The Puerto Rico Chamber of Commerce
and El Nuevo Día present the...

PUERTO RICO

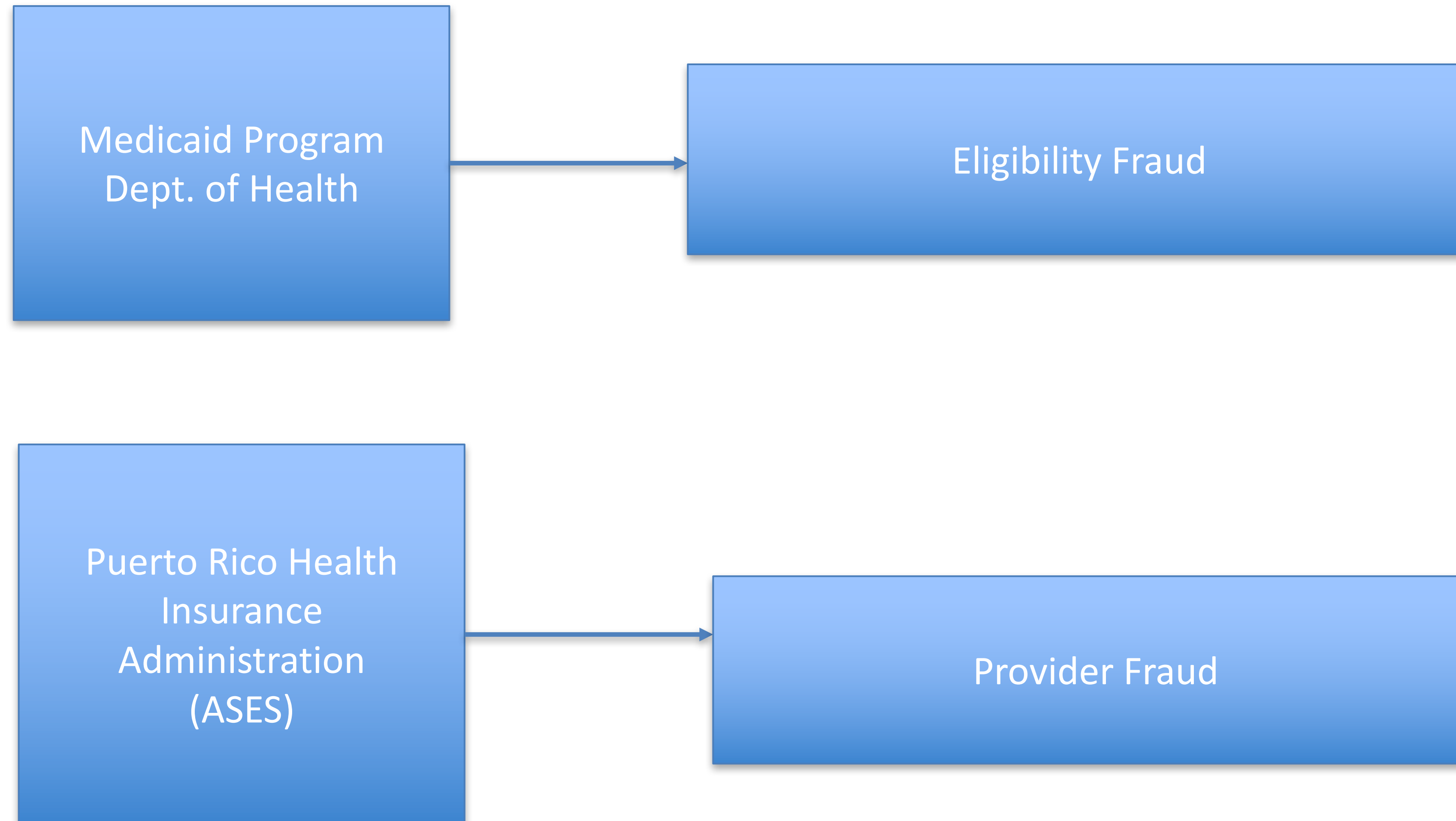
Health & Insurance

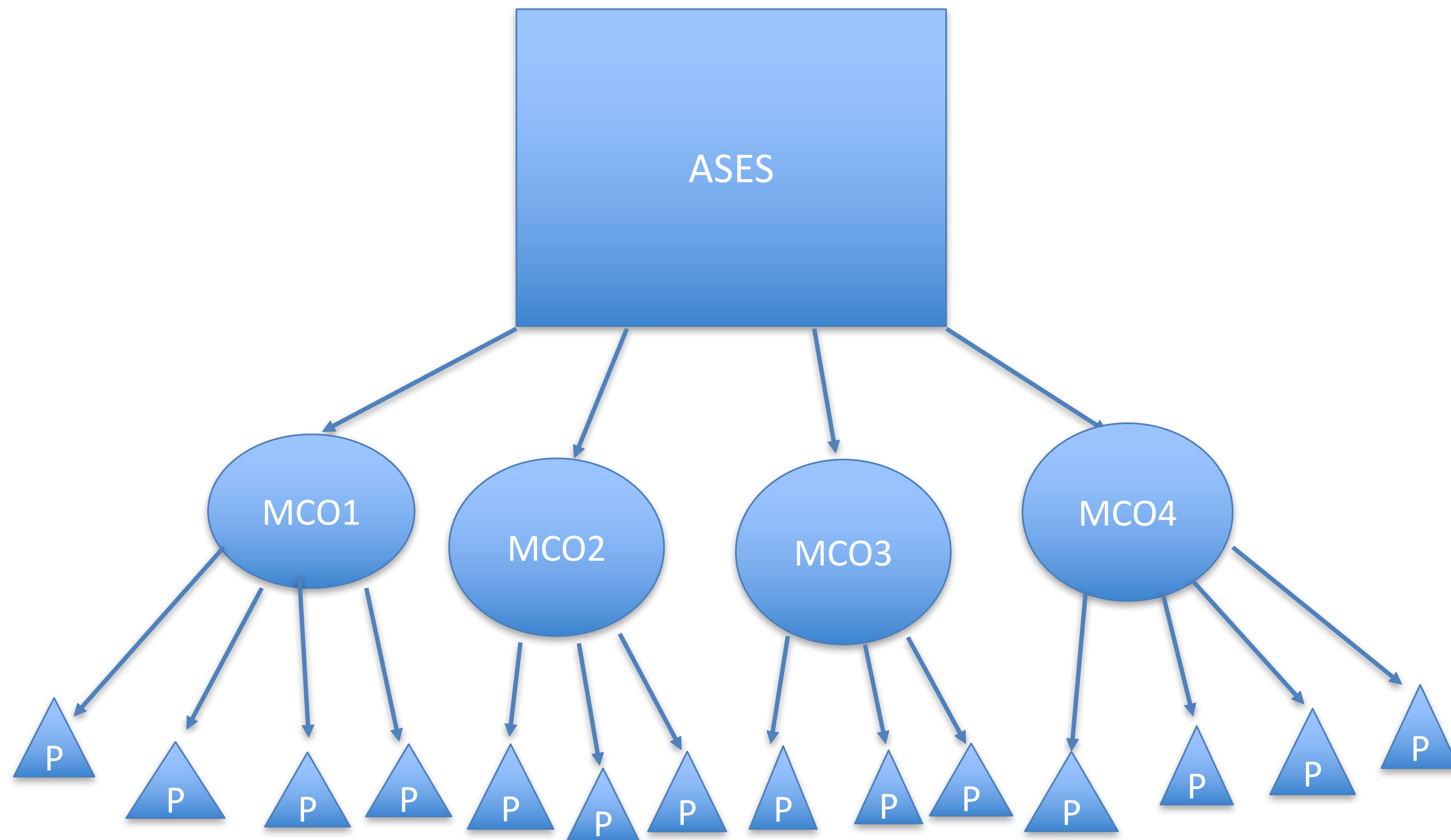
CONFERENCE 2018

DEVELOPMENT BY STORM: HOW TO TURN POST-MARÍA RECOVERY AS THE OPPORTUNITY TO FIX HEALTHCARE IN PUERTO RICO

Addressing Fraud in Medicaid Managed Care Contracts

Marla Hadad, Esq.


Medicaid Program
Dept. of Health
Eligibility Fraud
Puerto Rico Health
Insurance
Administration
(ASES)
Provider Fraud


ASES
MCO1
MCO2
MCO3
MCO4
P
P
P
P
P
P
P
P
P
P
P
P
P
P
P
P
P
P

ABUSE

- Means :
    - provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary
    - or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Ex.: Charging excessively for items or services, misusing codes, etc.

WASTE

- Means :
  - To use, consume, spend or expend thoughtlessly or carelessly
  - It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

- Example: A physician (unaware of the generic alternative) consistently prescribes a high priced medication for his patients instead of the less expensive drug available in the formulary

FRAUD

- Means :
    - An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit for him/her or some other person.

FRAUD

- ❑ - Billing for services not rendered.
- ❑ - Billing for a non-covered service as a covered service.
- ❑ - Misrepresenting dates of service.
- ❑ - Misrepresenting locations of service.
- ❑ - Misrepresenting provider of service.
- ❑ - Incorrect reporting of diagnoses or procedures (includes unbundling).
- ❑ - Overutilization of services.
- ❑ - Corruption (kickbacks and bribery).
- ❑ - False or unnecessary issuance of prescription drugs.

MCO Contracts

- Article 13: Fraud, Waste, and Abuse
  - Manage Care Organizations (MCO)

- ❑ The Contractor shall have and implement a comprehensive internal administrative and management controls, policies, and procedures in place designed to prevent, detect, report, investigate, correct, and resolve potential or confirmed cases of Fraud, Waste, and Abuse in the administration and delivery of services detailed in this Contract

- ❑ The Contractor shall have surveillance and Utilization control programs and procedures (see 42 CFR 456.3, 42 CFR 456.4, 42 CFR 456.23) to safeguard against under-utilization, unnecessary or inappropriate use of Covered Services and against excess payments for Covered Services

- Article 13: Fraud, Waste, and Abuse
  - The Contractor shall inform ASES of any meetings it holds with any other GHP MCOs related to compliance and program integrity issues at least forty-eight (48) hours prior to the meeting. The Contractor shall provide a copy of the meeting minutes as well as the results of any follow-up investigations to ASES in writing Immediately
  - Ensure that Providers and Enrollees are educated about Fraud, Waste, and Abuse identification and reporting in the materials provided to them.

- Article 13: Fraud, Waste, and Abuse
  - Include a monitoring program that is designed to prevent and detect potential or suspected Fraud, Waste, and Abuse. This monitoring program shall include but not be limited to:
    - Monitoring the billings of its Providers to ensure Enrollees receive services for which the Contractor is billed;
    - Requiring the investigation of all reports of suspected cases of Fraud and over-billings;
    - Reviewing Providers for over, under and inappropriate Utilization;
    - Verifying with Enrollees the delivery of services as claimed; and
    - Reviewing and trending Enrollee Complaints regarding providers

Provider Contracts

- Specify that ASES, CMS, the Office of Inspector General, the Comptroller General, the Medicaid Fraud Control Unit, and their designees, shall have the right at any time to inspect, evaluate, and audit any pertinent records or documents, and may inspect the premises, physical facilities, and equipment where activities or work related to the GHP program is conducted. The right to audit exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later;

- Require that Providers not employ or subcontract with individuals on the Puerto Rico or Federal LEIE, or with any entity that could be excluded from the Medicaid program under 42 CFR 1001.1001 (ownership or control in sanctioned entities) and 1001.1051 (entities owned or controlled by a sanctioned person);

Provider Contracts

- Require the Provider to notify the Contractor Immediately if or whether the Provider falls within the prohibitions stated in Sections 29.1, 29.2, or 29.6 of this Contract (crimes involving corruption, fraud, embezzlement, or unlawful appropriation of public funds) or has been excluded from the Medicare, Medicaid, or Title XX Services Programs;

- Include a penalty clause to require the return of public funds paid to a Provider that falls within the prohibitions stated in Section 29.1, 29.2 or 29.6 of this Contract;

- The Contractor guarantees payment for all **Medically Necessary** Services rendered by Providers.

Program Integrity

- The organization must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.
- If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occur in the Medicaid program, the organization must take the appropriate actions.
- The full investigations must continue until the cases are referred, solved or closed.
- The organization must submit a progress report the fraud and abuse information and statistics to the appropriate department / grantee / sub-grantee on quarterly basis.

Program Integrity

- The organization must submit a progress report the fraud and abuse information and statistics to the appropriate department / grantee / sub-grantee on quarterly basis.

- The organization must have a method for verifying with recipients whether services billed by providers were received.

- The organization must suspend payments to providers as a mechanism to prevent wrong disbursement of payments when there is a credible allegation of fraud for which an investigation is pending unless the agency have a good cause to not suspend payments or to suspend payment only in part.

Medicaid Integrity Group

- Meets quarterly
- Discusses confidential information regarding potential provider fraud
- ASES + Medicaid Program + Office of the Inspector General (OIG) + MCOs
- Training
- “Do not pursue”

IMPROVEMENTS

- Continuing Education of Waste, Fraud and Abuse
- Provider Contract Review
- Medicaid Fraud Control Unit (MFCU)

Medicaid Fraud Control Unit

- Department of Justice
- Medicaid Program
- Office of the Inspector General

BIPARTISAN BUDGET ACT OF 2018

Sec. 20301(a-c): Increased Caps. From January 1, 2018 to September 30, 2019 Puerto Rico's matching grant amount will be increased pursuant to 42 U.S.C. 1308(g)(5) by an additional $3,600,000. This amount will be further increased by $1,200,000,000 if the Secretary certifies that Puerto Rico has taken reasonable and appropriate steps, in accordance with a time line established by the Secretary, to:
[…]

Demonstrate progress in establishing a state Medicaid fraud control unit

Implementation of Medicaid Management Information System

Thank You

Follow us:

www.camarapr.org