



Ohio Health Plan's Procedures for
Detecting Fraud, Waste and Abuse

The Ohio Department of Job and Family Services (ODJFS) as the Single State Medicaid Agency has numerous processes to prevent and detect fraud, waste, and abuse in the Medicaid program. Various areas of ODJFS, the Ohio Attorney General's Office (AG), the Ohio Auditor of State (AOS), the United States Department of Justice, and the Department of Health and Human Services (HHS) each contribute to the oversight, detection and prevention of fraud, waste, and abuse for the ODJFS's, Office of Health Plans (OHP). ODJFS has dual overall purposes for Program Integrity of Medicaid: pre-payment education; and prevention of provider fraud waste, and abuse.

Within ODJFS are various auditing, tracking, referral, monitoring, education/prevention, and collection responsibilities.

Auditing, including final fiscal audits and limited reviews, is the responsibility of the Office of Research, Assessment, and Accountability (ORAA) -- primarily its Surveillance and Utilization Review Section (SURS). The responsibility of prosecution of all fraud cases lies within the Health Care Fraud (referred to as the Medicaid Fraud Control Unit, or MFCU) section of the AG, County Prosecutors and the U.S. Attorneys Office.

OHP is responsible for the activities of provider education, pre-payment prevention of overpayments, quality control and quality assurance, in addition to promulgating policy. Collection activities are provided through the Office of Fiscal Services (Fiscal). Fiscal monitors and tracks all overpayment recovery. Fiscal is responsible for certifying overpayment collections to the Collections Enforcement Section of the AG and for monitoring and reporting the collection activities.

Program integrity resolution functions, including litigation support and negotiating settlements or payment plans, is the responsibility of the Office of Legal Services (OLS).

The overall responsibility of the Office of the Chief Inspector (OCI) is to ensure that all programs administered or supervised by ODJFS comply with state and federal laws, rules and regulations as they relate to or involve internal controls, safety practices and ethical or legal considerations for ODJFS staff through technical assistance, coordination, and inquiry.

The AOS, has independent audit authority pursuant to R.C.117.10, to perform audits of Medicaid providers and also performs limited claims review as part of the annual State of Ohio Single State Audit.

Data mining of claims is a technique utilized by SURS and the AOS that may result in investigations, audits and prosecutions of Medicaid fraud, waste and abuse committed by providers. The AG also accesses ODJFS claims data

to support its investigations. Various task forces (local, state and national) also provide referrals for such investigations, audits, and prosecutions.

Within ODJFS many areas conduct activities designed to detect and prevent fraud, waste and abuse of Medicaid funds.

The Bureau of Long Term Care Facilities Section completes a statistical analysis of the nursing facilities and intermediate care facilities for the mentally retarded and provides the selections to the Office of Research, Assessment and Accountability (ORAA), Bureau of Audits (BOA) for audit or review. Such audits are completed either by ORAA staff or by contracted CPA firms who follow agreed-upon procedures.

The Bureau of Home and Community Services (BHCS) conducts annual structural (program) compliance reviews of providers participating in ODJFS administered waivers through the contracted case management agency, CareStar. If the review identifies possible overpayments or suspicious billing, BHCS makes referrals to SURS or AGMFCU for further review and potential recovery.

The Hospital section of OHP conducts Audits regarding Hospital payments through a two-step process including an Interim Settlement and a Final Settlement. Hospitals are required to have independent audits of the Hospital Care Assurance Program (HCAP) data completed by a CPA before filing their cost report. ODJFS then reviews a sample of the audit reports for compliance and makes adjustments in review procedures based upon their findings. Additionally, hospitals are subject to precertification review, and targeted reviews on admissions and/or medical procedures by a Hospital Utilization Management Contractor.

Pharmacy utilization is subject to review by an outsourced contractor, currently Affiliated Computer Services (ACS) State Healthcare, and by the Drug Utilization Review (DUR) Board for identifying patterns of utilization that may be unnecessary or wasteful. SURS and AOS may also conduct audits of providers related to pharmaceutical patterns of use. For consumers of Medicaid benefits, when patterns of utilization indicate abuse of the benefits they are proposed for enrollment in the Primary Alternative Care and Treatment (PACT) Program or may be reviewed by the DUR committee.

OHP staff provides general oversight and subrecipient monitoring of other agencies within the State of Ohio that receive Medicaid funding for programs of health care.

The Payment Error Rate Measurement, commonly referred to as PERM, is a comprehensive on-going federal audit to measure how frequently errors may occur when providers submit claims to States and States pay those claims. All

50 states will be measured over a three year period; Ohio has been selected to be one of the first States in the federal audit of federal fiscal year 2006. Ohio will subsequently be selected to participate in PERM every three years, so the next audit will be for claims paid during federal fiscal year 2009. PERM is authorized by the "Improper Payments Information Act of 2002".

ODJFS provides oversight of Managed Care Plan contracts for assessment of accountability and performance, including access, quality of care, consumer satisfaction, and administrative capacity. Each Managed Care Plan contracting with ODJFS must have a compliance plan that is designed to guard against fraud and abuse, in accordance with federal guidelines, that is monitored by ODJFS and must promptly report all instances of fraud and abuse to ODJFS. The plans followed by the Managed Care Plans have been approved by the Centers for Medicare and Medicaid Services. Additionally, each Managed Care Plan annually submits to ODJFS a report summarizing the fraud and abuse activities for the previous year and identify any proposed changes to the fraud and abuse program for the upcoming year.

ODJFS has employed a contractor, Public Consulting Group (PCG), to examine potential third-party payors for claims. PCG provides services relating to those individuals eligible for Medicaid payment of their medical services who also have independent sources for payment of medical services, such as insurance policies. Additionally, PCG assists in the recovery of payments made as a result of tort actions where another individual is found to be at fault in an accident and has an insurance policy or other source of payment to reimburse for medical services provided.

The Bureau of Audits (BOA) within ORAA is responsible for providing audit services on behalf of ODJFS and audits county agencies, state agencies, long-term care providers, clinics, developmental centers, PASSPORTs, and other Medicaid sub grantees and sub recipients of ODJFS. The audit staff utilizes audit methodologies consistent with professional auditing standards in the review and audit of Medicaid payments and are in accordance with "Generally Accepted Auditing Standards" as required in the Ohio Administrative Code Section 5101:3-1-27.

SURS, in its audits of Medicaid providers, accesses provider information through the Decision Support System (DSS) and through the Medicaid Management Information System (MMIS) for investigating provider utilization of Medicaid reimbursement. SURS uses several types of exception reports to identify potential overpayments, abuse or fraud. SURS also responds to complaints of questionable practices, including allegations of fraud, for initiating investigations. SURS conducts limited investigations and full scope audits to determine whether a provider has been overpaid or has abused Medicaid reimbursements.

ODJFS is a participant in the Medi-Medi program that is a federal and state partnership program to compare claims submissions between Medicare and Medicaid to discover inappropriate or duplicate claims submission by Medicaid and Medicare providers. The program identifies possible programmatic vulnerabilities, identifies overpayments.

The County Departments of Job and Family Services are primarily responsible for pursuing cases of Medicaid recipient fraud with oversight from ODJFS in ORAA.

If you become aware of Medicaid fraud, waste or abuse you should report the activity to one of the following:

ORAA at 614-466-7936

MFCU at 1-800-642-2873.

AOS at 1-800-282-0370.



State And Federal False Claims Act

And Whistleblower Protections

OVERVIEW

The Federal False Claims Act (FCA) is an important mechanism for the Ohio Attorney General (OAG) and the Ohio Department of Job and Family Services (ODJFS) because it permits these state agencies as well as private citizens to sue anyone who submits a false claim to obtain funds from Ohio's Medicaid program for civil damages. Furthermore, the FCA amplifies Ohio state law because unlike Ohio, the FCA permits anyone who files a false claim to be sued for damages whereas Ohio only permits providers of health care services to be sued if they file a false claim. Other important aspects of the FCA are the incentives and protection afforded to whistleblowers under the FCA. Whistleblowers are entitled to a portion of the damages recovered in a suit to which he or she participated, and employees who come forward to report suspected fraud are protected from retaliation by their employers.

WHAT IS THE FCA?

The purpose of the FCA is to recover taxpayers' money that was fraudulently paid to individuals who deceived the government.

The FCA was revised in 1986 because of the increase in fraud perpetuated against the federal and state governments. These revisions helped to strengthen the joint effort needed between the federal and state governments to eliminate the fraud, waste and abuse of government funds, particularly those funds illegally earned through government contracts. These revisions also included more incentives for whistleblowers to come forward with reports of fraud. "By doing so, Congress put into play a powerful public-private partnership for uncovering fraud against the federal fisc and obtaining the maximum recovery for American taxpayers."

The FCA is a valuable device to the OAG and the ODJFS to help maintain the integrity of Ohio's Medicaid program because it specifically provides a mechanism for the government or private individuals to file a civil lawsuit against those who would otherwise be outside the reach of civil prosecution by Ohio because of its limited false claims act. Ohio's false claim act applies only to providers of medical services who receive compensation from the Medicaid program. Together, with knowledge of the FCA, the OAG, ODJFS and private citizens can help eliminate the fraud, waste and abuse of government funds in Ohio.

1. Analysis of the Federal Provisions

The FCA holds anyone who submits or causes someone else to submit a false or misleading claim for government funds liable for civil damages. 31 U.S.C. §§3729-3733. Entities such as businesses, corporations, managed care

providers, among others, can also be liable under this act for submitting false claims. A claim is simply some demand for money or property to which the government provides any portion of the money or property requested, and it is the filing of an untrue claim that brings liability upon the person who purported it to be true.

The FCA encompasses several different examples of falsifying claims including, but not limited to: falsifying medical records submitted, billing for services not rendered or goods not provided, duplicating billing to obtain double compensation, and billing, certifying, or prescribing services medically unnecessary. Additionally, no proof of specific intent to defraud the government is required to be held liable under the FCA. All that is required is that the person has actual knowledge, or has acted with deliberate ignorance or reckless disregard of the truth/falsity of his or her claim. Basically, the defense of “I didn’t know it was illegal or that my timesheet was false” does not work.

The FCA also mandates whistleblower protections and incentives for employees to come forward and report misconduct. 31 U.S.C. § 3730. Generally, a person who knows about the filing of false claims (the whistleblower) may bring a civil action on behalf of the government for a violation of FCA. After the whistleblower files a suit, the government can pursue the claim on its own, or decline to intervene and allow the whistleblower to continue. If the whistleblower’s case goes forward, no one else can bring a separate action later. Furthermore, depending on the outcome of the case and the whistleblower’s involvement in the prosecution of the case, the whistleblower may be entitled to up to thirty-percent (30%) of the proceeds of the action or settlement.

Under the FCA, a whistleblower also has protection from possible retaliation by his or her employer or fellow employees. For example, after the initial filing of a case, the case remains under seal for sixty (60) days and is not accessible by the public. Moreover, any person who is harassed or discriminated against in any way because of his or her involvement in a FCA action has the right to be made whole. The whistleblower’s damages include reinstatement of their job position, two times (2x) back pay, plus interest, and compensation for any special damages including reasonable litigation and attorneys’ fees.

2. Federal Administrative Remedies

The Civil Monetary Penalties (CMP) law is a federal administrative remedy that allows the federal government to pursue civil monetary penalties against anyone who files a false or misleading claim. 42 U.S.C. § 1320a-7a. Such claims are pursued by the Office of the Inspector General. Penalties for filing a false or fraudulent claim include a possible fifty-thousand dollar (\$50,000.00) fine for each act and the assessment of damages three times (3x) the amount of overpayment due.

3. State Provisions – False Claims

Although Ohio does not have a law equivalent to the FCA there are still laws that regulate the filing of false claims in an attempt to defraud Medicaid. Under Ohio law, only providers can be civilly liable for obtaining or attempting to obtain “payments . . . to which the provider is not entitled pursuant to the provider agreement, or the rules of the federal government or the department of job and family services.” RC 5111.03. Similar to the FCA no actual intent to deceive or defraud the government is necessary. If a provider is found to have violated this particular law he or she could be subject to several civil penalties, including, but not limited to: payment of interest (at the maximum rate) on the amount of the excess payments, payment of three times (3x) the amount of any excess payments, a fine between five (5) and ten thousand dollars (\$10,000.00) for each false filing, and any other reasonable expenses determined by the court. Moreover, a provider will also have his or her provider agreement terminated for five years.

In some circumstances, a provider or any other person who has to repay funds because they provided a false statement to the Medicaid program may also be criminally liable for Medicaid Fraud. RC 2913.40. However, a civil judgment is not a pre-requisite to the filing of a criminal charge, and criminal charges are not limited solely to providers; therefore, anyone who files a false claim or in some way participates in a scheme to file false claims for Medicaid funds can be charged with fraud. Anyone charged with Medicaid Fraud faces a misdemeanor or felony charge depending on the amount of money received fraudulently. If convicted, the individual could go to jail and be ordered to pay fines and restitution. Additionally, if someone, specifically a licensed medical provider, is found guilty of Medicaid Fraud either civilly or criminally, their license can come under review and be suspended or permanently revoked as a result of their fraudulent activity.

4. State Whistleblower Protections

In accordance with Ohio Revised Code (ORC) 124.341 state employees are permitted to file a written report that identifies either 1) a violation of state or federal law or 2) the misuse of public resources that the employee becomes aware of in the course of employment. The written report is to be filed with the employee’s supervisor or appointing authority (assuming the supervisor or appointing authority has the authority to correct the violation or misuse).

The statute also permits the employee to report the violation of state or federal law or misuse of public resources to a prosecuting attorney, law enforcement or similarly situated person, if the employee reasonably believes that the violation is a criminal offense, or to the Ethics commission if the employee believes that is appropriate.

ORC 124.341 permits a state employee to file an appeal with the state personnel board of review if retaliatory or disciplinary action is implemented as a result of the employee filing a report of a violation of state or federal law or the misuse of public resources. ORC 124.341 further provides that the appeal is the only recourse available to the reporting employee and must be filed within thirty days of the employee receiving the notice of action.

Similarly, ORC 4113.52 provides protections for non-state employees. This statute permits employees to report to their supervisor or other responsible officer of their employer, violations of state or federal statute or any ordinance or regulation of a political subdivision that the employer has authority to correct and the employee reasonably believes that the violation either is a criminal offense that is likely to cause an imminent risk of physical harm to persons or a hazard to public health or safety or is a felony. The non-state employee shall orally notify the supervisor or other responsible officer of his employer of the violation and subsequently file a written report describing the violation.

This statute also provides that if the employer neither corrects nor makes a reasonable and good faith effort to correct the violation within twenty-four hours after receiving notice of the violation, the employee may file a written report of the violation with any of the following: 1) the prosecuting attorney of the county or municipal corporation where the violation occurred, 2) law enforcement, 3) any governmental entity that has regulatory authority over the employer, or 4) the inspector general (if the violation is within his jurisdiction).

If an employer takes disciplinary or retaliatory action against the reporting non-state employee, ORC 4113.52(B) permits the non-state employee to file a civil action for injunctive relief or other remedies in a court of common pleas, provided the action is brought within one hundred eighty days after the date the disciplinary or retaliatory action was taken. The court may render a judgment that may order reinstatement of the employee, payment of back wages, reinstatement of fringe benefits and seniority rights or any combination of remedies. The court may also award the prevailing party all or a portion of the costs of litigation in an amount the court determines to be appropriate.

Both statutes provide protections for employees who follow the statutory procedures in reporting any of the previously stated matters. The employee must make a reasonable effort to ensure the accuracy of information included in the report and, if it is shown that the employee purposely, knowingly, or recklessly reported incorrect or false information, the employee is subject to disciplinary action, including suspension or removal.

If you have any questions about these federal and state provision you can contact the Ohio Attorney General, Health Care Fraud Section at 1-800-642-2873.