

MISSOURI DEPARTMENT OF MENTAL HEALTH POLICY TO PROVIDE INFORMATION ABOUT COMBATING WASTE, FRAUD AND ABUSE AND THE ABILITY OF EMPLOYEES TO REPORT WRONGDOING

Legal Reference: Public Law 109-171, Deficit Reduction Act of 2005, Sec. 6032

It is the policy of The Missouri Department of Mental Health (DMH) that all claims for payment made to the Medicaid program shall only be for payment and services actually rendered. DMH, in accordance with the False Claims Act, shall have policies and procedures in place that assure that only legitimate claims are filed and for monitoring the claims process to assure that only proper claims are filed.

This policy and the information contained in it shall be distributed to all current and new employees and to all current and future contractors of DMH.

This policy includes the following information concerning tools DMH uses to fight fraud, waste and abuse in the administration of federal and state programs within DMH.

- A summary of the Federal False Claims Act
- A summary of administrative remedies found in the Program Fraud Civil Remedies Act
- A summary of laws of the state of Missouri that impose civil or criminal penalties for false claims or statements
- A summary of protections for employees (whistleblowers) who report suspected violations of these federal and state laws.
- DMH's existing policies and procedures for detecting and preventing fraud

The Federal False Claims Act 31 U.S.C. 3729 to 3733

The Federal False Claims Act (FCA) applies to any federally funded contract or program, except tax fraud. The FCA was expanded to include Medicare and Medicaid programs in 1986.

Summary of Provisions: The FCA prohibits knowingly making a false claim against the government. False claims can take the form of overcharging for a product or service, delivering less than the promised amount or type of service, delivering less than the promised amount or type of goods or services, underpaying money owed to the government and charging for one thing while providing another.

Penalties: The FCA imposes civil penalties and is not a criminal statute. Therefore, no proof of specific intent as required for violation of a criminal statute is necessary.

Persons may be fined a civil penalty of not less than \$5,000 nor more than \$10,000, plus three (3) times the amount of damages sustained by the government for each false claim. The amount of damages in health care terms is the amount paid for each false claim that is filed.

Qui Tam (Whistleblower) Provisions

Any person may bring an action under this law (called a *qui tam* relator or whistleblower suit) in federal court. The case is initiated by causing a copy of the complaint and all available relevant evidence to be served on the federal government. The case will remain sealed for at least sixty (60) days and will not be served on the defendant so the government can investigate the complaint. The government may obtain additional time for good cause. The government on its own initiative may also initiate a case under the FCA.

After the sixty (60) day period, or any extensions, has expired, the government may pursue the matter in its own name, or decline to proceed. If the government declines to proceed, the person bringing the action has the right to conduct the action on their own in federal court.

If the government proceeds with the case, the *qui tam* relator bringing the action will receive between fifteen (15) and twenty-five (25) percent of any proceeds, depending upon the contributions of the individual to the success of the case. If the government declines to pursue the case, the *qui tam* relator will be entitled to between twenty-five (25) and thirty (30) percent of the proceeds of the case, plus reasonable expenses and attorneys fees and costs awarded against the defendant.

Any case must be brought within six (6) years of the filing of the false claim.

Anyone initiating a *qui tam* case may not be discriminated or retaliated against in any manner by their employer. The employee is authorized under the FCA to initiate court proceedings to make themselves whole for any job related losses resulted from any such discrimination or retaliation.

Program Fraud Civil Remedies Act, 31 U.S.C. Chapter 38

The Program Fraud Civil Remedies Act created administrative remedies for making false claims separate from and in addition to, the judicial or court remedy for false claims provided by the Civil False Claims Act.

The Act is quite similar to the Civil False Claims Act in many respects, but is somewhat broader and more detailed, with differing penalties. The Act deals with submission of improper “claims” or “written statements” to a federal agency.

Specifically, a person violates this Act if they know or have reason to know they are submitting a claim that is:

- False, fictitious or fraudulent; or

- Includes or is supported by written statements that are false, fictitious or fraudulent; or
- Includes or is supported by a written statement that omits a material fact; the statement is false, fictitious or fraudulent as a result of the omission; and the person submitting the statement has a duty to include the omitted facts; or
- For payment for property or services not provided as claimed.

A violation of this prohibition carries a \$5,000 civil penalty for each such wrongfully filed claim. In addition, an assessment of two times the amount of the claim may be made, unless the claim has not actually been paid.

- A person also violates this Act if they submit a written statement that they know or should know; or
- Asserts a material fact that is false, fictitious or fraudulent; or
- Omits a material fact and is false, fictitious or fraudulent as a result of the omission. In this situation, there must be a duty to include the fact and the statement submitted contains a certification of the accuracy or truthfulness of the statement.

A violation of the prohibition for submitting and improper statement carries a civil penalty of up to \$5,000.

Missouri Anti-Fraud Laws Related to Health Care

Health Care Payment Fraud and Abuse (§§ 191.900 – 191.910, RSMo)

The Missouri General Assembly has enacted statutes directed at prosecuting Medicaid fraud. The statutes carry both civil and criminal penalties. Because violation of the statutes can be criminal in nature, the element of intent is required. This is a higher standard than found in the two federal statutes discussed, above, which require only that a person knew or should have known they were committing a violation. There are no whistleblower protections contained in this particular set of statutes. However, whistleblower protections contained in other Missouri statutes would apply to reporting of violations of this statute. These protections are described elsewhere in this policy.

The acts proscribed by state statute fall into two categories: direct fraudulent conduct and conduct related to improper remuneration in exchange for referrals or purchasing of “health care.” “Health care” is defined very broadly to include all health care services and products. The statute addresses two types of conduct – direct fraud and kickbacks.

❖ **Direct Fraud** – § 191.905.1, RSMo, prohibits:

- Knowingly presenting a claim for payment that falsely states the health care provided was medically necessary.

- Knowingly concealing an event affecting initial or continued payments by a medical assistance program for providing care.
 - Knowingly concealing or failing to disclose any information in order to obtain a payment from a medical assistance program to which the health care provider is not entitled or improperly increasing the amount of any such payment to which the health care provider is entitled.
 - Knowingly making a claim for payment for health care that was provided that has a lesser value than the amount of the claim.
- ❖ **Anti-referral (antikickback)** – § 191.905.2, RSMo, parallels the federal Medicare antikickback statute. The state statute prohibits knowingly offering or paying, or soliciting or receiving in any manner whatsoever, remuneration (anything of value) in exchange for referring another person for health care services or for purchasing or furnishing of health care. The statute provides for an exception for discounts that are properly disclosed and accounted for in cost reports and for remuneration paid to employees. The statute also incorporates the safe harbors provided for in federal regulations as additional exceptions.

Other statutes that may be violated:

- ❖ **Stealing** – §§ 570.030 and 570.040, RSMo.
- ❖ **Unlawfully obtaining public assistance benefits** – § 205.967, RSMo.
- ❖ **False Declaration to a public servant** – § 575.060, RSMo.

✚ Whistleblower Protections

“Whistleblowers” are generally employees who observe activities or behavior that may violate the law in some manner. These individuals report their observations either to management or to governmental agencies. Laws have been enacted to protect these individuals. Protections afforded to *qui tam* relators are discussed, above, under the section describing the federal Civil False Claims Act.

Missouri law (§ 105.055, RSMo) requires the following protections for state employees reporting potential mismanagement or violations by a state agency:

- Prohibits any supervisor with power to hire or fire from using their authority from discriminating against, retaliating against, dismissing or in any manner penalizing any employee making reports described below.

The forgoing protections apply to any employee who in good faith reports—

- Alleged mismanagement, a gross waste of funds or abuse of authority, or a substantial and specific danger to public health or safety;
- Alleged violations of federal or state laws or administrative rules.

However, these requirements are not meant to:

- Prohibit a supervisor from requiring that an employee inform the supervisor as to legislative requests for information or the substance of an employee's testimony made or to be made to legislators;
- Permit an employee to leave their assigned work area during normal working hours without following applicable policies and procedures;
- Authorize an employee to represent their views as those of their employer; or
- Preclude an employer from taking appropriate disciplinary actions against an employee if: the employee knew that the information was false; the information is closed or is confidential under the provisions of the open meetings law or any other law; or the disclosure relates to the employee's own violations, mismanagement, gross waste of funds, abuse of authority or endangerment of the public health or safety.

Pursuant to section 105.055.7, RSMo, an employee may also bring a civil action for damages within ninety (90) days after the occurrence of the alleged violation in the circuit court for the county where the alleged violation occurred, the county where the complainant resides, or the county where the person against whom the civil complaint is filed resides. Such employee must show by clear and convincing evidence that he or she or a person acting on his or her behalf has reported or was about to report, verbally or in writing, a prohibited activity or a suspected prohibited activity. A court, in rendering a judgment in an action brought pursuant to this section, shall order, as the court considers appropriate, actual damages, and may also award the complainant all or a portion of the costs of litigation, including reasonable attorney fees.

DMH, through Department Operating Regulation 6.015, establishes a department wide policy confirming the rights and protections of DMH employees as set forth above in section 105.055, RSMo.

✚ DMH, through its Divisions, utilizes policies and procedures to detect and prevent fraud and works in collaboration with the Missouri Medicaid Audit and Compliance Unit

The state of Missouri has a unit within the Department of Social Services, Missouri Medicaid Audit and Compliance (MMAC), which has the primary responsibility for auditing Medicaid claims and conducting Medicaid provider reviews in the state to ensure the integrity of the Medicaid program and that payments are appropriate, and to detect fraud, waste and abuse. DMH has a cooperative agreement with MMAC to coordinate activities and share information. Per this agreement, DMH participates in Medicaid related training as necessary and provides training in conjunction with MMAC to providers regarding eligibility, due process and billing

and payment. DMH reports instances of providers' noncompliance to MMAC and cooperates with MMAC in pursuing sanctions or other action necessary and appropriate to remedy the noncompliance. Such actions may include, but are not limited to:

- Recovery of funds
- Corrective action plan
- On-site monitoring
- Technical assistance
- Cancellation of contract
- Denial of certification
- Suspension or termination from Medicaid program

DMH, through its Divisions, has policies and procedures in place to assure against waste, fraud and abuse. This is accomplished through prevention, detection and remediation practices that are incorporated into the operation of each Division.

❖ **Division of Alcohol and Drug Abuse (ADA)**

All contracted ADA treatment providers enroll consumers into DMH's Customer Information Management, Outcomes, and Reporting (CIMOR) System. The CIMOR system includes business rules that ensure claims will not be processed and paid if it does not meet established criteria for the service being provided. There are similar edits within the MMIS system at the state Medicaid agency (MO HealthNet). Reimbursement for services is also subject to the Customary Service Authorization that limits the amount that can be paid for any given client unless a request is made to the Division's Clinical Review Unit for additional authorization. The Clinical Review Unit may request submission of any document(s) or record(s) to evaluate whether services are necessary, appropriate, likely to benefit the client, and provided in accordance with admission criteria and service definitions.

For those programs without accreditation from a nationally recognized accreditation body, annual safety and basic assurance reviews are conducted, along with triennial certification surveys, to determine agency compliance with the ADA's certification, contract, and billing requirements. A random sample of invoices and client records are examined during these reviews. For all contracted programs, billing reviews of non-Medicaid services are conducted on an annual basis.

As part of the core rules for substance abuse programs, ADA requires all community providers receiving Medicaid funding for DMH-ADA programs to have a corporate compliance officer and corporate compliance plan within their agency to prevent and detect healthcare fraud.

❖ **Comprehensive Psychiatric Services (CPS)**

All contracted CPS treatment providers enroll consumers into DMH's CIMOR System. The CIMOR system includes business rules that ensure claims will not be processed and paid if it does not meet established criteria for the service being provided. Edits limiting paid claims to appropriate service levels are established in both the CIMOR system and in the MMIS system at MO HealthNet.

For those programs without accreditation from a nationally recognized accreditation body, annual safety and basic assurance reviews are conducted, along with triennial certification surveys, to determine agency compliance with the CPS's certification, contract, and billing requirements. A random sample of invoices and client records are examined during these reviews. For all contracted programs, billing reviews of non-Medicaid services are conducted on an annual basis.

As part of the core rules for psychiatric programs, CPS requires all community providers receiving Medicaid funding for DMH-CPS programs to have a corporate compliance officer and corporate compliance plan within their agency to prevent and detect healthcare fraud.

❖ **Division of Developmental Disabilities (DD)**

All contracted DD treatment providers enroll consumers into the DMH's Customer Information Management, Outcomes, and Reporting (CIMOR) System. The CIMOR system includes business rules that ensure claims will not be processed and paid if it does not meet established criteria for the service being provided. Edits limiting paid claims to appropriate service levels are established in both the CIMOR system and in the MMIS system at MO HealthNet.

Staff employed with the DD Regional Offices, County Boards for Developmental Disability Services (also called "Senate Bill 40 Boards"), and local not-for-profit organizations provide case management that is billed to MO HealthNet as targeted case management (TCM) when the individual is Medicaid eligible. Regional offices designate supervisory staff responsibility for reviewing a sample of one full day of logging per case manager annually to ensure logging procedures are followed. Case managers are provided feedback regarding any errors that are detected and all errors must be remediated. Remediation may include staff training, claim adjustments, disciplinary action, etc. The outcome of the monitoring is entered into a data base maintained by the Division and staff from the Federal Programs Unit randomly reviews data to insure inter-rater reliability. Quality Enhancement staff generates annual reports that are made available to MO HealthNet. Other entities that have an agreement with the Division to also provide TCM, must have a similar monitoring process. Regional Office staff monitors the provision of TCM by non-state entities.

All services provided through Home and Community Based Waivers administered by DD must be prior authorized and providers must bill against the prior authorization file. Case managers monitor consumer services to ensure individuals are receiving

the services that are included in their plan and are authorized. When there are significant discrepancies (evidence services have not been provided), a referral to the Missouri Medicaid Audit and Compliance office is made.

Providers under contract with the Division of Developmental Disabilities whose reimbursements from the Division exceed \$300,000 annually including both state and federal funds are required to submit a uniform cost report to the Division every three years. Contractors providing only personal care attendant, transportation, therapy, specialized medical equipment or environmental accessibility adaptations are exempt from the requirement to submit a uniform cost report.

The expenditures of the DD Medicaid Waiver Programs are subject to the State of Missouri Single Audit conducted by the Missouri State Auditor's Office

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