Advisory

JUNE 2015

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Five Tips from Wiggin and Dana's Health Care Compliance and Enforcement Roundtable

On May 14, 2015, Wiggin and Dana held its annual Health Care Compliance and Enforcement Roundtable with an in-depth focus on the Connecticut False Claims Act. Attendees heard insights from representatives from the three state agencies that oversee health care fraud and abuse enforcement: Michael E. Cole, Assistant Attorney General, Chief of the Antitrust and Government Program Fraud Department, Connecticut Attorney General's Office; Christopher Godialis, Medicaid Fraud Control Unit Director, Chief States Attorney's Office; and John McCormick, Director, Office of Quality Assurance, Connecticut Department of Social Services. Wiggin and Dana's Litigation Department Chair, James Glasser, moderated the session.

Based on the panel's lively discussion, health care providers may want to consider the following:

1. **The state and federal agencies responsible for health care fraud enforcement communicate early and often.** When a health care fraud case is referred to a state or federal agency, representatives from the agencies communicate with each other to determine which agency is best suited or able to investigate. Fraud enforcement is approached as a team. According to Christopher Godialis, Medicaid Fraud Control Unit Director, Chief States Attorney's Office, the state and federal agencies work "independently, but together." He explained that providers should feel confident that these agencies will all be on the same page regarding the disposition of a case. In fact, the agencies collaborate through a four way Memorandum of Understanding among the Connecticut Department of Social Services, the Connecticut Chief State's Attorney's Office, the Connecticut Attorney General's Office, and the United States Department of Health and Human Services Office of Inspector General. These agencies hold quarterly calls and/or meetings to coordinate and discuss their open cases.

2. **Data mining is a major source of fraud detection.** John McCormick, Director, Office of Quality Assurance, Connecticut Department of Social Services, explained that state enforcement officials receive referrals concerning alleged fraud from the very active Connecticut healthcare fraud hotline. The state also relies heavily on data mining to detect seemingly aberrant patterns and to identify potential targets for investigation. He stated that the state uses its own analysts, as well as outside consultants, including 21CT, a company located outside Connecticut, to perform these analytics. Each state agency responsible for health care fraud enforcement receives reports from 21CT identifying suspect providers.

3. **Behavioral health providers are being targeted with increasing frequency.**

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While audits and enforcement have been focused on pediatric dentists, a shift has begun and a focus in on behavioral health care providers. Since these providers use time-based codes to bill for their services, fraud is often easier to detect, investigate and prove. Billing patterns for these providers lends itself to data mining. If a provider is billing for more hours than there are in a day, "that is a clue," and investigators will assume fraud.

4. **The expectation is that every provider has a compliance plan.** Michael E. Cole, Assistant Attorney General, Chief of the Antitrust and Government Program Fraud Department, Connecticut Attorney General's Office, explained that the Affordable Care Act mandated that every Medicaid provider have a compliance plan. He said that despite the lack of regulations setting forth the requirements for such compliance plans, a provider that completely lacks any plan will not be viewed favorably.

5. **Mock audits can be a double-edged sword.** The panelists agreed that providers are well-advised to conduct their own internal audits and reviews. John McCormick specifically mentioned mock audits to ensure that providers fare well when they are eventually audited by state or federal authorities. In conducting these audits, however, providers must also be aware that any overpayments identified in the course of an audit must be returned. It is not enough for providers to simply take corrective actions going forward; they must also focus on returning the overpaid funds to the government. According to John McCormick, Director, Office of Quality Assurance, Connecticut Department of Social Services, his office is very open to self-disclosure. Although there is no formal process in place, Mr. McCormick explained that he wants to encourage providers to self-disclose and, to that end, will work with providers to determine a workable payment plan for return of the overpayment.

SAVE THE DATE

Save the date for our next Roundtable discussion on *Whistleblowers and the False Claim Act: What You Need to Know*, taking place on Wednesday, October 21, 2015 at the Indian Harbor Yacht Club in Greenwich.