance Risks
Types of value and risk-based payment models

Center for Medicare and Medicaid Innovation (CMMI) has spearheaded 62 demonstration projects to pilot linking payment to performance.

Accountable Care Organizations (ACOs)

- ACOs are groups of health care providers that agree to share responsibility for coordinating lower-cost, higher-quality care for a group of patients.
- There are currently six ACO demonstrations, with two ongoing.

Bundle payments

- Bundled payments are fixed amount paid to health care providers for a bundle of services or for all the care that a patient is expected to need during a period of time.

http://innovation.cms.gov/initiatives/#views=models
ACO models

These models will increase in significance in the coming years - understanding them now is critical to future growth for providers and plans.

Congress created the Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs.

The payment models being tested in the first two years of the Pioneer ACO model are a shared savings payment policy with generally higher levels of shared savings and risk for Pioneer ACOs than levels currently proposed in the Medicare Shared Savings Program.

Each participating ACO gets an upfront shared-savings payment in hopes to allow for better quality and maintenance of care for the Provider by giving them more capital to work with.

It will allow these provider groups to assume higher levels of financial risk and reward than are available under the current Pioneer model and Shared Savings Program (MSSP). The goal of the model is to test whether strong financial incentives for ACOs can improve health outcomes and lower expenditures for Original Medicare fee-for-service (FFS) beneficiaries.

First disease-specific Accountable Care Organization (ACO) model designed by CMS to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with end stage renal disease.

http://innovation.cms.gov/initiatives/#views=models
## Compliance risks

New models of payment create new insurance, utilization and performance compliance risks that must be addressed.

### Accountable Care Organizations

- Burden of care is on all providers within the organization
  - Depending on the ACO model, some organizations are taking on nearly complete financial risk
- In an ACO, healthcare organizations are responsible for patient populations and a patient's transition through the continuum of care
- As an ACO, the healthcare organization will be responsible for decreasing admissions and in effect potentially decreasing their revenues, unless they simultaneously increase their market share and patient population

### Bundle payments

- Bundles only impact providers involved in the bundle
- Bundled payments are only considered with an episode of care
- With a bundled payment, the organization is only concerned with the risk associated with the treatment associated with the bundled treatment
Understanding related laws/requirements
Federal guidelines are in place to protect all stakeholders involved.

CMS oversight

- Goal is for 50% of its Medicare payments to be made through alternative payment models by 2018, with an interim goal of 30% by 2016.

General compliance still applies but the law allows for payments based on value and quality

Laws & regulations

- False Claims Act
- Stark Law
- Federal Anti-Kickback Statute

Law inherently tries to address provider self interest in order to manage utilization of care

Applies to both bundle payment and ACOs that take federal funding

Meeting CMS quality measure goals

There are 33 measures across 6 categories that CMS will look for to determine reimbursement.

- **Safety**: Where care doesn't harm patients
- **Effectiveness**: Where care is evidence-based and outcomes-driven to better manage diseases and prevent complications from them
- **Smooth transitions of care**: Where care is well-coordinated across different providers and settings
- **Transparency**: Where information is used by patients and providers to guide decision-making and quality improvement efforts, respectively
- **Efficiency**: Where resources are used to maximize quality and minimize waste
- **Eliminating disparities**: Where quality care is reliably received regardless of geography, race, income, language, or diagnosis
How do quality measures impact your organization?

When value and quality are hallmarks of the new payment models, the impact to your organization will be based off your performance.

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<th>Reputation</th>
<th>Financial</th>
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<td>• They represent evidence-based patient care guidelines</td>
<td>• Because data is publicly reported, shared and used in national rankings, it influences public perception of the quality of care provided</td>
<td>• Where performance is tied to reimbursement</td>
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<td>• Studies show patients recover more quickly and with fewer complications</td>
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<td>• The public can use performance data to make an informed decision about where to go for care</td>
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<td>• They assess the ability to provide the right care to the right patient at the right time</td>
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Fair Market Value and Implications
Fair Market Value implications for related-party services agreements

• On July 20, 2015, the Office of the Inspector General (OIG) issued Advisory Opinion No. 15-101, in which a health system and a related psychiatric hospital sought an advisory opinion related to a non-clinical personnel lease and management services arrangement.

• The health system had proposed that the compensation be set at cost to provide the services (salaries, benefits, and overhead) without any mark-up or administrative fee.

• The health system attested the payment would not vary with volume or value of referrals; however it was unable to set the fee in advance because operational and management needs may change over the term of the agreement.

• The OIG concluded the proposed arrangement could generate prohibited remuneration since the rate may be below Fair Market Value.

Valuation Models- Income Based vs Market Based

Income Based Approach

• All valuation is about future cash flow, not historical cash flow, and a valuation multiple that is based upon the risk of that future cash flow
• Risk is based upon empirical evidence and judgment
  • Underestimating risk overstates value
  • Overestimating risk understates value
• Valuators without detailed healthcare industry knowledge typically underestimate risk
• Two major considerations:
  • Risk Assessment
  • Growth Rates

Market Based Approach

• Market Approach is premised on finding comparable data and applying it to what you are trying to value
• Generic Valuation
  • Comparable transactions
  “Usually the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition…” - The Code of Federal Regulations of the United States of America
• Business Valuation
  • Guideline Publicly Traded Company Method
  • Merged and Acquired Company Method
• Direct Market Method
  • Stark regulations create special rules – what is relevance of a transaction in Ohio to a proposed transaction in Texas?
  • Common source of valuation errors

Source: Establishing Fair Market Value under the Anti-kickback and Stark Laws
Latham & Watkins LLP, San Diego, CA
A Look at What’s Coming
DOJ to Issue Sample Questions on Corporate Compliance

February 9th, 2016

The Department of Justice plans to release a set of questions in the coming weeks that companies implicated in wrongdoing can expect to be asked by investigators concerning their compliance programs.

DOJ plans to publicize the list of sample questions to give the public and companies an idea of what investigators and compliance experts are concerned with. The list will be continually updated based on experiences officials have with companies.

Fraud Section hopes to implement a policy of trying to resolve within a year cases in which companies self-report violations, assuming there are no individual criminal prosecutions or the need for extended monitoring.

“We are not going to be looking for specific answers” or for companies to “check boxes,” “We don’t have a cookie-cutter view when it comes to compliance.”
DOJ to Issue Sample Questions on Corporate Compliance

February 9th, 2016

Message that officers and directors send to lower level employees

Looking at whether the company has disciplined or fired anyone for wrongdoing and if any bonuses have been reduced or clawed back

Compliance should be a responsibility shared among management and the business units

People who know the daily ins-and-outs of operations

Compliance experts are necessary for an effective program

DOJ will look to see that a company’s compliance personnel has the proper background.

Source: http://www.bna.com/doj-soon-issue-n57982067421/
CMS 60 Day Rule

February 12th, 2016

• Medicare and Medicaid overpayments be reported and returned by the latter of 60 days after the date on which the overpayment was identified, or the date any corresponding cost report is due (if applicable).

• Clarifies that the identification of an overpayment occurs when the provider or supplier has or should have, through the exercise of reasonable diligence, determined that it has received an overpayment and quantified the amount of the overpayment due to be returned.

• Establishes that Medicare providers and suppliers are subject to a six year lookback period.

Source: DEPARTMENT OF HEALTH AND HUMAN SERVICES, Centers for Medicare & Medicaid Services, 42 CFR Parts 401 and 405, Medicare Program; Reporting and Returning of Overpayments
Providers and suppliers who identify an overpayment must assess the scope of liability during a six year lookback period, and must report and return any overpayment in a timely manner.

Providers and suppliers will want to review their compliance programs to ensure that they contain policies and procedures to monitor for overpayments, and promptly return them once they are identified.

Periodic audits should be completed to ensure that these policies and procedures are being implemented.

Working with legal counsel may help establish whether a particular set of facts actually constitutes an overpayment and if so, can help determine the applicable lookback period.

Should now be on notice that the government expects them to proactively monitor for, and investigate credible information about, any potential overpayments.
Meaningful Use and EHRs
Meaningful Use Industry Update

CMS recently released key statistics that resulted from the adoption of EHRs through MU requirements. **As of the end of December 2015:**

- **Over $31.3 billion** has been issued in Medicare and Medicaid incentive payments.
- **95 percent** of all eligible and Critical Access hospitals have demonstrated meaningful use of certified health IT.
- **56 percent** of all office-based physicians have demonstrated meaningful use of certified health IT.

Meaningful Use – In the News

• Penalties for failure to achieve Meaningful Use in 2014 took effect January 1 “Nearly 209,000 doctors and other health care providers will receive 2 percent cuts in their Medicare payments in 2016 for failing to meet meaningful use standards in 2014”¹

• With MACRA on the way in 2016, expect changes to the Meaningful Use program, but it isn’t going away. “The approach to meaningful use under MACRA won’t happen overnight” ²

• Congress passes bill to streamline hardship application process. “A giant step in supplying relief to the provider community” ³

Sources: ¹http://www.healthcareitnews.com/news/209000-organizations-pay-medicaid-penalties-missing-meaningful-use-requirements
²https://blog.cms.gov/2016/01/19/ehr-incentive-programs-where-we-go-next/
Meaningful Use Audit Landscape

• CMS is targeting approximately 10% of all providers for audit in a given year. All aspects of the attestation are subject to audit, as Meaningful Use is an “all-or-nothing” program.

• CMS began pre-payment audits in January 2013 after pressure from GAO and OIG. OIG has added elements of Meaningful Use to their work plan for fiscal year 2014.

• CMS audits require supporting documentation to be provided to the auditor to validate the submitted attestation data.

• Audits to date have typically requested the following information:
  – Proof of ownership of certified EHR (i.e. vendor letter, license agreement, etc.)
  – Explanation of what locations the EP practices at and whether they utilize CEHRT
  – Meaningful Use reports for Core and Menu measures
  – Evidence of the completion of the Security Risk Analysis
  – Evidence of compliance with Public Health Measures

“Non-compliance with the Security Risk Analysis measure is the top reason providers fail Meaningful Use audits” - Elizabeth Holland, CMS

Source: EHR Incentive Programs Supporting Documentation for Audits and EHR Incentive Programs Audit Overview
Meaningful Use & MACRA

• On April 14, 2015, President Obama signed the Medicare Access and CHIP Reauthorization Act (MACRA) into law –definitively repealing the troubled Sustainable Growth Rate (SGR) formula.

• MACRA
  – Replaces SGR
  – Consolidates Physician Quality Reporting System (PQRS), Value Based Modifier (VBM) and Meaningful Use of Electronic Health Records (EHR MU) into The Merit-Based Incentive Payment System (MIPS).
  – Alternatively, providers can choose to use Alternative Payment Models (APM)

• MIPS: Establishes a single score on a per physician basis versus continuing the fragmented three-part performance evaluation and penalty programs that exists under current law.
  – Quality
  – Resource use
  – Clinical practice improvement
  – Meaningful use of certified EHR technology

• APM: provides a 5% annual bonus payment to physicians who are participating in alternative payment models and it exempts them from participating in the Merit-Based Incentive Payment System.
Meaningful Use & MACRA
Compliance Implications

CLAIM EDITS AND INTEROPERABILITY

CMS to establish automated claim edits that would identify payments made for services provided to individuals who are incarcerated, deceased or not lawfully present in the United States and ineligible for coverage. Any improper payments identified through these edits must be recouped, either through RAC audits or other recovery activities. The Act also requires CMS to specify incentives that would encourage states to participate in a data match and data mining program for Medicaid.

IMPROPER PAYMENT OUTREACH AND EDUCATION

Each regional Medicare Administrative Contractor (MAC) will establish an improper payment outreach and education program. The MAC must provide every provider and supplier with a quarterly report reflecting its most frequent and expensive payment errors and also provide each provider and supplier with specific instructions on how to correct or avoid those errors.

THE SENIOR MEDICARE PATROL

Congress has required CMS to develop a plan to revise the incentives for encouraging individuals to report Medicare fraud and abuse and to develop a public awareness and education campaign to publicize the Senior Medicare Patrols. CMS must recommend ways to enhance the rewards for reporting individuals, include rewards based on information that leads to an administrative action, and extend the incentive program to Medicaid.
MACRA Payment Timeline

April – June 2015
Eligible professionals who participate in Medicare will continue to enjoy the pre-April 1 payment rates, averting a 21 percent pay cut.

June 2015-December 2015
Physician payments will increase by 0.5 percent.

January 2016-December 2019
Physician payments will continue to increase by 0.5 percent each year.

January 2020-December 2025
No further payment updates will be scheduled. Physicians will choose from two payment tracks
APM / MIPS
Meaningful Use Update – Incentives and Penalties

From January 2011 to November 2015, over $31 billion in Electronic Health Record (EHR) Incentive Program payments have been made to over 559,000 Eligible Professionals (EPs) and Eligible Hospitals (EHs).

- For EPs and EHs who have not started Meaningful Use, the incentive payment opportunity has past or been significantly reduced from the maximum.

- For EPs and EHs who have met Meaningful Use, the majority of the available incentives have been exhausted and the focus of Meaningful Use compliance has shifted to penalty avoidance.

<table>
<thead>
<tr>
<th>Penalty Year</th>
<th>Penalty Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>0.25%</td>
</tr>
<tr>
<td>2016</td>
<td>0.50%</td>
</tr>
<tr>
<td>2017+</td>
<td>0.75%</td>
</tr>
</tbody>
</table>

*Inpatient Prospective Payment Schedule

Penalties began in 2015 for EPs and EHs who have not attested for Stage 1 Meaningful Use prior to October 1, 2014 and July 1, 2014 respectively. The opportunity to receive penalties remains indefinitely. EPs and EHs who do not attest to Meaningful Use in a given year are subject to a penalty two years from the missed attestation. Example Timeline:

Penalized due to failure to attest in 2014

Penalty assessed in 2019
RAC Updates
News and updates: Medicare RAC

Medicare RAC contracts

• RAC Contracts for four regions in 2015:
  – Region A: Performant Recovery
  – Region B: CGI Federal, Inc.
  – Region C: Connolly, Inc.
  – Region D: HealthDataInsights, Inc.

Medicare RAC activities through December 2015

• All Recovery Auditors may continue active recovery auditing activities, including sending additional documentation requests (ADRs)
• CMS holds firm on disputed Medical necessity of inpatient care (two-midnight rule) pay cut to hospitals

Medicare RAC upcoming news

• CMS begins to close out the current contracts so the Recovery Auditors can complete all outstanding claim reviews and other processes by December 31, 2015, the end date of the current contracts.
• CMS is also pursuing contract modifications to the current Recovery Auditor contracts to allow each of the four existing Recovery Auditors to continue recovery auditing activities through July 31, 2016.
• CMS also recently invited a Request for Information to collect feedback to design an expanded RAC program for Medicare Advantage Plans (Part C) Plans

Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Recent_Updates.html
News and updates: Medicare RAC

RAC Backlog

• Federal government has a backlog of more than 800,000 appeals from health care providers challenging denied Medicare claims
• Lawsuit brought by hospitals seeking to force the government to churn through those appeals more quickly tossed out of district court last year
• Federal appeals court ruling in February, 2016 sends case back to district court for reconsideration
• Commentators say it also might nudge Congress toward passing legislation that seeks to address the massive backlog

“Although the audit program has recovered billions of dollars in fraudulently or otherwise improperly paid funds, it has also contributed significantly to a volume of appeals that makes compliance with the statutory time frames impossible, .....the problem as it now stands — worse, not better.”

Appellate Judge David Tatel

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