

# Ethics and Consumer Choice

Provider Orientation Cumberland  
County Mental Health LME

# Introduction



- What is it all for?
- Why are you in business?
- What is your guide to making ethical choices?



- Referral and Client Recruitment Practices- May 12, 2004 memo from the Division. It's the law.



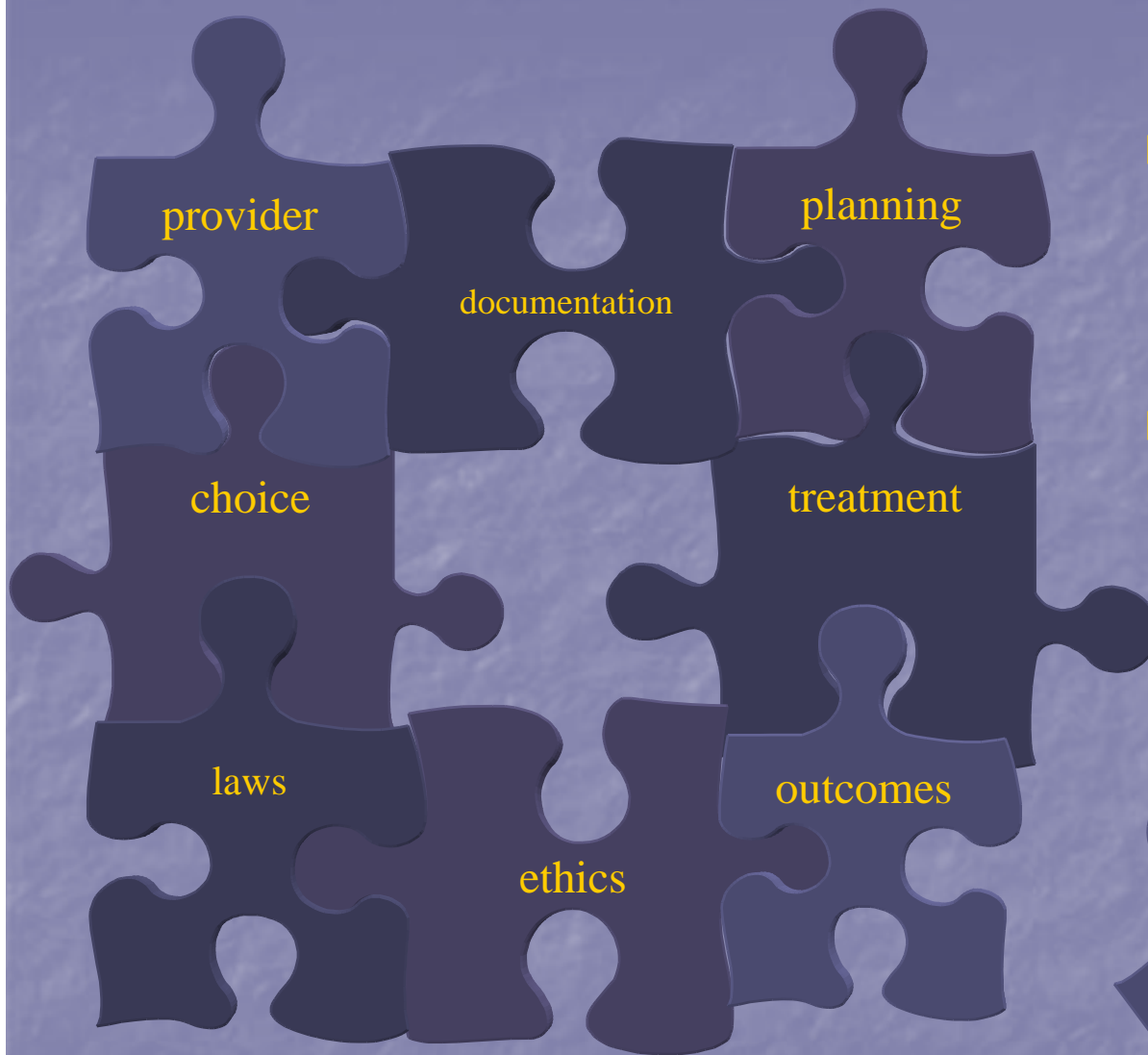
- Disclosure of Financial Interests



- Clients' Rights. Consumer choice – or provider convenience.



- False Claims Act

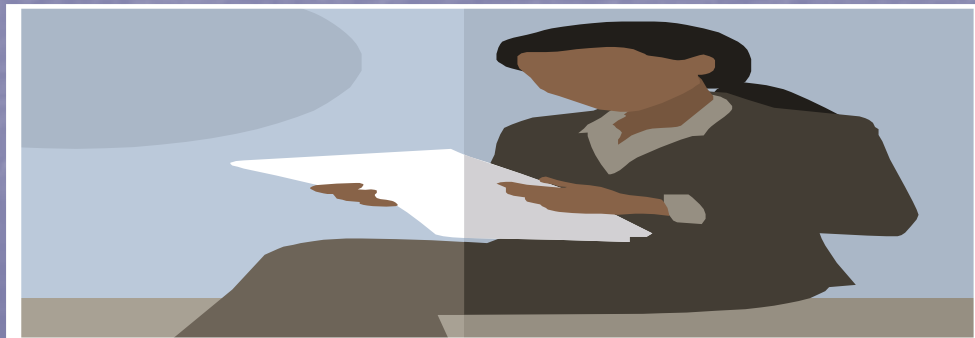


- ❑ What is best for the consumer?
- ❑ Doing the “right” thing – hard choices.



# Referral and Client Recruitment Practices

- In 2004 in response to becoming aware of “some questionable practices concerning the recruitment and solicitation of consumers by providers”, the Division of Mental Health, Developmental Disabilities and Substance Abuse issued a memo citing cases that were “in violation of one or several applicable laws”.



# Referral and Client Recruitment Practices

## Situation #1:

"Provider A is going to Provider B's employees and telling them they will pay the employee more per hour if they work for them and bring the client with them."

Verdict



Violation of the Federal anti-kickback statute.

# Referral and Client Recruitment Practices

## Situation # 2

"Provider is offering clients 'Bonus' services if they will sign with the provider (i.e., sign with me for 50 hours of personal care and we will give you five for free). The additional hours are not charged to the Medicaid program.

Verdict



Violation of the Federal anti-kickback statute.

# Referral and Client Recruitment Practices

## Situation #3

"Provider puts an advertisement in the newspaper soliciting client referrals from anybody, and promising a referral fee."



Verdict

Violation of the Federal anti-kickback statute.

# Referral and Client Recruitment Practices

## Situation #4:

“Providers are giving referral fees to case managers for referrals to their agencies.”

Verdict



Violation of the Federal anti-kickback statute;  
a serious violation.



## NEW RULE 10A NCAC 27G .0212 DISCLOSURE OF FINANCIAL INTEREST OF PROVIDERS OF MH/DD/SA SERVICES TO POTENTIAL CLIENTS



- (a) When a provider refers a potential client to another provider in which the referring provider holds a financial interest, the referring provider shall disclose and document the disclosure of the financial interest to the potential client prior to or at the time of referral.
- (b) A referring provider shall be considered to have a financial interest when the referring provider is an owner, principal, employee, a potential employee of the provider who is in the hiring process, immediate family member of an owner, principal employee or an affiliate of the provider that the potential client is referred to.

**NEW RULE**  
**10A NCAC 27G .0212 DISCLOSURE OF FINANCIAL  
INTEREST OF PROVIDERS OF MH/DD/SA SERVICES  
TO POTENTIAL CLIENTS**

- (c) For purposes of this Rule, a "referring provider entity" includes:
  - (1) an agency;
  - (2) an organization;
  - (3) a local management entity (LME) as set forth in G.S. 122C-3(20b); or
  - (4) an individual employee or contractor of an agency, organization or LME.
  
- (d) For purposes of this Rule, "immediate family member of an employee" means husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.



## NEW RULE 10A NCAC 27G .0212 DISCLOSURE OF FINANCIAL INTEREST OF PROVIDERS OF MH/DD/SA SERVICES TO POTENTIAL CLIENTS

- (e) For the purposes of this Rule, "affiliate" means any person or organization that controls or did control a provider agency or any person or organization who is controlled by a person or organization who controls or did control a provider agency. Two or more providers who are under common control are affiliates

*History Note: Authority G.S. 122C-3(20b); 122C-26(5)(e); Effective July 1, 2008.*

<http://www.ncoah.com/rules/register/Volume23Issue03August12008.doc>



# Consumer Choice

- Reform: Individualized Service and Choice
- Clients' Rights
- Assessments and Continuity of Care



# Consumer Choice

- "One of the principles of a consumer focused system is the ability of consumers to choose their service provider. We are committed to this 'freedom of choice' requirement" from Enhanced Services Implementation Update #6
- "Offering choices is the initial step in honoring the individualized needs of persons with disabilities." from Performance Agreement

# Clients' Rights

- ❑ "A written summary of client rights as specified in G.S. 122c, Article 3 shall be available to each client and legally responsible person."
- ❑ From Core rules 10A NCAC 27D. 0201; GS122c -3 which can be found at :  
[http://www.ncleg.net/EnactedLegislation/Statutes/RTF/ByArticle/Chapter\\_122C/Article\\_3.rtf](http://www.ncleg.net/EnactedLegislation/Statutes/RTF/ByArticle/Chapter_122C/Article_3.rtf)
- ❑ Two client rights training modules (samples) are on the Division website at :  
<http://www.dhhs.state.nc.us/mhddsas/training/consumerrights.htm>



# Clients' Rights

"If there is reasonable cause to believe"...that an adult or child receiving services...."may be abused, neglected or exploited and in need of protective services"...initiate procedures outlined in GS 108A, Article 6"

from Core Rules 10A C-NCAC 27G .0610; GS108A, Article 6 can be found at:

[http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/ByArticle/Chapter\\_108A/Article\\_6.html](http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/ByArticle/Chapter_108A/Article_6.html)

# Assessments and Continuity of Care

- ❑ Medically necessary services are determined by a comprehensive and objective assessment of the consumer's needs.
- ❑ When a consumer changes his/her mind and chooses another provider, both providers are responsible for making the transition as smooth as possible.
- ❑ Consumer complaints are collected and analyzed by the LME. "Provider Choice" is one of the customer service issues on which data is compiled.



# Medicaid 101/Audits

For any Medicaid service there must be:

- ❑ A treatment plan/PCP;
- ❑ Assessments and clinical recommendations justifying the course of treatment or service being rendered;
- ❑ Appropriate prior authorization;
- ❑ Medical order or service order;
- ❑ Progress notes or other “documentation” that proves delivery of service.

From Medicaid 101: Focused Training for Audited  
Community Support Providers:  
<http://www.ncdhhs.gov/mhddsas/servicedefinitions/ommsupports/Medicaid%20101-tara.ppt>



# Medicaid 101/Audits

Some of the unacceptable practices found during recent audits:

- ❑ PCP /Plan should not be signed prior to the plan meeting date.
- ❑ Plans are not valid until the consumer/legally responsible person and the person who developed the plan sign and date it.
- ❑ No consumer should have only a DD diagnosis for CS services (Dual diagnosis is okay).
- ❑ No stamped signatures allowed.
- ❑ White out is not acceptable on any records.
- ❑ No canned documentation.
- ❑ Progress notes should not be preprinted or predated.

From Medicaid 101: Focused Training for Audited Community Support Providers:

<http://www.ncdhhs.gov/mhddsas/servicedefinitions/commsupports/Medicaid%20101-tara.ppt>



# False Claims Act



## False Claims Act Education

- Effective January 1, 2007, Section 6023 of the Deficit Reduction Act (DRA) of 2005, requires providers receiving annual Medicaid payments of five million or more to educate employees, contractors, and agents about Federal and State fraud and false claims laws and the whistleblower protections available under those laws.

Found on DMA website:

<http://www.dhhs.state.nc.us/dma/fca/falseclaimsact.html>

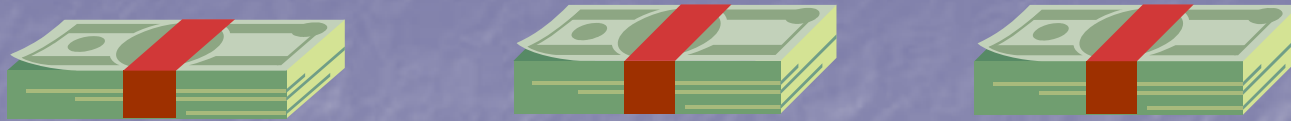
## False Claims Act

- ❑ The False Claims Act is the single most important tool U.S. taxpayers have to recover the billions of dollars stolen through fraud by U.S. government contractors every year.
- ❑ Under the False Claims Act, 31 U.S.C. §§ 3729-3733, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of \$5,500 to \$11,000 per false claim.
- ❑ The False Claims Act explicitly excludes tax fraud. If you wish to report tax fraud, please call the IRS Fraud Hotline at 800-829-0433.



From Taxpayers Against Fraud (TAF) website: <http://www.taf.org/whyfca.htm>

# False Claims Act and Audits



## False Claims and Liability

Any person who:

- ❑ “Knowingly presents, or causes to be presented, to an officer or employee of the United States Government...a false or fraudulent claim for payment or approval.”
- ❑ “Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government.”
- ❑ “Conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.”

Found on page 6 of the following document under false claims

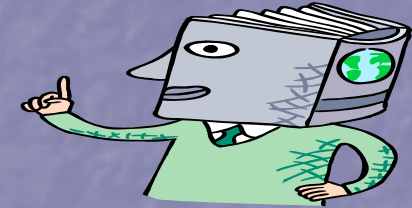
[http://www.aahsa.org/advocacy/legal\\_issues/documents/DRA\\_MedicaidCompliance.pdf](http://www.aahsa.org/advocacy/legal_issues/documents/DRA_MedicaidCompliance.pdf)

# False Claims Act and Audits

## Knowing and Knowingly Defined

Any person with respect to information who:

- ❑ "has actual knowledge of the information;
- ❑ Acts in deliberate ignorance of the truth or falsity of the information; or
- ❑ Acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required."



Found on page 7 of the following document under false claims

[http://www.aahsa.org/advocacy/legal\\_issues/documents/DRA\\_MedicaidCompliance.pdf](http://www.aahsa.org/advocacy/legal_issues/documents/DRA_MedicaidCompliance.pdf)

# False Claims Act

## False Claims Act Education

- ❑ The Federal False Claims Act – *or qui tam law* – is a federal statute that allows citizens to file suits on behalf of the government against anyone who may be defrauding the state through a contractual agreement.
- ❑ The person who originally files the suit – called the relator – is given a portion of any damages the government receives. Most *qui tam* cases are filed against the defense and healthcare industries.

Found at: [http://www.whitecollarcrimefyi.com/healthcare\\_fraud.html](http://www.whitecollarcrimefyi.com/healthcare_fraud.html)



## False Claims Act



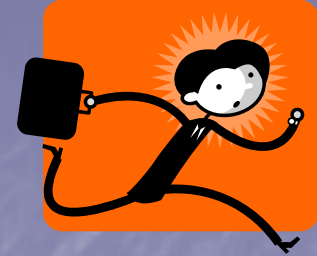
- ❑ **Qui Tam** : An abbreviated version of the Latin phrase "*Qui Tam pro domino rege quam pro si ipso in hac parte sequitur,*" which means "Who sues on behalf of the King, as well as for Himself."
- ❑ **Qui Tam** laws have existed for hundreds of years, with roots in England in the middle ages.
- ❑ Abraham Lincoln was responsible for enactment of the 1863 False Claims Act, which was necessary to protect the government from the fraudulent suppliers of faulty war equipment during the Civil War. Although a significant narrowing of the provisions of the False Claims Act took place in 1943, the law was revitalized by Congress in 1986, with a significant expansion of the scope of the law and renewed attention to the federal whistleblower and his or her attorney as a key to enforcement.



From: <http://www.ashcraftandgerel.com/whistleb.html>



## False Claims Act



“A civil action under G.S. 108A-70.12 may not be brought more than six years after the date the violation of G.S. 108A-70.12 is committed, or more than three years after the date when facts material to the right of action are known or reasonably should have been known by the official of the State of North Carolina charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed, whichever occurs last.”

NC General Statutes:

[http://www.ncga.state.nc.us/enactedlegislation/statutes/pdf/bysection/chapter\\_108a/gs\\_108a-70.13.pdf](http://www.ncga.state.nc.us/enactedlegislation/statutes/pdf/bysection/chapter_108a/gs_108a-70.13.pdf)



It has been estimated that almost 10% of the United States annual budget is paid to companies or persons who are defrauding the government.

It is estimated that in the year 2005 \$3.1 billion was collected from businesses defrauding the federal government.

Most of the money was recovered from hospitals or other health care providers that fraudulently over billed the government. In fact, the biggest settlement (\$920 million) came against the nation's second-largest hospital chain, Tenet, for over billing the government for \$806 million in Medicare payments and paying \$49 million in kickbacks to doctors who referred patients to the chain

From: <http://www.ashcraftandgerel.com/whistleb.html> and  
[http://www.corruptionchronicles.com/2006/11/whistle\\_blowers\\_recover\\_billio.htm](http://www.corruptionchronicles.com/2006/11/whistle_blowers_recover_billio.htm)

# FRAUD

## Most Common Types of Provider Fraud:



- Billing for Services not rendered (25%)



- Misrepresentation of services provided (35%)



- Provision of medically unnecessary service (10%)

From The National Consumer Protection Technical Resource Center, May 7, 2007 presentation:

<http://www.smpresource.org/eSeries/Content/ahqaNavigationMenu/SMPResources/Webinars/MedicaidFraudTraining2007/medicaidfraud101.ppt>

# What is your guide to making ethical choices?



- ❑ Provide excellent customer service – does not mean “give them what they want”.
- ❑ Strive to give each person you serve what they need based on a comprehensive evaluation of their needs and your expansive knowledge of available services and best practices.
- ❑ Collect outcomes data and use your quality improvement plans to produce the best outcomes.
- ❑ Be honest and knowledgeable about what you are doing.