



Community Care's Compliance Program

Community Care developed its Compliance Program in accordance with the Office of Inspector General's Guidelines for Effective Compliance Programs. Providers interested in learning more about Compliance Programs as well as obtaining assistance for developing their own programs can access this material on the web at: <http://oig.hhs.gov/fraud/complianceguidance.html>.

During the past seven years, our department has conducted trainings for Providers that outline the basic concepts of Compliance, promote awareness of initiatives that are currently being developed by the state and federal governments, and provide objective information related to the regulations that must be followed by all providers in order to be reimbursed for services. This article will serve to reinforce those trainings and provide another vehicle for dissemination of the information for those who were unable to attend one of our trainings.

Exploding Health Care Costs

It is estimated that the government loses between \$80-100 billion each year as a result of fraud and abuse. National spending on health care has risen to more than \$1 trillion each year. Of special interest to all of us working with HealthChoices is the fact that Medicaid program spending climbed from \$3.9 billion in 1968 to more than \$300 billion in 2005. These staggering figures have caused the federal government to significantly increase their resources in the area of fraud and abuse investigation. In addition, the federal government has charged the individual states with developing their own fraud and abuse special investigation units.

In the state of Pennsylvania, the Bureau of Program Integrity is charged with overseeing all Compliance activity. In turn, the Bureau has mandated all managed care organizations that hold HealthChoices contracts to maintain a comprehensive compliance program. This program includes monitoring all providers that receive medical assistance funding in order to ensure that all regulations are being met.

The Federal Deficit Reduction Act of 2005

Community Care is obligated to inform all employees of the organization, as well as their contracted providers and any business associates, of the requirements set forth in the Deficit Reduction Act.



This act, which was signed into law in February 2006, mandates states to require entities who receive at least \$5 million in annual Medicaid payments to establish specific written policies regarding the entity's procedures for detecting and preventing fraud, waste, and abuse. Section 6032 of the Act requires that as a condition of payment, each entity shall:

- Establish written policies for all employees of the entity and any contractors of the entity and provide information regarding the False Claims Act established under section 3729-3733 of Title 31.
- Outline administrative remedies for false claims and statements under Chapter 38 of Title 31.
- Educate employees about Whistleblower protection under such laws.

The Federal False Claims Act was signed by President Lincoln in 1863 in order to make it illegal to present, or cause to be presented, a claim to the federal government for payment when the person or entity submitting a claim knows that the claim is false. In 1986, an amendment was made to the Act that included claims submitted to the government by the Healthcare industry.

The False Claims Act also establishes liability for any person who knowingly presents or causes to be presented with a false or fraudulent claim to the U.S. government for payment. "Knowingly" is defined by the federal government as a person who:

- Has actual knowledge of falsity of information in the claim.
- Acts in deliberate ignorance of the truth or falsity of the information in a claim.
- Acts in reckless disregard of the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished, or otherwise causing false claims to be submitted.

False Claims Act Violations

The False Claims Act allows for both government and individuals to file suit against the alleged wrong doer on behalf of the United States. Health care providers and suppliers who violate the False Claims Act can be subject to:

- Civil monetary penalties ranging from \$5,500 to \$11,000 for each false claim submitted.
- Paying three times the amount of damages sustained by the U.S. government.
- Exclusion of the provider or supplier from participation in federal health care programs.
- Imprisonment from 5 to 10 years respectively.



Pennsylvania's Whistle Blowers Law

Under the law all employees and associates of Community Care have a responsibility to report in good faith any instances of wrongdoing to appropriate authorities without fear of retaliation.

Community Care's Provider Auditing Process

Community Care's Compliance Department is responsible for ensuring that all Providers delivering services to our HealthChoices members are adhering to federal and state regulations. The General Provisions for MA Programs, Established by Title 55 Chapter 1101 of the Pennsylvania Code, is the primary resource used by the auditors when conducting an audit. The scope is clearly defined in the language of the regulation, "This chapter sets forth the MA regulations and policies which apply to **all providers.**" Regulations specific to each type of provider are located in separate chapters relating to each provider type.

In addition to Chapter 1101 of the PA Code, any DPW issued bulletins that apply to the program being reviewed are used during the auditing process. Contractual agreements, including fee schedules, and previously submitted corrective action plans are all a part of the audit review process.

What Auditors Look For

- Does the documentation substantiate the claim (i.e., does the progress note clearly outline the interventions that were used during the session)?
- Did the provider bill for the time actually spent providing treatment with the member?
- Does the documentation reflect that services provided meet the service definitions, performance specifications and state and federal regulations?
- Is there missing documentation?
- Is there an inappropriate rounding-up of units?
- Is there a falsification of services/credentials?

Community Care's Compliance Department is always available to assist providers with questions or concerns surrounding any compliance issue. In addition, trainings are offered to providers in order to ensure that all regulations are being followed and that services are being delivered appropriately.