

*Under the government's
microscope now more
than ever, providers
must take steps to
ensure compliance*



Rooting Out Fraud

*under Medicare and
Medicaid.*

Meg LaPorte

Nov. 22, 2009, marked a significant milestone for Tamar Abell. It was the end of a 10-year ordeal that cost her family's skilled nursing facility business more than \$2 million in settlement costs and legal fees, not to mention numerous sleepless nights and hundreds of hours of paperwork.

It began in the spring of 2000: After three decades of successfully owning and operating nursing facilities, one of Abell's properties was hit with an investigation prompted by the allegations of a "whistleblower" who recently had been fired from the company.

The U.S. Health and Human Services (HHS) Office of Inspector General (OIG) spent four years investigating the facility before a lawsuit was filed. Each of the business owners—Abell, her husband, brother, and father—were sued by the federal government under the civil False Claims Act (FCA) and placed under a quality-of-care corporate integrity agreement (CIA) that required federal officials to monitor each of the company's facilities for a period of five years. It never occurred to Abell that she would be sued. "I considered myself to be a 'typical' mom and pop provider," she says. "I thought everything was going well. I thought this only happened to the big companies."

Making matters worse, the facility under investigation had been managed by Abell's company for only 16 months when at least a dozen federal officials marched into the lobby with subpoenas in hand. What's more, the facility itself was unlike any other she had managed before. Having "grown up" with skilled nursing facilities, this particular building, which served inner-city young adults with mental illnesses, was a very different ballgame.

"We knew going in that this was not going to be easy, but we did make improvements, and we had just had a good survey," says Abell.

But by the time they pulled out of the facility, just 18 months in, it was too late.

Abell's story does have a happy ending, but it serves as a cautionary tale of how earnest the federal government has become in its efforts to crack down on fraud, waste, and abuse in the Medicare and Medicaid programs. OIG and the U.S. Department of Justice (DOJ), as well as the Office of the U.S. Attorney General (AG), the Centers for Medicare & Medicaid Services (CMS), and most of the states have intensified their efforts in unprecedented ways to recoup overpayments, prevent billing errors and upcoding, and snag more onerous perpetrators in the act of billing for services never rendered or for deceased beneficiaries.



Turning Lemons Into Lemonade

Implementing the CIA was arguably one of the most challenging aspects of her family's entire calamity, says Abell, but it was also one of the best things that has happened to her business. "The OIG monitors were extremely helpful throughout the entire process," she says. "They really helped us grow; they were really unbelievable consultants."

In fact, says Abell, her business has never before run as well as it does now.

A CIA is typically negotiated as part of the settlement agreement with OIG in cases brought against health care providers under the FCA.

In some cases, OIG will agree to allow a provider's continued participation in Medicare and Medicaid in exchange for the imposition of a CIA, which is what Abell did.

In addition to writing quarterly or monthly reports to OIG, CIAs may require providers and their staff to undergo

rigorous training and education. In Abell's case, her CIA required all direct care workers in each of the company's facilities to be trained within the first 120 days of the program and annually thereafter.

But tracking and monitoring the training programs for so many employees became unwieldy for Abell. So she created a solution that eventually became a separate—and successful—business.

"I couldn't figure out how to manage training all those people, so I developed an online training and tracking system that records who has been trained, when they were trained, and what tests they took," she says. As she likes to say, "I made lemonade from lemons."

In 2009, Abell launched Upstairs Solutions, a company that helps senior care facilities educate staff to ensure compliance and mitigate risk.

Abell has also recounted her harrowing experience to

other long term care owners and operators in an effort to raise awareness about how susceptible providers are to government investigations.

“There isn’t an operator in the country who can’t be the next one. I don’t care how big, how small; everybody’s vulnerable and accountable,” Abell says.

But because she took advantage of OIG’s help and implemented a company-wide compliance program, the likelihood of her facing another OIG investigation or lawsuit has been minimized.

Now Is The Time

As a result, Abell is now a strong advocate of every nursing facility adopting a corporate compliance program (CCP) “before someone else makes you put [one] in place.”

Hers is one of many examples driving defense attorneys’ efforts to implement CCPs for their nursing facility clients.

Why the urgency? “There are some very real dangers to health care companies out there, and there are some very real benefits to the protections provided by a corporate compliance program,” says Dan Small, a trial and health care partner with the Boston and Miami offices of Holland & Knight.

According to nearly any expert with knowledge of the long term care industry, CCPs are the best defense against government accusations of fraud.

Small says some studies of CCPs have found that nursing facilities with strong compliance programs are better run, have reduced capital costs, and have less expensive liability insurance rates. In fact, he says, the

government has used some cases where there is either a lack of a compliance program, or a deficient one, to demonstrate that “any company that is in the health care industry and does not have a compliance program, is almost, *per se*, recklessly disregarding their obligations under the law.”

OIG also favors the idea. A recent guidance document suggests that all long term care providers should establish and maintain effective compliance

programs with the goal of improving quality of care and services.

Resistance to adopting a CCP most likely comes from two sources, says Small. Some have a hard time believing that an industry that is as highly regulated as nursing facilities would need yet another layer of regulation on top of it. “The truth is, you have to layer on a compliance program precisely because we’re one of most heavily regulated industries in the country,” he says.

The other hurdle to getting providers to implement compliance programs is cost. Owners and operators often see a CCP as an expense rather than an investment. “But it’s one of the best investments a facility can make,” says Small.

Both whistleblowers and the government will use any violation of those regulations as evidence that someone is committing fraud, he adds. “It puts people that don’t have a compliance program in a very dangerous situation.”

Small also touts an additional benefit for facility owners who are selling a property. “Acquiring parties are taking a strong look at a compliance program during the due diligence process,” he says. “Because if you buy a facility that has poor compliance practices, you’re buying the unknown: investigations and potential FCA risks.”

Focus Is On Fraud

Driving the heightened interest in CCPs is the government’s renewed fervor to root out wasteful spending, overpayments,

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Reform Measures Go Further

At press time, members of Congress were preparing to hammer out a final health care reform measure that is likely to contain a number of provisions aimed at boosting anti-fraud efforts and imposing mandatory compliance programs and disclosure requirements for nursing facilities that participate in Medicaid or Medicare.

Specifically, facilities could be required to implement a “compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations.”

According to Teresa Cagnolatti, AHCA government affairs director, the specific elements or formality of a program may vary with the size of the organization. “For example, larger organizations could be forced to have a more formal and rigorous program,” she says.

Additional provisions would require facilities to make available to OIG, the state, and the state long term care ombudsman specific

information about facilities’ board of directors and organizational structure: the names, dates, and period of service of each member of the governing body, as well as officers, directors, members, partners, trustees, or managing employees of the facility; each person or entity who is an additional disclosable party of the facility; and information on the organizational structure of each entity.

Under the legislation, facilities must also make this information available to the public upon request and update such information as necessary.

Other provisions likely to remain in the final bill would impose more onerous compliance requirements on nursing facilities, such as the imposition of greater responsibility for the integrity of contractors, the disclosure of transparency information on CMS’ Nursing Home Compare Web site, expanded whistleblower protections, and background checks for all direct care employees.

A Tidal Wave Of Activity



In recent years, the government and states have intensified their efforts to root out fraud, waste, and abuse in the Medicare and Medicaid programs. Agencies like the Department of Justice (DOJ), the Office of Inspector General (OIG), and the Centers for Medicare & Medicaid Services

(CMS) have joined forces in an effort to streamline and combat fraud in new and, most likely, more effective ways.

The following table is intended to illustrate the magnitude and complexity of these efforts within the Medicare and Medicaid programs.

Medicare

Medicare Integrity Program (MIP)

The term “program integrity” refers to all of the agencies’ programs aimed at detecting and preventing fraud in the Medicare Fee-For-Service, Medicare Advantage, and Part D programs; ensuring the integrity of the Medicare Fee-For-Service enrollment process; and promoting compliance with Medicare rules.

Program Safeguard Contractors (PSCs) and Zone Program Integrity Contractors (ZPICs): These entities are responsible for preventing, detecting, and deterring Medicare fraud. They do so by identifying program vulnerabilities—areas that are at high risk for fraud; investigating allegations of fraud made by beneficiaries, providers, CMS, OIG, and other sources; exploring all available sources of fraud leads in its jurisdiction, including the Medicare Fraud Control Unit (MFCU) and its corporate anti-fraud unit; and initiating appropriate administrative actions to deny or suspend payments that should not be made to providers.

PSCs and ZPICs are required to use a variety of techniques and tools, both proactive and reactive, to address any potentially fraudulent billing practices, data analysis, the Internet, the Fraud Investigation Database, the news media, and the identification of leads by any internal, Affiliated Contractor (AC) or Medicare Administrative Contractor (MAC) component.

Medicare Contractors And Programs

Technically speaking, PSCs and ZPICs are the MIP contractors. However, MACs can qualify as ZPICs. More importantly, there is cooperation among the various claims review contractors and MIP contractors. PSCs, ZPICs, ACs, and MACs must ensure that they pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers.

CMS strategies in meeting this goal include preventing fraud through effective enrollment and through education of providers and beneficiaries; early detection through medical review and data analysis; and close coordination

Medicaid

Medicaid Integrity Program (MIP)

Created under the Deficit Reduction Act of 2005, MIP is the first comprehensive federal strategy to prevent and reduce fraud, waste, and abuse in the Medicaid program. CMS has two broad responsibilities, including:

- Hiring Medicaid Integrity Contractors (MICs) to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others in Medicaid integrity issues.

- Providing effective support and assistance to the states in their efforts to combat Medicaid provider fraud and abuse. The states remain primarily responsible for combating Medicaid fraud.

The Medicaid Integrity Group (MIG) is part of the CMS Center for Medicaid and State Operations, which serves as the focal point for all CMS activities relating to Medicaid, the Children’s Health Insurance Program (CHIP), the Clinical Laboratory Improvement Act, and survey and certification of health facilities.

MIG detects and prevents fraud, waste, and abuse in Medicaid; supports and assists the states; identifies overpayments and reduces the inappropriate payment of Medicaid claims; educates on payment integrity and quality of care; makes referrals of suspected practices and providers to federal and/or state law enforcement agencies; and conducts data mining and analysis to identify emerging trends.

Medicaid Contractors And Programs

There are three different types of MICs:

- Review-of-Provider MICs analyze claims to identify potential vulnerabilities, provide leads and target audits for Audit MICs, focus on aberrant billing practices, and work with CMS’ Division of Fraud Research & Detection.

- Audit MICs conduct post-payment audits, perform field audits and desk reviews, and identify overpayments. These MICs also make referrals to the Department of Health and Human Services (HHS) and OIG, which, in turn, share the information with state Medicaid Fraud Control Units. No Audit MIC is ever random, and MIC auditors will not duplicate state investigations. ►

with PSCs, ZPICs, ACs, MACs, and law enforcement agencies.

Fiscal Intermediaries (FIs) and Medicare Administrative Contractors (MACs): With the goal of preventing improper payments, FIs and MACs identify suspected billing problems through analysis of claims data and other information, such as complaints. If the MAC verifies that an error exists through a review of a small sample of claims, the contractor classifies the severity of the problem as minor, moderate, or significant and imposes corrective actions.

Comprehensive Error Rate Testing (CERT): The main objective of CERT is to measure the degree to which CMS and its contractors are meeting the goal of “paying it right.” CMS established two programs to monitor the accuracy of the Medicare Fee-For-Service (FFS) program: the CERT program and the Hospital Payment Monitoring Program (HPMP). HPMP monitors prospective payment system short-term and long-term acute care inpatient hospitalizations and discharges. The CERT program monitors all other claims.

Recovery Audit Contractors (RACs): The goal of the RAC program is to detect and correct past improper payments so that CMS, carriers, FIs, and MACs can implement actions that will prevent future improper payments. The RAC program is tasked with applying statutes and regulations; CMS national coverage, payment, and billing policies; and local coverage decisions that have been approved by the Medicare claims processing contractors.

■ Education MICs develop training materials and awareness campaigns and highlight value in preventing fraud and abuse. No contracts have been awarded yet.

Payment Error Rate Measurement (PERM): PERM measures improper payments in the Medicaid program, including CHIP, and performs statistical calculations, medical records collection, and medical and data processing reviews of selected claims.

Medicaid Fraud Control Unit (MFCU): A single identifiable entity of state government, annually certified by HHS. MFCUs conduct a statewide program for the investigation and prosecution of health care providers that defraud the Medicaid program. MFCUs also review complaints of abuse or neglect of nursing facility residents and are charged with investigating fraud in the administration of the program.

Medicaid Management Information System (MMIS): The master claims database that identifies potential Medicaid claims problems.

The regional office receives a subset of the MMIS database and uses that subset to identify algorithms. Once an issue is identified, staff pull the provider number from the subset, and the CMS regional office sends a letter to the respective state’s OIG to ascertain whether any of the providers are already under audit or investigation.

CMS has identified problems with the database, such as stale data and a lack of contact names or numbers.

Joint Medicare And Medicaid Initiatives

Provider Compliance Group: The Provider Compliance Group has responsibilities for both Medicare and Medicaid. The group must implement and maintain medical review activities, administer the CERT and PERM programs, conduct data analysis and assess the scope and severity of suspected vulnerabilities, and administer the RAC program.

Joint Agency Programs: The Health Care Fraud Prevention and Enforcement (HEAT) program was announced in May 2009 and is a joint task force consisting of “senior level” leadership from both DOJ and HHS. HEAT builds on the Medicare Fraud Strike Force program initiated in south Florida and utilizes advanced data analysis techniques

to identify and detect fraud schemes. HEAT plans to enlist providers to help ensure integrity of billing practices and will focus on both Medicare and Medicaid providers who are believed to be defrauding the government.

Medi-Medi: Established in 2006, Medi-Medi is designed to identify improper billing and utilization patterns by matching Medicare and Medicaid claims information on providers and beneficiaries to reduce fraudulent schemes that cross program boundaries. CMS contracts with third parties to identify program vulnerabilities through the examination of billing and payment abnormalities.

Source: Dianne De La Mare, vice president of regulatory affairs, American Health Care Association (AHCA), Priscilla Shoemaker, legal counsel, AHCA; the Centers for Medicare & Medicaid Services; and the U.S. Department of Health and Human Services Office of the Inspector General

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overbilling, and criminal activity.

In an effort to recoup dollars back into the system, state and federal watchdogs have turned their attention to nursing facilities, home health agencies, and durable medical equipment suppliers with an eye on the tremendous potential for cost savings that preventing and prosecuting fraud can bring.

Behind the eagerness to ferret out and return funds to the government is the fact that fraud has become big business for criminals—so big, in fact, that organized crime leaders have gotten into the game.

Although no one is certain what the exact figure is, the National Health Care Anti-Fraud Association estimates that some \$60 billion, or about 3 percent of total annual health care spending, is drained from the Medicaid, Medicare, and other government-sponsored health care programs each year thanks to fraud, waste, and abuse.

In testimony before a Senate committee hearing last May, Malcolm Sparrow, a professor at Harvard's John F. Kennedy School of Government, asserted that the "units of measure for losses due to health care fraud and abuse in this country are hundreds of billions of dollars per year. We just don't know the first digit. It might be as low as one hundred billion. More likely two or three. Possibly four or five. But whatever that first digit is, it has 11 zeroes after it," he said.

Sparrow, who is considered to be a leading expert on the topic, emphasized that reining in such losses "warrants a great deal of serious attention." He advised committee members that defeating fraud would take drastic measures, including the use of "surveillance, arrest, or dawn raids."

With the potential for savings and recoupment so great, pressure has also come from the executive branch in

the form of promises. During a joint session of Congress last year, President Obama pledged to fight health care fraud and alluded to using the recoupments to cover the cost of health care reform.

Heightened Activity

Federal agencies are also working together in new ways to ramp up their data sharing and enforcement activities in an effort to better detect and identify fraudulent providers. HHS, for example, recently joined forces with the Office of the U.S. Attorney General last May to launch the Health Care Fraud Prevention and Enforcement Action Team, or HEAT, which deploys "top-level" DOJ and HHS officials to both prevent fraud and enforce current anti-fraud laws around the country.

HEAT has made some headway in its early stages, according to Tony West, assistant U.S. attorney general, who testified last October before the Senate Judiciary Committee.

"We are actively analyzing data in unprecedented coordination between our two agencies, and in as real time as possible, to identify fraud 'hot spots' and expand Strike Force operations to those areas where there is the most need," West said.

Already under way is enhanced training of prosecutors and investigators on enforcement measures; increased compliance training for providers to prevent honest mistakes and help

stop potential fraud before it happens; and efforts to educate the public about ways they can assist DOJ in detecting, preventing, and prosecuting fraud.

OIG investigators are also implementing "state-of-the-art" technology to identify and analyze potential fraud with unprecedented speed and efficiency, said West.

According to OIG, the use of this technology has enabled federal law enforcement officials to obtain "electronic evidence" that previously took months to analyze using traditional investigative tools.

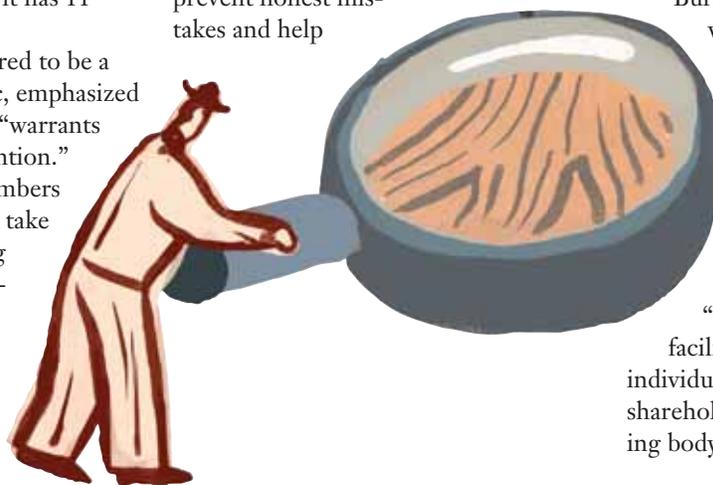
Taking The Plunge

Industry advocates like the American Health Care Association (AHCA) have kept track of this flurry of anti-fraud efforts over the past few years and concluded that its members would benefit from more guidance about how to implement a CCP. As a result, the organization launched a series of Webinars aimed at guiding providers through the process of planning, implementing, and maintaining a compliance program.

At least one dozen presentations on AHCA's Web site illustrate the importance of adopting a CCP and drive home the idea that planning and developing one is key to its effectiveness. CCPs need to be well-implemented and monitored on a regular basis, and they must be embraced by the company's leadership, according to Ken Burgess, a health care attorney with Poyner Spruill in Raleigh, N.C., who worked closely with AHCA to develop the Webinars.

Effective compliance programs take the commitment of the company owners, managers, and board of directors as well, he says. "Whether your company and facilities are owned by a single individual, a partnership, or corporate shareholders, and whether your managing body is small or large, those folks

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Enforcement, Investigation, Prosecution

The following descriptions outline the government's various strategies in preventing and prosecuting fraud, waste, and abuse in the Medicare and Medicaid programs.

Follow-up Prosecution: Medicare and Medicaid audits are now more likely to be followed by investigation and prosecution for health care fraud. Recent legislation has given both federal and state agencies a tremendous amount of power in dealing with fraud in the health care industry. Private citizens, beneficiaries, and employees are being encouraged by the government and plaintiffs' attorneys to pursue civil health care fraud cases against medical providers with the lure of increased monetary incentive.

Agency Coordination: Primary responsibility for enforcing federal laws regarding health care fraud rests with DOJ and U.S. attorneys. The FBI plays a major role in assisting DOJ in investigating and developing health care fraud cases. OIG is responsible for investigating fraud cases and bringing enforcement actions involving administrative sanctions. Individual states have their own MFCUs, and local prosecutors can bring such cases as well.

Private companies that contract with CMS to administer programs such as MACs and RACs have some responsibilities in reviewing claims, detecting upcoding and other improper billing practices, and recovering overpayments. In certain circumstances, private parties can pursue health care fraud through a civil lawsuit, although the government has the option of taking over the case.

Investigation and Prosecution: Investigations into Medicare and Medicaid fraud begin with OIG, which has the power to execute search warrants and serve subpoenas in connection with their investigation. In cases involving suspected Medicaid fraud, OIG has delegated its investigative activities to the MFCUs established by individual states. The majority of MFCUs are located within state attorney general (AG) offices. MFCUs have the power to issue subpoenas, serve and execute search warrants, and take sworn statements.

Choice of Law and Remedy: In dealing with Medicare and Medicaid fraud and abuse, law enforcement entities can choose among a wide array of criminal, civil, and administrative responses. On the criminal side, offenses can be addressed with general statutes or with health care-specific statutes. In addition to possible criminal liability, providers also are exposed to substantial civil liability for health care fraud under the False Claims Act (FCA) and the Civil Monetary Penalties law. The government in many cases will pursue both civil and criminal liability for the same action, in an effort to force a settlement.

Relevant Civil Statutes: The civil FCA is the government's primary tool for combating fraud. The statute imposes liability on persons who knowingly present false or fraudulent claims to the United States, knowingly make false records or statements to get false or fraudulent claims paid, or conspire to defraud the government by getting a false or fraudulent claim paid.

The FCA permits private citizens, known as *qui tam* plaintiffs, or "relators," to hire attorneys and file actions asserting violations of the FCA on behalf of the United States. DOJ has the opportunity to investigate the action and decide whether to intervene in the lawsuit and

take the lead in prosecuting the action. If the government declines to intervene, relators, sometimes known as "whistleblowers," and their attorneys can proceed with the action. The incentive for relators and their attorneys is financial—if the action is successful, the relator receives up to 30 percent of the proceeds awarded.

Relevant Criminal Statutes: Multiple criminal statutes may be utilized for the prosecution of fraud cases, including conspiracy to defraud the United States, false statements, mail fraud, wire fraud, and money laundering.

The health care-specific federal statutes include kickbacks, health care fraud, theft or embezzlement, false state-



The FBI plays a major role in assisting DOJ in investigating and developing health care fraud cases.

ments, obstruction of criminal investigations, and money laundering.

Depending on the statute applied, those individuals or entities convicted of health care fraud face punishments that can range from fines of \$1,000 to \$250,000 and prison terms ranging from five years to 20-years-to-life, in cases where severe bodily injury or death are attributed to the case.

Provider Exclusion: In addition to penalties, a health care provider may be subject to expulsion from the Medicare and Medicaid programs. Mandatory exclusion is imposed when there is a felony conviction of fraud in certain circumstances. Exclusions may also be permitted when



a provider's conviction is related to the obstruction of an investigation, submission of claims for excessive charges that do not rise to the level of fraud, failure to disclose statutorily required information, and failure to provide required access to records.

One of the most potent weapons in the prosecutor's arsenal, however, is the power to suspend and withhold a provider's payments under Medicare, upon indictment or other reliable evidence of fraud.

Payments can be suspended without a hearing once the prosecutor has obtained an indictment. As a result, the government is able to exert tremendous pressure on targeted health providers to force a settlement.

Source: Dianne De La Mare, vice president of regulatory affairs, American Health Care Association (AHCA), Priscilla Shoemaker, legal counsel, AHCA; the Centers for Medicare & Medicaid Services; and the U.S. Department of Health and Human Services Office of the Inspector General

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have to dedicate sufficient resources to the program on a daily basis.”

Burgess likens the implementation of a CCP to “designing, building, maintaining, and repairing a house.”

“The construction of any house begins with a planning and design process,” Burgess says. “So does an effective compliance program.”

A CCP should be viewed as two separate components, he adds: the physical structure—the elements that govern the operation of a CCP—and the furniture and appliances inside the house—the substantive laws and policies that ensure compliance.

Mitigating Factors

Chris Myers, a partner at Holland & Knight and editor of “The Corporate Compliance Answer Book 2009,” says one of the first things a nursing facility operator should do when creating a CCP is to review the OIG guidance documents that identify risk areas for long term care providers. “This guidance identifies risk areas that should be addressed and walks through the elements of an effective compliance program,” says Myers.

Another important document to review is published by the U.S. Sentencing Commission. It was originally designed for use in criminal sentencing, but is now used by organizations hop-

ing to avoid being investigated for, or convicted of, criminal activity, according to Myers.

“[It] is beneficial to providers because it provides guidelines on factors that may be considered either mitigating or exacerbating in determining the appropriate sentence,” he says.

The manual contains a series of calculations, based on the seriousness of an offense, “and the most favorable mitigating factor [in sentencing] is whether or not you have an effective corporate compliance program,” says Myers. “It uses a detailed outline of what an effective compliance program should look like.”

Another important element of a CCP, says Myers, is that it be risk based. “It should be designed and implemented to address the particular legal and regulatory compliance risks that affect a business,” he says. “And so for nursing facilities, since Medicare billing regulations are high up on the list, a compliance program needs to address those things.”

Myers says that most well-run compliance programs begin with a risk assessment whereby the facility identifies the legal and regulatory provisions that affect the business and how it is conducted.

“Providers also should look at their relationships with various government agencies, whether it's Medicaid or

Medicare or private insurance,” he says. “You need to list the various regulations that affect your business and determine if you have or need to develop special policies and procedures that will help you comply with that particular set of regulations.”

Once a facility has a written set of policies and procedures, the staff must be trained, Myers adds. “They need to know what they're supposed to do, how to comply with the policies, and where to go for questions,” he says.

A Word About The False Claims Act

An effective, well-implemented, and well-run compliance program is the best defense against one of the most powerful tools the government has to fight fraud—the civil FCA.

The statute imposes liability on persons who knowingly present—or cause to be presented—false or fraudulent claims to the United States, knowingly make false records or statements to get false or fraudulent claims paid, or conspire to defraud the government by getting a false or fraudulent claim paid. It also provides for treble damages plus penalties of \$5,500 to \$11,000 for each false claim.

It has been a very potent weapon in the government's arsenal against fraud, Myers stresses, and it presents some “extraordinary challenges to long term care facilities because any disgruntled

employee who believes that there has been fraud in billing or any other related areas can bring one of these cases," he says.

The bad news is that the FCA just became more powerful, thanks to the passage of the Federal Enforcement and Recovery Act last year.

Myers advises providers to be "very concerned" about the amendment. First, it expands the presentment of claims component to cover claims submitted to government contractors or grantees, as long as they are paid with federal money. Since Medicaid is a joint federal and state program, claims presented to Medicaid may now be subject to the FCA.

Other Changes

Another major change to the FCA pertains to how DOJ shares information with a *qui tam* whistleblower's counsel within the context of an FCA case.

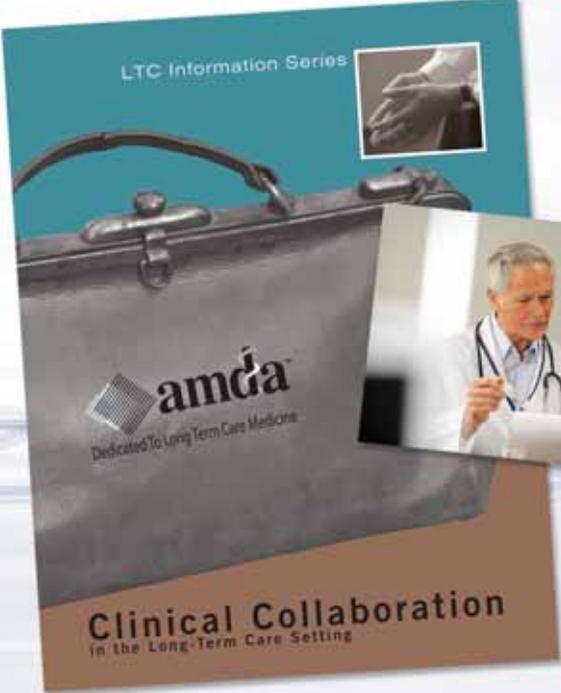
"It used to be that DOJ would hold things close to the vest," Myers says. "Now they are expressly permitted to share information with the [whistleblower's] counsel and with state and local health care agencies that want to get involved."

Yet another FCA amendment worth noting is something called "reverse false claims." This means that if a nursing facility discovers a billing inaccuracy that results in receiving an overpayment, even if the mistake that led to the overpayment was completely innocent, the facility must return the money or be subject to an FCA suit.

"Even if you didn't do anything fraudulent, it entitles the government to bring a reverse false claim suit," Myers says. "It makes it easier for whistleblowers to proceed but makes it more difficult to defend against these kinds of claims."

The *qui tam* bar is "all excited about these changes because they think it will increase liability and increase their opportunities to bring cases," Myers says.

Also related to the FCA is a grow-



The image shows the cover of a tool kit titled "Clinical Collaboration in the Long-Term Care Setting". The cover features the AMDA logo, which includes a diamond-shaped graphic and the text "amda Dedicated To Long Term Care Medicine". Above the logo, it says "LTC Information Series" and "Clinical Collaboration". Below the logo, it says "Clinical Collaboration in the Long-Term Care Setting". The cover also includes a photograph of two healthcare professionals, a man and a woman, looking at a document together. The background of the cover is a light blue and white gradient.

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ing trend among the various agencies to pay attention to quality-of-care issues, Myers says. "Nursing facilities in particular are vulnerable to these kinds of claims. For example, if a nursing home bills for services and the residents receive poor quality of care, DOJ now uses that situation to assert false claim liability."

Abell's case was among the first quality-of-care FCA suits to be brought against a small nursing facility.

Additional FCA amendments pertaining to long term care providers are as follows:

- Allows for government complaints, for the purposes of the statute of limitations, to "relate back" to the filing date of the complaint originally made by the whistleblower;

- Expands whistleblower protections to include contractors and agents, in addition to employees; and

- Allows for designees of the attorney general to issue a civil investigative demand, which is similar to a subpoena.

States are also collaborating more and more often with federal entities to bring suits against nursing facilities and other health care providers, says Myers.

The Deficit Reduction Act of 2005 encourages states to enact an FCA law that is as stringent as the federal one. Once a state has done so, it can retain an extra 10 percent of recovered Medicaid funds. As a result, 32 states and the District of Columbia have enacted false claims acts.

The government's many and varied efforts to step up health care fraud-fighting capabilities must not be taken lightly by long term care providers, both Small and Myers stress. "With nursing homes, you have an industry that is so heavily regulated and is now

facing another tidal wave of regulation," says Small.

"And part of the problem more globally here is that with everyone talking about health care reform and talking about how much money will be saved by fighting fraud against Medicare and Medicaid, it puts an enormous amount of pressure on the agencies to develop the kinds of programs we're talking about," he says.

"People have to understand that this is not going away; the government is going to put a lot of time and money and energy into these programs because of a commitment at the highest levels, and it's been promised at the highest levels that they would yield extraordinary results."

For more information: Go to AHCA's compliance Web site at: www.ahcancal.org/facility_operations/complianceprogram/pages. ■

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We love SeniorTV*

SAVE BIG ON TV PROGRAMMING

- ✓ Quality TV Channels
- ✓ Message channels
- ✓ Automated DVD playback
- ✓ Internet
- ✓ Dual remote LTC LCD TV's
- ✓ Wiring repairs and new construction installation



Serving hundreds of long term care facilities coast to coast

Why complicate the lives of your residents? REDUCE OPERATING COSTS and simplify. Customize your channel lineup--show just the channels residents want. Ask how. Don't settle for desirable channels being removed. With SeniorTV every channel is crystal clear -- you can change channels using the original remote control. NO converter boxes needed!



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