



House of Representatives
Commonwealth of Pennsylvania

Government Oversight Committee

Staff Report on Medicaid:

Provider Fraud & Improper Payments

November 21, 2019

Honorable Chairman Seth Grove
Honorable Chairman Matt Bradford

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**GOVERNMENT OVERSIGHT
COMMITTEE**

HONORABLE
SETH M. GROVE
CHAIR

EXECUTIVE DIRECTOR
MICHAEL J. KANE, Esq.



ADDRESS
7 EAST WING
P.O. BOX 202196
HARRISBURG, PA 17120-2196

TELEPHONE
(717) 783-2655

House of Representatives

Commonwealth of Pennsylvania

July 25, 2019

MEMO

TO: Mike Kane, Republican Executive Director
Bridget Lafferty, Democrat Executive Director

FROM: Chairman Seth Grove & Chairman Matt Bradford

SUBJECT: GOC Staff Report on Improper Payments and Provider Fraud

Background

The adopted FY 2019-2020 budget projects to spend \$12.7 billion of state funds in the Department of Human Services (DHS), which does not include other augmented spending through various assessments or the Tobacco Master Settlement. Human Services is the single largest expenditure of government resources in the Commonwealth of Pennsylvania and provides the safety net of programs to help Pennsylvania's most vulnerable. However, current expenditures are exceeding the Commonwealth's revenue collections, thus creating budgetary pressure to crowd out other government expenditures to maintain the Commonwealth's safety net. In order to provide better services at a lower cost to taxpayers, we feel it is imperative to review improper payment and provider fraud policies of the commonwealth.

Improper Payments

In March of 2019, the United States Government Accountability Office (GAO) released a report entitled, "Medicare and Medicaid: CMS Should Assess Documentation Necessary to Identify Improper

Payments” citing Medicaid Fee For Service (FFS) improper payments were \$41.2 billion nationally.¹ Improper payments cover a broad category of errors and is not just fraud, but can be lack of documentation, incomplete documentation, procedure error coding or number of units error. The Federal Improper Payments Information Act of 2002, which has been amended twice, requires federal agencies to report and reduce improper payments. It also requires state agencies, such as DHS to review and report on improper payments through the Payment Error Rate Measurement (PERM) program. DHS’s last PERM Cycle 1 report in 2015 shows an improper payment error rate of 9.8% for FFS and 0.5% for managed care and for the state FFS is 7.5% and managed care is 0%.² Further the PERM 2015 report shows a projected dollar in error of \$694.1 million for FFS. While this is one state agency, states have yet to fully engage to eliminate improper payments which can reduce costs and provide more freed up state dollars to reallocate to critical programs such as education funding or the Department of Corrections.

For example, according to the PA Waiting List campaign, removing 4,494 people from the emergency list of ID and the 1,270 people on the priority 1 list for autism costs \$76.9 million.³ According the 2015 PERM report, Medicaid FFS Data Processing Review Errors for ICF for Individuals with Intellectual Disabilities/Group Homes was \$78.3 million.⁴ Just by correcting the errors in data processing review under this one service type we can eliminate the emergency waiting list for ID and the Priority 1 waiting list for autism.

In 2002, the U.S. Treasury started the Do Not Pay program⁵ which was codified in federal law with the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA).⁶ The Do Not Pay program uses data analytics to verify eligibility and to identify and prevent fraud, waste, and abuse associated with improper payments. Pennsylvania already uses one tool, the Death Master File, but a full implementation can reduce improper payments and help with uncollected taxes owed to the Commonwealth.

Provider Fraud

While improper payments do cover fraud, provider fraud has been such an ongoing issue that the Grand Jury issued recommendations for the General Assembly to identify and prevent fraud within the Medical Assistance (MA) program.⁷ “Through the course of our investigation, we identified systemic issues within the MA program that permit the exploitation of care-dependent Pennsylvanians for financial gain and impact the quality of care provided”. The Grand Jury identified three systemic changes:

- (1) Require individuals providing services to be identified on the claim submitted for payment.

¹ United States Government Accountability Office. “Medicare and Medicaid: CMS Should Assess Documentation Necessary to Identify Improper Payments.” March, 2019. <https://www.gao.gov/assets/700/697981.pdf>.

² United States Department of Health and Human Services. “Fiscal Year 2015 Pennsylvania Medicaid Payment Error Rate Measurement (PERM) Cycle 1 Summary Report.” November 16, 2016. http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_278846.pdf.

³ <https://pawaitinglistcampaign.org/wp-content/uploads/2015/12/fall-2015-fact-sheet.pdf>.

⁴ United States Department of Health and Human Services. “Fiscal Year 2015 Pennsylvania Medicaid Payment Error Rate Measurement (PERM) Cycle 1 Summary Report.” November 16, 2016. Page 17.

⁵ <https://fiscal.treasury.gov/dnp/>.

⁶ <https://fiscal.treasury.gov/files/dnp/IPERIA.pdf>.

⁷ <https://www.attorneygeneral.gov/wp-content/uploads/2019/04/2019-04-15-GJ-Recommendations-for-Medicaid-Program.pdf>.

- (2) MA claims submitted for payment should require specific date and time information before payment if made.
- (3) Increase training to individuals providing services for proper billing.

On September 19, 2006, the Center for Medicare and Medicaid services (CMS) issued a letter to State Medicaid Directors encouraging states to implement a State False Claims Act, “The CMS strongly supports State program integrity measures and wants States to be aware that State False Claims Acts may enhance the recovery of falsely or fraudulently obtained Medicaid dollars”.⁸ Currently there are 29 states, District of Columbia, three large cities including the municipalities of Philadelphia and Allegheny County have implemented a State False Claims Act.⁹ According to the Taxpayers Against Fraud¹⁰:

- Since 1987, the Federal False Claims Act has returned over \$53 billion in civil recoveries to the federal government.
- Federal False Claims has resulted in over \$7 billion in criminal fines.
- Federal False Claims Act lawsuits have returned over \$10 billion back to the states.

As an incentive for states to adopt a False Claims Act, which meets federal requirements, the Commonwealth can receive an additional 10% for recoveries, instead of the traditional 50/50 split between the federal government and state government.

Scope of the Report

Improper payments and provider fraud have plagued this Commonwealth for far too long. By comprehensively targeting these two areas, the Commonwealth can create more efficiencies and reduce costs to taxpayers without sacrificing program reductions. We are requesting a staff level report to analyze and discuss:

- State level improper payments law.
 - Team of OIG, Auditor General and Treasury will develop a baseline improper payments analysis for agencies, develop an improper payment elimination plan with each state agency targeted towards a 0% improper payment within 5 years of the agency report being finalized and perform a follow up audit of the improper payment elimination plan after 5 years.
- Mandating state agencies to use US Treasury’s Do Not Pay program and the possibly of Pennsylvania’s Treasurer’s Office developing further state specific analytics to enhance the federal Do Not Pay program.
- Grand Jury Recommendations on MA fraud.
- Implementing a State False Claims Act.

Please assign Republican and Democrat staff to coauthor the report.

⁸ <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD091906.pdf>.

⁹ <https://taf.org/state-false-claims-acts/>.

¹⁰ <https://taf.org/wp-content/uploads/2018/03/fcabrief16.pdf>. Page 5.

Executive Summary

Staff of the House Government Oversight Committee is issuing the following report based on publicly available resources detailing incidents of Medicaid improper payments made by the Medical Assistance program and incidents of provider fraud uncovered by the Attorney General and other resources. It is our intention to raise awareness of improper payments and provider fraud incidents so corrective action can be taken to ensure state taxpayer resources and services are both protected and preserved.

Our research shows there are a number of recommendations listed in a 2019 Grand Jury Report that should be considered by the General Assembly to help identify and prevent fraud occurring within Medicaid (MA).¹¹ Deficiencies highlighted in that Report include the MA system not requiring the individual providing services to be identified on claims submitted for payment; claims submitted for payment do not require specific date and time information before payment is made; and, providers lack the knowledge and training to provide quality care and to properly bill for services. Based on the findings in the 2019 Grand Jury Report, we suggest the following recommendations to be considered: (1) the use of state provider identification numbers; (2) standardized training; (3) requiring additional information such as date and time services were rendered to be included on claims submitted to MA; and (4) ensuring penalties and remedies are properly in place to address providers and individuals who are providing services.

We extensively reviewed the False Claims Act¹². Unlike 35 other states (and two larger municipalities located within Pennsylvania—Philadelphia and Allegheny County), the Commonwealth of Pennsylvania has not enacted a state-specific False Claims Act. The federal law has been an effective tool for the federal government to combat fraud and abuse. The law imposes liability on anyone who submits a claim for payment to the government that they know is false, comparable to a provider who bills for services not provided. The federal law provides a financial incentive for states that adopt a state-specific law relating to false or fraudulent Medicaid claims. Those states whose False Claims Act meets federal requirements receive a 10 percentage point increase in their share of the amounts recovered.

The U.S. Department of Justice (DOJ) has investigated hundreds of claims, including lawsuits filed by whistleblowers.¹³ The DOJ has collected more than \$59 billion since 1986, when Congress strengthened the federal False Claims Act. The relator share awards for this time

¹¹ Forty-Second Statewide Investigating Grand Jury Report No. 1, Pennsylvania Medical Assistance Program, March 1, 2019, <https://www.attorneygeneral.gov/wp-content/uploads/2019/04/2019-04-15-GJ-Recommendations-for-Medicaid-Program.pdf>.

¹² 31 U.S.C. §§ 3729-3733.

¹³ “Justice Department Recovers Over \$2.8 Billion from False Claims Act Cases in Fiscal Year 2018,” U.S. Department of Justice, <https://www.justice.gov/opa/pr/justice-department-recovers-over-28-billion-false-claims-act-cases-fiscal-year-2018>.

period are over \$7 billion.¹⁴ If Pennsylvania enacted a qualified state-specific law, the Commonwealth would be awarded additional dollars. Pennsylvania currently receives about 48 percent of damages recovered in an MA program fraud case; under a qualified state False Claims Act, it would receive 58 percent. A state law would also provide incentives for whistleblowers to come forward with claims extending beyond health care providers. Given the number of cases being pursued against individuals, companies or industries within Pennsylvania, the extra financial incentive offered by the federal government, and the history of passing legislation twice in the House of Representatives in past sessions, further consideration should be given to enacting a state-specific False Claims Act.

In examining the latest Payment Error Rate Measurement (PERM) Summary Report for Pennsylvania (for fiscal year 2015), Pennsylvania's dollars in error for MA FFS are \$694.1 million. The Report states the following improper payment rates for Pennsylvania: 7.5% for state FFS claims; and, no sampled errors for managed care. However, we believe the full picture of errors is not being uncovered. For the managed care measurement, PERM only reviews the payments made by states to managed care organizations and not the claims submitted by providers for services rendered. Efforts should be made to reduce our errors of payment rates to a rate between 0.0% and 3.0%.

Section 139b of the Social Security Act restricts payments to states with an error rate that exceeds the rate of 0.03 (or 3 percent):

Notwithstanding subsection (a)(1), if the ratio of a State's erroneous excess payments for medical assistance (as defined in subparagraph (D)) to its total expenditures for medical assistance under the State plan approved under this subchapter exceeds 0.03, for the period consisting of the third and fourth quarters of fiscal year 1983, or for any full fiscal year thereafter, then the Secretary shall make no payment for such period or fiscal year with respect to so much of such erroneous excess payments as exceeds such allowable error rate of 0.03.

42 U.S.C.A. § 1396b.

While the Pennsylvania Department of Human Services is one state agency, states, such as Pennsylvania, have yet to fully engage to eliminate improper payments which can reduce costs and provide more freed up state dollars to reallocate to critical programs such as education funding or the Department of Corrections. The Report advocates for the corrective action process – to establish a Corrective Action Plan. Some of the recommendations outlined in the Attorney General's Grand Jury Report are the same causes given for the disbursement of improper payments. The call for greater action and oversight is also echoed in the Office of

¹⁴ Fraud Statistics – Overview, Civil Division, U.S. Department of Justice: https://www.falseclaimsact.com/wp-content/uploads/2019/02/fy18_fraud_statistics_002_final_for_2018.pdf.

Inspector General’s Report. It is important to note that a full review of improper payments has never been performed across all state agencies in this Commonwealth. This process should be performed.

The Commonwealth does not participate in the federal Do Not Pay program as a means to cross-check payments to be released to providers.¹⁵ While systems are in place to screen providers for participation in the program and the Bureau of Program Integrity was established to review fraud and abuse, we believe more should be done to protect taxpayer dollars before they are released to providers.

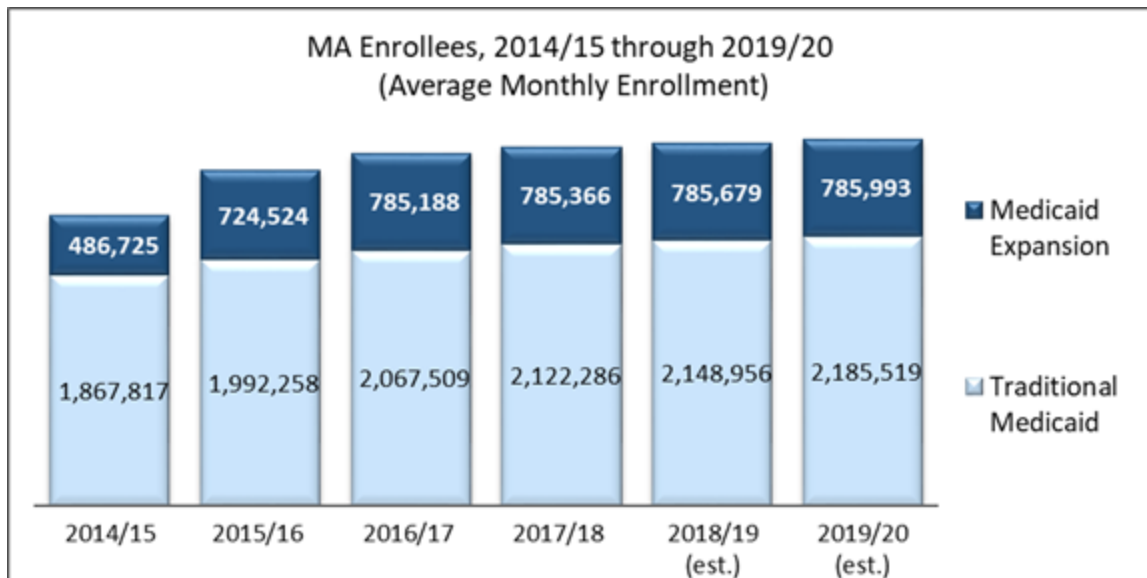
¹⁵ In 2009, President Obama issued Executive Order 13520 -- Reducing Improper Payments and Eliminating Waste in Federal Programs. In 2011, the Treasury’s Bureau of the Fiscal Service, in partnership with others, developed the Do Not Pay Business Center as part of the “Do Not Pay” solution.

The Analysis

Background

The Department of Human Services (DHS) is the administrative authority responsible for overseeing the Pennsylvania’s Medicaid program, known as Medical Assistance (MA). The MA program provides health coverage to low-income Pennsylvanians, including: children, pregnant women, senior citizens and individuals with disabilities. It also provides long term services and supports to elderly MA recipients and individuals with disabilities. Over the years, the Commonwealth has expanded services and created programs. Today, more than 2.9 million Pennsylvanians are enrolled in Medicaid.¹⁶

The Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), together referred to as the Affordable Care Act (ACA), authorized states to expand eligibility rules and access to the states’ MA programs. Under the ACA, states were given permission to expand Medicaid eligibility to portions of their uninsured population. In February 2015, the expansion of the Medicaid program was implemented in Pennsylvania giving more low-income adults access to the state insurance plan.¹⁷ At the end of CY 2015, 559,851 individuals were enrolled in the expanded MA program in the Commonwealth.¹⁸



¹⁶ <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>.

¹⁷ Press Release, February 9, 2015. <https://www.governor.pa.gov/newsroom/medicaid-expansion-in-pennsylvania/>

¹⁸ http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_257436.pdf.

More enrollees in the program required an increase in participating providers to handle the increase in service demands. While the increased enrollment in the MA program has decreased the uninsured rates, the rise in claims being processed for payment every year creates the potential for missed “fraud” and “error” payments for various reasons including incomplete documentation, procedure error coding or number of units errors. Incidents of reported provider fraud have increased and lead to various investigations, arrests and citizen concerns.¹⁹ Payment in error concerns for years has led to increased federal agency oversight and enhanced requirements to reduce improper payments.²⁰

Over the last ten years, overall funding for the MA program has grown by 54 percent. Looking at state general fund dollars, the increase grows by 71 percent (from \$5,341,780,000 in 2010-11 to \$9,121,053,000 in 2019-20); however, in 2010-11, general fund dollars were reduced and federal funds were increased by \$1.77 billion due to the Enhanced Federal Medical Assistance Percentage (FMAP) included in the Federal American Recovery and Reinvestment Act of 2009.²¹ Taking these enhanced federal dollars into account, state-related expenditures grew by 28 percent.

The table below illustrates how the number of enrollees being provided MA services has continued to grow over the last ten years. The greatest share of MA funding is for the elderly and persons with disabilities, reflecting their intensive use of acute and long-term care services. Although the elderly and disabled represent less than 30 percent of all recipients, they account for nearly 70 percent of MA expenditures.

¹⁹ See: Department of Justice, U.S. Attorney’s Office Western District of Pennsylvania, Press Release November 27, 2018. <https://www.justice.gov/usao-wdpa/pr/twelve-individuals-charged-extensive-health-care-fraud-conspiracy-defraud-medicare-home>; Attorney General Press Release, June 29, 2018. <https://www.attorneygeneral.gov/taking-action/press-releases/attorney-general-shapiro-announces-15-arrests-in-statewide-medicare-fraud-sweep/>; and Skiba, Katherine. 24 Charged in Alleged Massive Medicare Fraud. AARP. April 10, 2019. <https://www.aarp.org/money/scams-fraud/info-2019/feds-crackdown-medicare-fraud.html>.

²⁰ The Federal Improper Payments Information Act of 2002.

²¹ Governor’s Executive Budget books for FY 2010-11. FY 2018-19 amounts are the SAP accounting System. FY 2019-20 is enacted.

Select DHS Program Measures										
Source: Governor's Executive Budget Book										
Program	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Medical Assistance:										
Medical Assistance (monthly avg)	2,134,477	2,225,011	2,123,710	2,147,889	2,354,542	2,716,782	2,852,697	2,907,652	2,934,635	2,971,512
MA Workers w Disabilities (monthly avg)	22,795	27,208	29,897	34,933	37,067	31,032	29,223	29,697	28,702	27,976
Long-Term Living (monthly averages) :										
Institutional Care	N/A	N/A	56,342	49,764	48,119	49,543	50,451	39,069	27,256	5,976
CHC - Institutional Care (new January 2018)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	11,085	23,172	44,760
Subtotal Institutional Care	0	0	56,342	49,764	48,119	49,543	50,451	50,154	50,428	50,736
Home & Community-Based Services	N/A	N/A	38,080	40,496	46,020	51,271	55,994	57,971	22,178	670
Community HealthChoices - HCBS	N/A	N/A	N/A	N/A	N/A	N/A	N/A	11,059	54,111	80,627
People with DD in OBRA waiver	N/A	N/A	incl above	1,400	1,360	1,340	1,389	1,116	558	347
Subtotal HCBS	0	0	38,080	41,896	47,380	52,611	57,383	70,146	76,847	81,644
LIFE Program	N/A	N/A	3,664	4,048	4,698	5,321	5,767	6,247	6,671	7,096
Mental Health:										
Community Mental Health Services (unduplicated):										
People Served w MA Funding	428,225	411,678	476,206	480,014	531,912	570,175	600,000	601,050	602,100	603,155
Intellectual Disabilities:										
Persons receiving autism services	323	398	447	568	661	695	819	875	909	909
Persons receiving ID services	53,455	53,569	53,613	53,648	54,091	54,692	55,199	55,699	57,399	58,264
Home and Community Service Waivers (unduplicated):										
ID Services Base and Waiver	N/A	N/A	50,827	50,952	51,459	52,210	52,860	53,457	55,251	56,116
Consolidated Waiver	N/A	N/A	16,757	17,251	17,594	18,085	18,267	18,396	18,651	18,751
Person/Family Directed Supports	N/A	N/A	11,861	12,586	13,039	13,647	13,721	14,658	14,658	14,658
Community Living Waiver (new in FY 17-18)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1,006	2,600	3,365
Total ID HCBS Waivers			28,618	29,837	30,633	31,732	31,988	34,060	35,909	36,774

As funding and enrollment continues to grow year-over-year, before the General Assembly asks taxpayers to increase their contributions for MA, a serious look at all forms of fraud and error payments should be considered. To provide quality services to more citizens at a lower cost to taxpayers, it is imperative to review the improper payment and provider fraud policies of the Commonwealth.

Attorney General: Provider Fraud

In April of 2019, Attorney General Josh Shapiro announced recommendations made from a statewide Grand Jury investigation into how to identify and prevent fraud occurring within Medicaid to ensure delivery of satisfactory care.²²

“Medicaid provides essential care to some of Pennsylvania’s most vulnerable citizens, including low-income individuals, children with serious health conditions, and individuals suffering from substance use disorder,” said Attorney General Josh Shapiro. “When bad actors take advantage

²² Attorney General Press Release, April 15, 2019. <https://www.attorneygeneral.gov/taking-action/press-releases/attorney-general-josh-shapiro-announces-grand-jury-recommendations-for-the-pennsylvania-medicaid-program/>.

of the system, they deny these people the care they deserve, take advantage of hard-working care providers, and scam Pennsylvanians out of their hard-earned tax dollars.”

The investigation was prompted by two independent Medicaid Fraud investigations of individuals who fraudulently billed the program for services not rendered. The evidence in the investigation revealed “deficiencies within the MA program, its complexities and many subdivisions.”²³

According to the Grand Jury Report, the investigation “...identified systemic issues within the MA program that permit the exploitation of care-dependent Pennsylvanians for financial gain and impact the quality of care provided.”²⁴ These deficiencies include the MA system not requiring the individual providing services to be identified on claims, information providing the date and time are not required on claims for payment, and providers lacking the knowledge and training to provide quality care and proper billing for services.

Deficiency #1

First, many provider agencies that offer community-based services use employees or independent contractors to provide services such as personal care and home health; these individuals do not have an MA provider identification number (MAID). The provider agency is the entity who submits a claim to MA using its own MAID. Typically, these claims do not identify the individual who directly performed the services. In the case of independent contractors, these individuals will not be listed on the Pennsylvania Department of Labor and Industry database to reveal where they are working. Without the claim identifying who performed the service, it is impossible to determine (through a review of claims process) whether a claim should be denied because these individuals are banned from providing MA services. It is important to note that for some services, such as therapeutic services paid through long-term care waivers, the submitted claim identifies the individual performing the service. This inclusion should be a continued practice spanning across all of MA submitted claim services.

A similar lack of identification of the individuals performing services also exists with MA claims submitted to the managed care organizations (MCOs) that operate DHS’s managed care programs: HealthChoices Physical Health, HealthChoices Behavioral Health, and Community HealthChoices.²⁵ MCOs contract with a network of MA providers and negotiate rates for services furnished to persons enrolled in their plan; the actual services are performed by the provider’s employees or independent contractors. While we understand MCOs are required to

²³42nd Statewide Grand Jury Investigation Report. March 1, 2019. p. 1. <https://www.attorneygeneral.gov/wp-content/uploads/2019/04/2019-04-15-GJ-Recommendations-for-Medicaid-Prgrm.pdf>

²⁴ Ibid, p. 2.

²⁵ Ibid, p. 7.

establish a fraud, waste and abuse unit to prevent, detect and investigate fraud, the responsibility remains in the hands of DHS. These are taxpayer dollars and every effort by the department should be made to ensure dollars are not spent on fraudulent activity, regardless of agreements made between DHS and MCOs or federal law requirements.

To address this deficiency, the Grand Jury recommended creating a system to assign each individual who provides services under MA a unique identifying number (a “State Provider Identification”) and to use that number to identify who provided services on all submitted claims for payment.²⁶ A unique identifying number is not a new idea, as many providers currently have either NPI (National Provider Identifier) or MAID numbers assigned. The point is to make all individuals who perform services be identified and not just the provider agency.

All individuals who provide goods or services paid for through MA, should be required to have either the NPI or a State Provider Identification number. We also believe it is important to be able to make a distinction between providers and the actual individuals who are performing the services who submit or cause to be submitted information for compensation in connection with MA.

The MA program would benefit from being equipped to perform pre-payment reviews for fraudulent activity; cross reference individuals for background checks with all necessary records including licensure registry, health care exclusionary and criminal records; make it easier to identify fraud; and pinpoint which individuals are providing services to clients. This would provide instant identification to enhance patient safety and situations where law enforcement is involved. This is a recommendation for the General Assembly for legislative guidance and enactment.

Deficiency #2

The Grand Jury spent time discussing various cases where individuals reported providing services in two places at the same time or providing services to an individual after his death. Because the date and times for the individual providing services was not submitted to DHS on the claim, this type of fraud was not detected. Instead, the provider agency and the number of units of service was provided.²⁷ The lapse of having this information on MA claims underscores any review the department does against MA enrollees with death records and provides a means for payments to be made that should not be made because of fraudulent activity. Fraudulent activity could be detected, prior to the release of any payments, if adequate information was contained within submitted claims for payment.

²⁶ 42nd Statewide Grand Jury Investigation Report. March 1, 2019. p. 17.

²⁷ Ibid, p. 12.

If the date and time of services provided are not contained within the claim for payment, any comparison of MA enrolled recipients against records of death can possibly be disputed by providers seeking payment. The date and time of services listed on each MA claim submission would validate any cost associated with comparing death records.

Under Act 22 of 2011, the General Assembly enacted several reforms to the state's welfare system..²⁸ One of those reforms included the codification of a computerized eligibility verification system that requires the department to match the social security number of an applicant and recipient with the death register information maintained by the Social Security Administration. Unfortunately, in practice, this is only done upon the time of enrollment and at renewal. Perhaps, a further review of the sharing of records and the promptness of the department to check the records should be executed.

The practice of including the date and time-specific information on MA claims is currently in practice in some fashion. While the date may be submitted on MA claims for payment, the time the services are started or finished is not. MA hospital claims are one example that can be mimicked by all MA claim submissions since they already contain date and time-specific information requirements.

Based on requirements under federal law,²⁹ states are required to implement electronic visit verification (EVV) for all Medicaid personal care services and home health services requiring an in-home visit. EVV is required to be in place for personal care services by January 1, 2020 and by January 1, 2023 for home health care services. Failure to do so will result in incremental FMAP reductions up to 1 percent unless the state has made both a good faith effort and experienced unavoidable delays.³⁰

While DHS is in the process of implementing EVV, legislative action should be examined to build off the federal requirement and incorporate it at the state level across all Medicaid services. The General Assembly should enact legislation that mandates all claims submitted include the date a service was provided, as well as the start and end times for each date of service. A broader range of provider identification and times of service for all MA programs has the potential to unveil fraudulent submissions by providers and save millions of taxpayer dollars.

²⁸Legislative Data Processing Center.

<https://ldpc6.legis.state.pa.us/CFDOCS/LEGIS/LI/uconsCheck.cfm?txtType=HTM&yr=2011&sessInd=0&smthLwInd=0&act=0022>.

²⁹ 21st Century Cures Act. <https://www.congress.gov/bill/114th-congress/house-bill/34/text>.

³⁰ Centers for Medicare & Medicaid Services. Electronic Visit Verification (EVV).

<https://www.medicare.gov/medicaid/hcbs/guidance/electronic-visit-verification/index.html>

Deficiency #3

Lastly, the Grand Jury Report revealed the individuals who provide services lack “standardized training on proper care, critical incident/fraud reporting, or appropriate billing practices.”³¹ This failure, as noted by the Grand Jury, results in incomplete, inaccurate, or conflicting information. This not only places recipients at risk, it also impedes law enforcement from proving fraud and holding those accountable for fraudulent acts.

Investigations into fraudulent activity are hampered by the lack of information shared with DHS by provider agencies. The scale of fraud may be even larger given the possibility of providers exploiting billing gaps. They lack supporting documentation. While records can be requested, this can lead to destruction or falsification of supporting documents. With the inclusion of identifying the individual providing services and standardized training, provider agencies could not point blame on the individuals providing the services.³²

While the focus of the Grand Jury was providing training for providers, we want to take the time to focus attention on the department to ensure employee vigilance against fraud. The department is the entity that processes millions of claims and the workers who assist in the processing of those claims play a vital role in being vigilant against fraud. Ensuring updated comprehensive employee anti-fraud training should be ongoing. An updated fraud risk assessment for Medicaid may be a matter worth consideration.

While the department has indicated provider training requirements are in place, the cases respectfully suggest the training is not sufficient. While the General Assembly will not duplicate any training currently required, consideration should be given to updating the training requirements to include a focus on provider fraud activity and keep pace with the services and delivery systems used to provide recipients with the care they need. Minimizing fraud and ensuring enrollees receive services should go hand in hand. The General Assembly should enact legislation mandating standardized training for all persons providing services. The legislation should involve the type of service, the level of care required and types of services that are appropriately billable, and how to report fraud within the MA program.

³¹ 42nd Statewide Grand Jury Investigation Report. March 1, 2019. p. 16.

³² Ibid, p. 17.

Overall Grand Jury Recommendations

The Grand Jury made three recommendations in their Report.³³

1. The Legislature should enact a statute mandating that any individual seeking to provide services paid for, in whole or in part, with MA funds who does not have an NPI be required to register with the Commonwealth of Pennsylvania and obtain a SPI prior to the performance of said services. The legislation should mandate that every claim for MA services identify the actual individual providing the services by requiring that the providing individual's NPI or SPI be placed on every claim.
2. The Legislature should enact a statute mandating that every claim for MA services document every date that a service was provided as well as the start and end times for each time of service.
3. The Legislature should require that DHS establish and mandate standardized training for all persons providing service utilizing SPI. The standardized training should be specific to the type of services being provided and focus on the required level of care the recipient is to receive and what services are appropriately billable under that program. The training should also provide information on how to contact Protective Services and where to report fraud within the MA program. The standardized training for each specific type of service must be completed prior to providing services.

While we acknowledge the recommendations made by the Grand Jury are not insurmountable, we appreciate some of the concerns expressed by DHS in response to the Grand Jury Report. The costs of system modifications should be considered in conjunction with recoveries and the effect these recommendations would have upon payment avoidance in the first place. As the Department noted, a total of \$2 billion in cost avoidance and recoveries has been realized since 2015. We believe millions of dollars could be added to this total if further efforts were made to incorporate the Grand Jury recommendations.

The actual loss of taxpayer dollars due to provider fraud is unknown. Given the examples of fraud recently investigated, there stands a possibility of a large number of providers who are submitting claims of services for payment that are taking advantages of the deficiencies currently existing in the MA program.

Safeguarding the integrity of the system while being mindful of the taxpayer dollars used to pay for such services is as important as ensuring those who are eligible and in need of services actually receive the services they need. There is need to protect these individuals from fraudulent billing, aside from fiscal concerns. Any services approved are needed and must be provided.

³³ 42nd Statewide Grand Jury Investigation Report. March 1, 2019. p. 22.

We also suggest the General Assembly consider updating the Human Services Code to ensure penalties and remedies are in place to properly address both providers and individuals performing services for MA that submit or cause to be submitted false information for compensation.

State False Claims Act

A federal law, called the False Claims Act (also called the “Lincoln Law”), imposes severe financial penalties against a provider who knowingly submits a fraudulent claim for payment involving federal dollars.³⁴ The law imposes liability on anyone who submits a claim for payment to the federal government that they know is false, like a provider who submits a bill to Medicare for services they did not provide. The person is liable for a civil penalty between \$5,000 and \$10,000, plus 3 times the amount of damages the government sustained.

The law allows private parties to bring an action on behalf of the United States (31 U.S.C. 3730 (b)). When the government intervenes, the private party stands to receive between 15 and 25 percent of the proceeds for the action. When the government does not intervene, the private party stands to receive between 25 and 30 percent of the proceeds.³⁵

Since it was amended in 1986, the False Claims Act has become an effective and efficient tool for the federal government to combat fraud. Between 1986 and 2018, the federal government has recovered \$59 billion from lawsuits brought by whistleblowers (qui tam). These whistleblowers have been paid over \$7 billion in rewards.³⁶ Whistleblower cases account for 71% of all FCA cases filed. Just this May, the United States Justice Department issued new formal guidelines to litigators under the law to incentivize companies to voluntarily disclose misconduct and cooperate with investigations.³⁷ This illustrates the continued success of the federal government’s reliance and partnership with private whistleblowers to identify fraud.

The Deficit Reduction Act of 2005 (DRA), enacted on February 8, 2006, contained provisions to incentivize states to enact anti-fraud legislation modeled after the federal False Claims Act (FCA). The incentive entitles any state that meets federal standards outlined in the Act to an

³⁴ Centers for Medicare & Medicaid Services. <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD032207Att2.pdf>.

³⁵ Centers for Medicare & Medicaid Services. <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD032207Att2.pdf>.

³⁶ <https://www.falseclaimsact.com/federal-false-claims-act>.

³⁷ U.S. Department of Justice. *Department of Justice Issues Guidance on False Claims Act Matters and Updates Justice Manual*. May 7, 2019. <https://www.justice.gov/opa/pr/department-justice-issues-guidance-false-claims-act-matters-and-updates-justice-manual>.

additional share of settlement amounts reached through their state FCA.³⁸ Just as the state and federal government jointly fund Medicaid expenditures, with the federal share of qualifying costs based on the federal medical assistance percentage (FMAP), so do the state and federal government share recoveries based on the FMAP. For fiscal year 2020, the annual FMAP for Pennsylvania is 52.25% which means the Commonwealth generally pays 47.75% of every Medicaid dollar spent on services and receives 47.75% of recoveries. The financial incentive for states with a qualified state False Claims Act is an increase by 10 percentage points of their share for any amounts recovered as the result of an action brought under the state law.

On August 21, 2006, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services published guidelines for evaluating State False Claims Acts to determine if the State law meets certain enumerated requirements that would qualify the state for the federal financial incentive.³⁹ The state laws must include provisions rewarding and facilitating whistleblower actions, contain a requirement for filing an action under seal for 60 days with review by the state Attorney General, and contain a civil penalty not less than the civil penalty under federal law.

The FCA has been amended three times since the enactment of section 1909 (provisions providing financial incentives to states to enact a state-specific False Claims Act): May 20, 2009 in the Fraud Enforcement and Recovery Act of 2009; on March 23, 2010, in the Patient Protection and Affordable Care Act; and on July 21, 2010, in the Dodd-Frank Wall Street Reform and Consumer Protection Act. New guidelines were published in 2013 on how the determination is made on whether a State law met the requirements of section 1909 of the Social Security Act.⁴⁰ Currently, the federal government recovers \$20 for every \$1 spent investigating, prosecuting whistleblower cases evolving from the FCA.⁴¹

In addition to the federal law, 35 states and the District of Columbia have enacted State-Specific False Claims Acts. Pennsylvania has not adopted a State False Claims Act (though two large municipalities—Philadelphia and Allegheny County—have adopted false claims ordinances to cover false or fraudulent claims made on their municipality).⁴² Those states that have approved state False Claims Acts qualify for the financial incentive under section 1909 of the Social Security Act.

³⁸ National Conference of State Legislatures. *Incentivizing State False Claims*. May 7, 2013. <http://www.ncsl.org/research/health/clarifying-requirements-for-a-state-false-claims-a.aspx>.

³⁹ Federal Register. Vol. 71, No. 161. August 21, 2006. <https://oig.hhs.gov/authorities/docs/06/waisgate.pdf>.

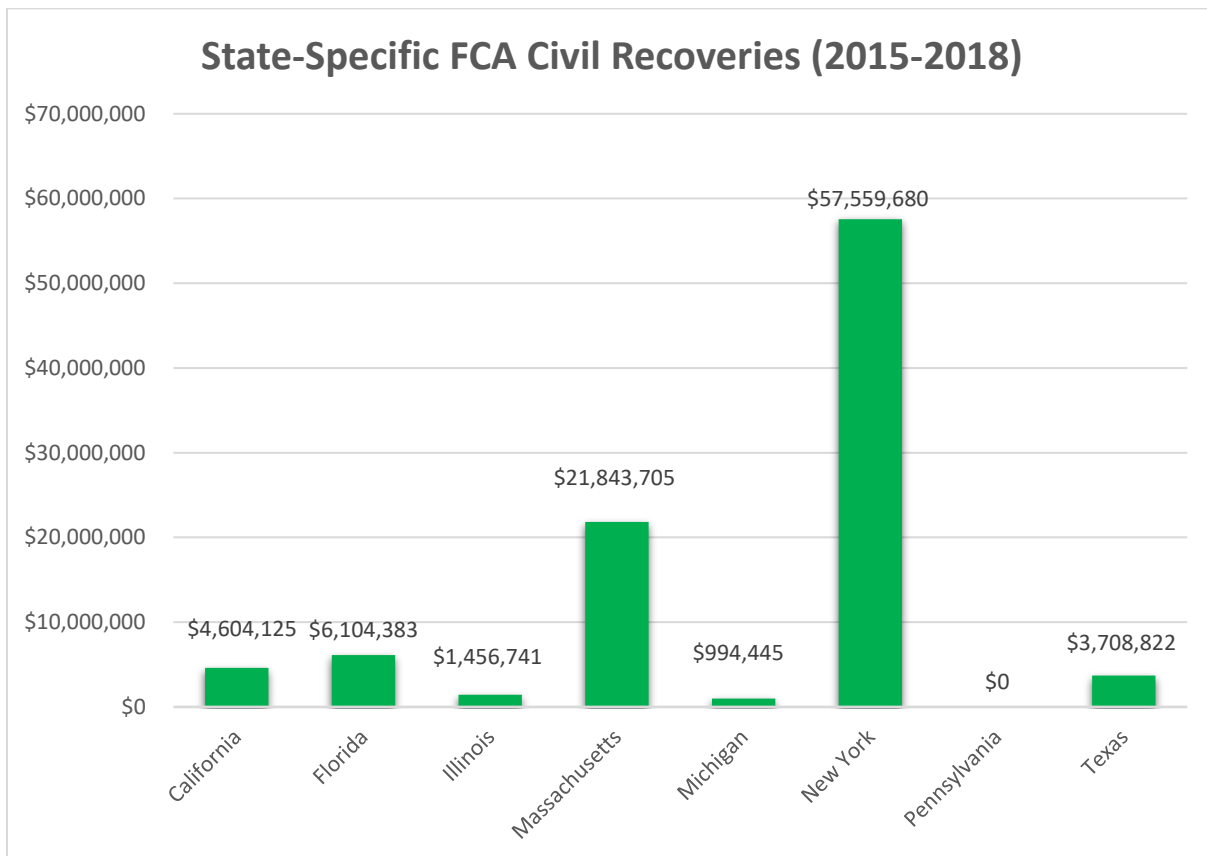
⁴⁰ U.S. Department of Health & Human Services, Office of Inspector General. *Updated OIG Guidelines for Evaluating State False Claims Acts*. March 15, 2013. <https://oig.hhs.gov/fraud/docs/falseclaimsact/guidelines-sfca.pdf>.

⁴¹ Niland, Kurt. *U.S. Recovers \$20 For Every \$1 Spent Investigating, Prosecuting Whistleblower Case*. October 19, 2015. <http://www.rightinginjustice.com/news/2015/10/19/u-s-recovers-20-for-every-1-spent-investigating-prosecuting-whistleblower-cases/>.

⁴² Taxpayers Against Fraud. *State False Claims Acts*. <https://taf.org/state-false-claims-acts/>.

While Pennsylvania does not have a State False Claims Act, under the FCA, the state is still able to collect its normal share of a recovery. However, because Pennsylvania has not enacted a state-specific False Claims Act, the Commonwealth is not able to receive the additional 10 percentage points in the State’s share of any recovery in an action under such a law. For Pennsylvania (using the fiscal year 2020 FMAP), this 10 percentage incentive would increase the Commonwealth’s recovery portion from 46.75 percent to 57.75%. We suggest fully arming the Attorney General’s office with the authority to pursue recoveries for false claims like so many other states who have a state-specific FCA.

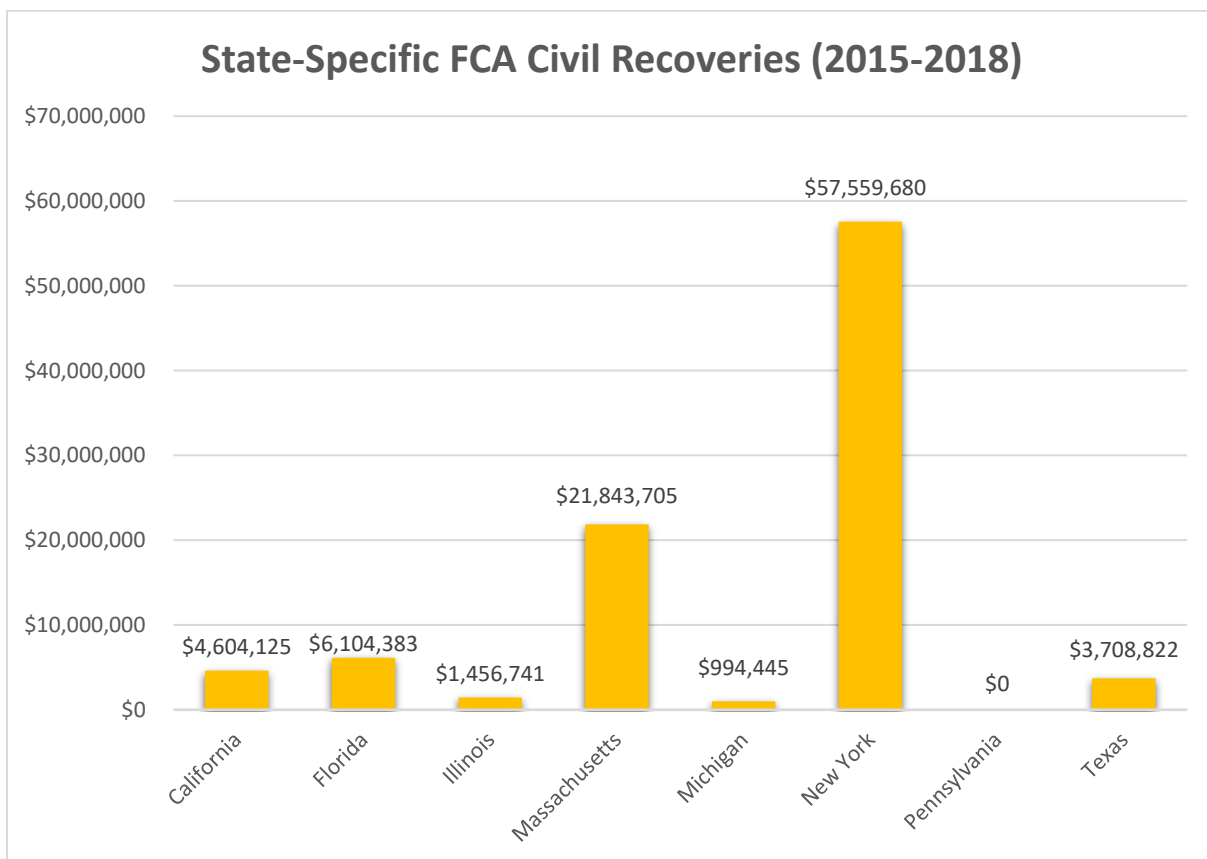
Aside from enhanced financial incentives offered by the federal government, states who have enacted a state-specific False Claims Act have pursued civil remedies for false claims. The Commonwealth has not. Below is a table depicting the actual recoveries made by states with a state-specific FCA over several years and a table showing the 2018 recoveries made as well as providing the Medicaid expenditures in 2018. We provided the longer table to provide a more accurate depiction since these cases can take up to 5 years to pursue.



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⁴³ Selected States Used.

During the time span of 2015 to 2018, the state of California received \$42.0 million in state-specific false claim civil remedies. During this time, it spent the most on Medicaid expenditures at \$354.7 billion. Florida received \$78.8 million in civil remedies and spent \$92.0 billion on Medicaid expenditures. Illinois received \$15.0 million in recoveries while spending \$77.3 billion on Medicaid expenditures. Massachusetts received \$38.5 million in recoveries while spending \$70.8 billion on Medicaid expenditures. Michigan received \$4.8 million in recoveries while spending \$68.4 billion on Medicaid expenditures. New York received the most in recoveries at \$236.2 million and it spent \$276.4 billion on Medicaid expenditures. Texas received \$13.6 million in recoveries while spending \$153.3 billion on Medicaid. Meanwhile, the Commonwealth spent \$112.1 billion on Medicaid expenditures and received \$0 in state-specific false claims remedies.⁴⁴



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During 2018, 43 states received civil remedies totaling \$178.3 million. California spent the most on Medicaid at nearly \$89 billion and received \$4.6 million in state-specific civil remedies. Florida spent \$23.7 billion on Medicaid and received \$6.1 million in recoveries. Illinois spent \$23.1 billion on Medicaid and received \$1.5 million in recoveries. Massachusetts spent \$18.7

⁴⁴ U.S. Department of Health and Human Services, Office of Inspector General. MFCU Statistical Data for Fiscal Years 2015-2018.

⁴⁵ Selected States Used.

billion on Medicaid and received nearly \$22 million in recoveries. Michigan spent \$17 billion on Medicaid and received nearly \$1 million in recoveries. New York spent \$75 billion and received the highest amount in recoveries at nearly \$56 million. Texas spent nearly \$39 billion on Medicaid and received almost \$4 million in recoveries. Pennsylvania spent \$30.7 billion on Medicaid and received \$0 in state-specific civil false claims remedies.⁴⁶

State False Claims Statutes⁴⁷

While some State False Claims laws encourage whistleblowers to file cases involving any type of fraud committed against the state, many specify only health care or Medicaid fraud. A few permit plaintiffs to bring claims on behalf of a city or town that has been the victim of fraud.

Arkansas [Medicaid only/No private right of action] Medicaid Fraud False Claims Act, Ark. Code Ann. 20-77-901, *et seq.*

California
False Claims Act
Cal. Gov't Code § 12650, *et seq.*

Colorado [Medicaid only] Medicaid False Claims Act
Colo. Rev. Stat. § 25.5-4-303.5, *et seq.*

Connecticut
False Claims Act
Conn. Gen. Stat. § 4-274, et seq.

Delaware
False Claims and Reporting Act
Del. Code tit. 6, § 1201, *et seq.*

District of Columbia
False Claims Law
D.C. Code Ann. § 2-308.01, *et seq.*

Florida
False Claims Act
Fla. Stat. Ann. § 68.083, *et seq.*

Georgia
Taxpayer Protection False Claims Act

Ga. Code Ann. § 23-3-120, *et seq.*
State False Medicaid Claims Act
Ga. Code Ann. § 49-4-168, *et seq.*

Hawaii
False Claims Act
Haw. Rev. Stat. § 661-22, *et seq.* (state)
Haw. Rev. Stat. § 46-171, *et seq.* (counties)

Illinois
False Claims Act
740 Ill. Comp. Stat. § 175/1, *et seq.*

Indiana
False Claims and Whistleblower Protection Act
Ind. Code § 5-11-5.7-1, *et seq.*

Iowa
False Claims Act
Iowa Code § 685.1, *et seq.*

Kansas [No private right of action] False Claims Act
Kan. Stat. Ann. § 75-7501, *et seq.*

Louisiana [Medicaid only] Medical Assistance Programs Integrity Law
La. Rev. Stat. Ann. § 46:437.1, *et seq.*

⁴⁶ U.S. Department of Health and Human Services. MFCU Statistical Data for FYI 2018. February 21, 2019. https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2018-statistical-chart.pdf.

⁴⁷ Kreindler & Associates. *State and Local Versions of the False Claims Act*. <http://blowthewhistle.com/services/false-claims/state-and-local-statutes/>; <https://www.falseclaimsact.com/states/DC.pdf>.

Maryland [Medicaid only] False Health Claim Act
Md. Code Ann. §8-101, *et seq.*

Massachusetts
False Claims Law
Mass. Ann. Laws Ch. 12, § 5, *et seq.*

Michigan [Medicaid only] Medicaid False Claims Act
Mich. Comp. Laws § 400.602, *et seq.*

Minnesota
False Claims Act
Minn. Stat. § 15C.01, *et seq.*

Missouri [Medicaid only/No private right of action] Health Care Payment Fraud and Abuse Act
Mo. Rev. Stat. § 191.900, *et seq.*

Montana
False Claims Act
Mont. Code Ann. § 17-8-401, *et seq.*

Nevada
False Claims Act
Nev. Rev. Stat. § 357.010, *et seq.*

New Hampshire [Medicaid only] Health Care False Claims Act
N.H. Rev. Stat. Ann. § 167:61-b, *et seq.*

New Jersey
False Claims Act
N.J. Stat. Ann. § 2A:32C-1, *et seq.*

New Mexico
Fraud Against Taxpayers Act
N.M. Stat. Ann. § 44-9-1, *et seq.*
Medicaid False Claims Act
N.M. Stat. Ann. § 27-14-1

New York
State False Claims Act
N.Y. Fin. Law Ch. 56 § 187, *et seq.*

North Carolina
False Claims Act
N.C. Gen. Stat. § 1-605, *et seq.*

Oklahoma
Medicaid False Claims Act
Okla. Stat title 63, § 5053, *et seq.*

Oregon [No private right of action] False Claims Act
Ore. Rev. Stat. § 180.750, *et seq.*

Rhode Island
State False Claims Act
R.I. Gen. Laws § 9-1.1-1, *et seq.*

Tennessee
False Claims Act
Tenn. Code Ann. § 4-18-101, *et seq.*
Medicaid False Claims Act
Tenn. Code. § 71-5-181, *et seq.*

Texas [Medicaid only] Medicaid Fraud Prevention Act
Tex. Hum. Res. Code, § 36.001, *et seq.*

Utah [Medicaid only/No private right of action] False Claims Act
Utah Code Ann. § 26-20-1, *et seq.*

Vermont
False Claims Act
Vt. Stat. Ann. tit. 32, § 630, *et seq.*

Virginia
Fraud Against Taxpayers Act
Va. Code Ann. § 8.01-216.1, *et seq.*

Washington [Medicaid only] Medicaid False Claims Act
Wash. Rev. Code § 74.66.005, *et seq.*

~~**Wisconsin** [Medicaid only] False Claims for Medical Assistance Act
Wis. Stat. § 635.20.931, *et seq.* REPEALED 2015~~

Wyoming [Medicaid only/No private right of action] Medicaid False Claims Act
Wyo. Stat. Ann. § 42-4-303, *et seq.*

Municipal False Claims Statutes and Ordinances⁴⁸

Bay Harbor Islands

False Claims Ordinance
§ 14-70, et seq.

Broward County

False Claims Ordinance
§ 1-276, et seq.

Chicago

False Claims Act
Municipal Code of Chicago § 1-21-010, et seq.

District of Columbia

False Claims Act
§ 2-308.03, et seq.

City of Hallandale Beach

False Claims Act
§ 19-100, et seq.

New York City

False Claims Act
N.Y.C. Admin. Code § 7-801, et seq.

Philadelphia

False Claims Act
Phila. Mun. Code § 19-3601, et seq.

The Philadelphia Ordinance is different from the FCA in that a private individual is only permitted to pursue a case after filing if the City Solicitor designates that person.⁴⁹

Allegheny County, Pennsylvania

False Claims Ordinance
Code of Ordinances § 485-1, et seq.

Allegheny County was the first municipal government in Pennsylvania, and the fourth in the nation to adopt a local FCA.⁵⁰

Miami-Dade County, Florida

False Claims Ordinance
Code of M.D.C. § 21-255, et seq.

Pennsylvania's Recent History of False Claims Legislation

For over the last 20 years, in nearly every regular legislative session since 1997, a member of the House of Representatives has proposed a State False Claims Act. No such legislation has been introduced during this legislative session.

⁴⁸ Pietragallo, Gordon, Alfano, Bosick & Raspanti, LLP. *False Claims Act Resource Center*.

<https://www.falseclaimsact.com/states-municipalities-fcas/municipality-false-claims-act-overview>

⁴⁹ Berger/Montague. *Philadelphia False Claims Ordinance*. <https://bergermontague.com/philadelphia-false-claims-ordinance/>.

⁵⁰ Pietragallo, Gordon, Alfano, Bosick & Raspanti, LLP. *Allegheny County Surfs the False Claims Waive*.

<https://www.fraudwhistleblowersblog.com/federal-false-claims-act/allegheny-county-surfs-the-false-claims-wave/>.

Legislative Session	Bill Number	Member	History
1997-1998 ⁵¹	HB 1671	Kenney	Amended in House Judiciary Committee, 4/28/98
1999-2000 ⁵²	HB 849	Kenney	Passed House (201-0), 6/15/99
2001-2002 ⁵³	HB 1285	Kenney	Passed House (197-0), 12/11/01
2005-2006 ⁵⁴	HB 2994	Kenney	Referred House Judiciary Committee, 10/4/06
2007-2008 ⁵⁵	HB 2509	Gerber	Re-committed to House Appropriations 6/16/08
2007-2008	HB 1523	Gerber	Referred to Health and Human Services, 6/13/07
2007-2008	HB 329	Kenney	Referred to Judiciary, 2/13/07
2009-2010 ⁵⁶	SB 1113	Williams	Referred to Senate Judiciary, 10/8/09
2009-2010	HB 1679	Gerber	Re-committed to Appropriations, 6/23/10
2009-2010	HB 1351	D. Evans	Referred to Health and Human Services, 4/28/09
2011-2012 ⁵⁷	SB 125	Williams	Referred to Senate Judiciary, 1/12/11
2011-2012	HB 1725	Gerber	Referred to Judiciary, 6/24/11

⁵¹ Legislative Data Processing Center.

https://ldpc6.legis.state.pa.us/cfdocs/billInfo/bill_history.cfm?syear=1997&sind=0&body=H&type=B&bn=1671

⁵² Legislative Data Processing Center.

<https://ldpc6.legis.state.pa.us/cfdocs/legis/search//KeywordSearchAction.cfm?searchType=txt&request=False+Claims+Act&index=19990txt&search=Search>.

⁵³ Ibid.

https://ldpc6.legis.state.pa.us/cfdocs/billInfo/bill_history.cfm?syear=2001&sind=0&body=H&type=B&bn=1285.

⁵⁴ Ibid.

https://ldpc6.legis.state.pa.us/cfdocs/billInfo/bill_history.cfm?syear=2005&sind=0&body=H&type=B&bn=2994.

⁵⁵ Ibid.

<https://ldpc6.legis.state.pa.us/cfdocs/legis/search//KeywordSearchAction.cfm?searchType=txt&request=False+Claims+Act&index=20070txt&search=Search>.

⁵⁶ Ibid.

<https://ldpc6.legis.state.pa.us/cfdocs/legis/search//KeywordSearchAction.cfm?searchType=txt&request=False+Claims+Act&index=20090txt&search=Search>.

⁵⁷ Ibid.

<https://ldpc6.legis.state.pa.us/cfdocs/legis/search//KeywordSearchAction.cfm?searchType=txt&request=False+Claims+Act&index=20110txt&search=Search>.

2013-2014 ⁵⁸	HB 1493	Neuman	Referred to Judiciary, 6/10/13
2015-2016 ⁵⁹	HB 654	Neuman	Referred to Judiciary, 2/26/15
2017-2018 ⁶⁰	HB 1027	Neuman	Referred to Judiciary, 3/30/17

According to the House Journal, when House Bill 849 was debated on the floor during third consideration it was amended three times before final passage.⁶¹

Of the amendments offered, one addressed a concern about provisions of the bill addressing employer penalties and unlimited punitive-damages going beyond the Federal version of the False Claims Act. With a vote of 170-30, amendment A2358 offered by Rep. Schroder was approved that would allow for international misconduct damages to be unlimited while limiting punitive damages to 200 percent of the compensatory damages awarded. Aside from the maker’s remarks on the amendment, no other discussion was held.

A comprehensive amendment, A2333, was offered by the maker of the bill. The amendment addressed “reasonable grounds,” the ability of the prosecuting authority to proceed in either the Commonwealth Court or the Court of Common Pleas, jurisdiction over an action brought by former employees, investigators or certain contracted employees. In addition, any settlements would require consultation with the political subdivision and the district attorney and the use of recoveries awarded. This amendment was unanimously adopted.

Representative Blaum offered amendment A2652 that was also unanimously adopted providing for good faith reporting to an employer. The amendment provided retaliation protections of an employee’s compensation, terms, conditions, locations or privileges if the employee made a good faith report to the employer regarding a false claim. Following the adoption of the amendment the bill was voted on final consideration and passed unanimously.⁶²

When the bill reached the Senate, it was amended in the Senate Judiciary Committee and later came to rest in the Senate Rules and Executive Nominations Committee. The Senate

⁵⁸Ibid.

<https://ldpc6.legis.state.pa.us/cfdocs/legis/search//KeywordSearchAction.cfm?searchType=txt&request=False+Claims+Act&index=20130txt&search=Search>.

⁵⁹Ibid.

<https://ldpc6.legis.state.pa.us/cfdocs/legis/search//KeywordSearchAction.cfm?searchType=txt&request=False+Claims+Act&index=20150txt&search=Search>.

⁶⁰Legislative Data Processing Center

<https://ldpc6.legis.state.pa.us/cfdocs/legis/search//KeywordSearchAction.cfm?searchType=txt&request=False+Claims+Act&index=20170txt&search=Search>.

⁶¹ Ibid. <https://ldpc6.legis.state.pa.us/WU01/LI/HJ/1999/0/19990615.pdf>.

⁶²Ibid. <https://ldpc6.legis.state.pa.us/WU01/LI/HJ/1999/0/19990615.pdf>.

amendments introduced the inclusion of a severability clause so the invalidity of one provision would not affect other provisions that can be given effect without the invalidated provision.⁶³

According to the Legislative Journal, when the bill was deliberated the following legislative session there were no amendments offered on the House floor and there was no debate.⁶⁴ This time, there was a fiscal note attached to the legislation that was favorable to taxpayers which stated there was an anticipation of increased revenues.⁶⁵ The House, again, passed the bill unanimously. Regardless, the legislation would ultimately die at the end of the legislative session without the Senate holding a vote on the measure.

***FISCAL IMPACT:** It is anticipated that enactment of the bill will increase revenue to the General Fund largely as a result of the qui tam provisions, which will give individuals an incentive to report over-billings and fraudulent claims being made against the Commonwealth and political subdivisions. The amount of revenue to be generated from the enactment of the bill is a minimum estimate, based on what other states with similar laws collect. It is anticipated that revenue generated from the act will increase as citizens and attorneys become familiar with the law's provisions. The Attorney General will incur costs to process the civil actions; however, the act provides that costs associated with the civil actions can be recovered from the persons submitting the false claims.*

United States Department of Justice

In 2018, the United States Department of Justice resolved affirmative civil enforcements (ACE) achievements by the U.S. Attorney's Office Civil Division. The U.S. recovered over \$108 million from False Claims Act cases, mostly from those alleging healthcare fraud violations. Whistleblowers recovered over \$18 million from these resolutions. These cases originated largely from qui tam, or whistleblower filings and agency referrals.⁶⁶ Some of these cases involved:

- Miller et. al. vs. Health Management Associates, Inc., et al.
 - The settlement amount is \$55 million for the joint venture piece of the litigation arising out of EDPA, with a global settlement of \$260 million for eight qui tams filed in five districts.
- Johnson v. Post Acute Medical, LLC, et al.
 - The settlement amount is \$13,031,502 to the United States, \$114,016 to Texas, \$22,482 to Louisiana, and \$2,345,670 to the qui tam whistleblower.
- Emanuele v. Medicor Associates, Inc., et al.

⁶³ Ibid.

<https://ldpc6.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=1999&sessInd=0&billBody=H&billType=B&billNbr=0849&pn=2541>.

⁶⁴ Ibid. <https://ldpc6.legis.state.pa.us/WU01/LI/HJ/2001/0/20011211.pdf>.

⁶⁵ Ibid. <https://ldpc6.legis.state.pa.us/WU01/LI/BI/FN/2001/0/HB1285P3012.pdf>.

⁶⁶ U.S. DOJ, "EDPA Announces 2018 Affirmative Civil Enforcement Achievements,"

<https://www.justice.gov/usao-edpa/pr/edpa-announces-2018-affirmative-civil-enforcement-achievements>.

- The settlement amount is \$20,750,000 to the United States and \$6,017,500 to the qui tam whistleblower.
- Thomas and Mizak v. Horizons Hospice LLC, et al.
 - The settlement amount is \$1,240,000 to the United States.

In fiscal year 2018, 646 qui tam complaints were filed. The United States intervened in 119 cases in 2018 (which may have been filed in years prior) for litigation or settlement purposes. Of those cases, 15 were in Pennsylvania.

Summary of Federal FCA Cases Filed in Pennsylvania

While not all inclusive, below are examples of cases and settlements reached by the United States with companies doing business or defendants residing within the Commonwealth who have been alleged of committing and settling FCA claims. More cases can be found at the United States Attorneys websites (USAO for Western District of Pennsylvania and the USAO of Eastern District of Pennsylvania).

On June 26, 2019, the trustees of the University of Pennsylvania Health System (Penn Medicine) agreed to pay \$275,000 to settle FCA allegations that Lancaster General Hospital's division of Maternal Fetal Medicine submitted false Medicaid claims for obstetric ultrasounds.⁶⁷

On July 23, 2019, the owner of E-Z Pharmacy II in Philadelphia agreed to pay \$400,000 to settle FCA allegations. The settlement resolves allegations the pharmacy violated the FCA by billing Medicare for prescriptions that were not dispensed.⁶⁸

On July 15, 2019, Millcreek Community Hospital agreed to pay \$2.45 million to settle FCA allegations of billing Medicare and Medicaid for medically unnecessary inpatient rehabilitation services.⁶⁹

On July 24, 2019, Eagleville Hospital agreed to pay \$2.85 million to settle FCA allegations the hospital submitted false claims to Medicare, Medicaid and the Federal Employees Health Benefits Program for detoxification treatment services for patients who were ineligible.⁷⁰

On June 6, 2019, a Florida doctor agreed to pay \$911,136.75 to settle allegations he received improper payments for making referrals to a drug testing lab (Universal Oral Fluid Laboratories)

⁶⁷ Department of Justice, U.S. Attorney's Office Eastern District of Pennsylvania, Press Release. June 26, 2019. <https://www.justice.gov/usao-edpa/pr/penn-medicine-agrees-pay-275000-settle-false-claims-act-allegations>.

⁶⁸ Ibid, July 23, 2019. <https://www.justice.gov/usao-edpa/pr/philadelphia-based-pharmacy-owners-agree-pay-400000-resolve-false-claims-act-liability>.

⁶⁹ Department of Justice, U.S. Attorney's Office Western District of Pennsylvania, Press Release. July 15, 2019. <https://www.justice.gov/usao-wdpa/pr/millcreek-community-hospital-will-pay-2451000-settle-claims-medically-unnecessary>.

⁷⁰ Department of Justice, U.S. Attorney's Office Eastern District of Pennsylvania, Press Release. July 24, 2019. <https://www.justice.gov/usao-edpa/pr/eagleville-hospital-pays-285-million-resolve-allegations-improper-billing-detox>.

in Greensburg, PA. These referrals resulted in false claims submitted to Medicare for drug testing services. The doctor was engaged in a financial relationship with UOFL.⁷¹

On May 29, 2019, the pharmaceutical company Almirall, LLC (Aqua Pharmaceuticals) agreed to pay \$3.5 million to resolve FCA allegations that it paid kickbacks to dermatology providers to induce prescriptions. The suit was filed under the FCA.⁷²

On May 31, 2019, Heritage Pharmaceuticals agreed to pay over \$7 million to settle civil FCA allegations that the company paid and received remuneration from other drug manufacturers between 2015 and 2015.⁷³

On February 22, 2019, Lehigh Valley Technologies, Inc. agreed to pay \$4 million to settle FCA allegations it avoided paying fees associated with new drug applications to the FDA.⁷⁴

On February 14, 2019, Prime Healthcare Services, Inc. agreed to pay \$1.25 million to settle FCA allegations that two hospitals in Pennsylvania (Roxborough Memorial and Lower Bucks) submitted false claims to Medicare.⁷⁵

On February 4, 2019, Pentec Health, Inc. (located in Glen Mills, PA) agreed to pay \$17 million to settle FCA claims that it submitted false claims to Medicare and other government healthcare programs.⁷⁶

On December 21, 2018, the United States intervened in a lawsuit brought against Wheeling Hospital, Inc., R & V Associates, Ltd by Ronald Violi who was previously employed as Wheeling's Executive Vice President under the whistleblower provisions of the FCA. The government intervened with the allegations that Wheeling violated the Stark Law and Anti-Kickback Statute, which prohibits a hospital from billing Medicare for services referred by physicians with an improper financial relationship with a hospital.⁷⁷

⁷¹ Department of Justice, U.S. Attorney's Office Western District of Pennsylvania, Press Release. June 6, 2019. <https://www.justice.gov/usao-wdpa/pr/florida-doctor-agrees-pay-91113675-settle-alleged-false-claims-act-violations-arising>.

⁷² Department of Justice, U.S. Attorney's Office Eastern District of Pennsylvania, Press Release. May 29, 2019. <https://www.justice.gov/usao-edpa/pr/pharmaceutical-company-pay-35m-resolve-allegations-paying-kickbacks-doctors>.

⁷³ Department of Justice, U.S. Attorney's Office Eastern District of Pennsylvania, Press Release. May 31, 2019. <https://www.justice.gov/usao-edpa/pr/heritage-pharmaceuticals-pays-over-7-million-resolve-civil-false-claims-act-allegations>.

⁷⁴ Ibid, February 22, 2019. <https://www.justice.gov/usao-edpa/pr/lehigh-valley-technologies-inc-pay-4-million-resolve-false-claims-act-liability-schem-0>.

⁷⁵ Ibid, February 14, 2019. <https://www.justice.gov/usao-edpa/pr/prime-healthcare-services-and-ceo-dr-prem-reddy-pay-125-million-settle-false-claims-act>.

⁷⁶ Ibid, February 4, 2019. <https://www.justice.gov/usao-edpa/pr/pentec-health-inc-pay-17-million-settle-false-claims-act-allegations>.

⁷⁷ Department of Justice, U.S. Attorney's Office Western District of Pennsylvania, Press Release. December 21, 2018. <https://www.justice.gov/usao-wdpa/pr/united-states-joins-false-claims-act-lawsuit-against-wheeling-hospital-r-v-associates>.

On December 13, 2018, Hospice Care Provider, SouthernCare, Inc., agreed to pay \$6 million to resolve FCA allegations that they submitted claims to Medicare for hospice care that was medically unnecessary or lacked documentation. The claim was submitted by whistleblowers.⁷⁸

On October 24, 2018, Passavant Memorial Homes and its subsidiaries (Passavant Development Corporation, PDC Pharmacy Pittsburgh, PDC Pharmacy Philadelphia, and PDC Pharmacy Colorado) agreed to pay the United States \$1.85 million to settle FCA and Controlled Substances Act violations. The settlement resolves a claim that Passavant dispensed controlled substances on Schedules III, IV, and V to patients for legitimate purposes but without a valid prescription and with only a physician order. Since the claims were submitted to Medicare and Medicaid, it was a violation of the FCA.⁷⁹

On October 26, 2018, Abbott Laboratories and AbbVie Inc. agreed to pay \$25 million to resolve FCA allegations of kickbacks and off-labeling marketing for TriCor brought about by a whistleblower claim filed by Amy Bergman. The State Medicaid program will receive \$1.8 million.⁸⁰

On September 25, 2018, Health Management Associates agreed to pay \$55 million civil settlement to resolve allegations relating to two hospitals in Lancaster. It is part of a larger \$260 million settlement arising from fraudulent billing practices in multiple healthcare facilities across the nation. The allegations were brought in eight lawsuits filed under the qui tam provisions of the FCA.⁸¹

On July 12, 2018, Weis Markets, Inc., agreed to pay \$77,320 to settle false claims allegations. The claim submitted that Weis violated the FCA by using gift cards to induce Medicare and Medicaid recipients to transfer or fill their prescriptions at its affiliated pharmacies.⁸²

On July 3, 2018, a former Pittsburgh family physician, Brent E. Clark, agreed to pay \$360,000 to settle an FCA allegation. Between February 2015 and February 2017, Dr. Clark billed Medicare and Medicaid for unreasonable and unnecessary office visits, procedures, and falsified records to support those payment claims.⁸³

⁷⁸ Department of Justice, U.S. Attorney's Office Eastern District of Pennsylvania, Press Release. December 13, 2018. <https://www.justice.gov/usao-edpa/pr/hospice-care-provider-pays-nearly-6-million-resolve-false-claims-act-allegations>.

⁷⁹ Department of Justice, U.S. Attorney's Office Western District of Pennsylvania, Press Release. October 24, 2018. <https://www.justice.gov/usao-wdpa/pr/passavant-memorial-homes-and-subsidiaries-settle-false-claims-act-allegations>.

⁸⁰ Department of Justice, U.S. Attorney's Office Eastern District of Pennsylvania, Press Release. October 26, 2018. <https://www.justice.gov/usao-edpa/pr/abbott-laboratories-and-abbvie-inc-pay-25-million-resolve-false-claims-act-allegations>.

⁸¹ Ibid, September 25, 2018. <https://www.justice.gov/usao-edpa/pr/national-hospital-chain-will-pay-over-260-million-resolve>.

⁸² Department of Justice, U.S. Attorney's Office Western District of Pennsylvania, Press Release. July 12, 2018. <https://www.justice.gov/usao-wdpa/pr/weis-markets-inc-settles-false-claims-act-allegations>.

⁸³ Ibid, July 3, 2018. <https://www.justice.gov/usao-wdpa/pr/family-practice-doctor-pays-360000-settle-false-claims-act-allegations>.

On July 3, 2018, North American Power Group, Ltd., and its owner agreed to pay the United States \$14.4 million to settle FCA allegations by submitting fraudulent claims under a cooperative agreement with the Department of Energy National Energy and Technology Laboratory.⁸⁴

On June 28, 2018, a company providing treatments for varicose veins (circulatory Centers of America, LLC) agreed to pay \$1.2 million to resolve FCA allegations. The settlement resolves a whistleblower suit contending the company submitted claims to the Medicare program for services performed by non-physicians with supervision of a physician, when no such supervision was performed. Billing services with physician supervision receives higher reimbursements. The suit also alleged the company submitted claims for medically unnecessary and unreasonable services performed by technicians without proper licensing and or training.⁸⁵

On May 7, 2018, three physicians agreed to pay \$700,000 to settle FCA violations for receiving improper payments for referrals from Greensburg, PA drug testing lab Universal Oral Fluid Laboratories. These referrals resulted in false claims submitted to Medicare for drug testing.⁸⁶

On Marcy 21, 2018, professor Christian Schunn at the University of Pittsburgh agreed to pay \$132,000 to resolve allegations of the FCA by submitting false documents to the National Science Foundation to obtain federal grants to fund his research. He will be prohibited from applying for or participating in federal grants through October 15, 2019. The settlement resolve claims from 2006 to 2016 Schunn created false institutional review board approvals and submitting them to the NSF for funding totaling over \$2.3 million.⁸⁷

On May 31, 2018, the owners of I&L Express Pharmacy in Philadelphia agreed to pay \$3.2 million to settle FCA allegations for billing Medicare for prescriptions that were not dispensed.⁸⁸

On February 8, 2018, a private owned for-profit hospice company agreed to pay \$1.24 million to settle two False Claims Act Whistleblower lawsuits, alleging the company fraudulently billed Medicare and Medicaid for services to patients who were ineligible for hospice.⁸⁹ The claims settled content from June 2007 to August 2012, the defendants submitted false claims to Medicare and Medicaid for patients who did not qualify for services because they did not have a

⁸⁴ Ibid, July 3, 2018. <https://www.justice.gov/usao-wdpa/pr/north-american-power-group-ltd-and-michael-ruffatto-agree-pay-144-million-resolve>.

⁸⁵ Department of Justice, U.S. Attorney's Office Western District of Pennsylvania, Press Release. June 28, 2018. <https://www.justice.gov/usao-wdpa/pr/varicose-vein-treatment-company-agrees-pay-1205000-resolve-false-claims-act-allegations>

⁸⁶ Ibid, May 7, 2018. <https://www.justice.gov/usao-wdpa/pr/three-physicians-agree-pay-total-700000-settle-alleged-false-claims-act-violations>

⁸⁷ Ibid, March 21, 2018. <https://www.justice.gov/usao-wdpa/pr/university-pittsburgh-professor-pays-132000-and-agrees-exclusion-resolve-allegations>

⁸⁸ Department of Justice, U.S. Attorney's Office Eastern District of Pennsylvania, Press Release. May 31, 2018. <https://www.justice.gov/usao-edpa/pr/pharmacy-owners-agree-pay-32-million-resolve-false-claims-case>.

⁸⁹ Department of Justice, U.S. Attorney's Office Western District of Pennsylvania, Press Release. February 8, 2018. <https://www.justice.gov/usao-wdpa/pr/hospice-company-and-owner-agree-pay-124-million-settle-two-false-claims-act>.

life expectancy of six months or less. They also contended records were falsified to support the false claims.⁹⁰

On December 19, 2017, Lancaster Physician Group (Physician's Alliance Ltd.) agreed to pay over \$4 million for receiving illegal remuneration to refer patients to two hospitals (Lancaster Regional Medical Center and Heart of Lancaster Medical Center). The suit was filed under the qui tam provisions of the FCA.⁹¹

On July 27, 2016, the University of Pittsburgh Medical Center, together with the University of Pittsburgh Physicians, UPMC community Medicine, Inc., and Tri-State Neurosurgical Associates-UPMC. Inc. agreed to pay the United States \$2.5 million to settle FCA violations. The complaint filed alleged neurosurgeons employed by UPMC submitted false claims to Medicare for assisting or supervising procedures performed when they did not participate in those procedures. In addition, it was alleged a neurosurgeon submitted claims for performing a procedure during spinal surgeries which was not performed. Not all claims asserted the whistleblowers in their Complaint are resolved by the settlement, therefore they will pursue those claims.⁹²

On April 15, 2015, Asbury Health Center agreed to pay \$1.3 million to settle FCA allegations. The settlement result from a self-disclosure regarding Medicare payments for skilled nursing facility services.⁹³

On July 13, 2013, the University of Pittsburgh Medical Center and a related joint venture agreed to pay \$956,590 to settle FCA allegations resulting from a self-disclosure to the United States Attorney's Office regarding referrals for home health services.⁹⁴

In September 2000, the University of Pennsylvania Health Systems settled a civil Medicare False Claims case for \$12 million. The complaint was filed by a whistleblower complaint who was a former mental health counsel for UPHS who alleged Medicare fraud involving unnecessary psychiatric treatment for nursing home patients.⁹⁵ The whistleblower was awarded \$2 million.

⁹⁰ Ibid, February 8, 2018. <https://www.justice.gov/usao-wdpa/pr/hospice-company-and-owner-agree-pay-124-million-settle-two-false-claims-act>.

⁹¹ Department of Justice, U.S. Attorney's Office Eastern District of Pennsylvania, Press Release. December 19, 2017. <https://www.justice.gov/usao-edpa/pr/lancaster-physician-group-pays-over-4-million-resolve-kickback-claims-involving-hma>.

⁹² Department of Justice, U.S. Attorney's Office Western District of Pennsylvania, Press Release. July 27, 2016. <https://www.justice.gov/usao-wdpa/pr/false-claims-act-violation-upmc-resolved-25-million>.

⁹³ Ibid, Press Release. April 15, 2015. <https://www.justice.gov/usao-wdpa/pr/13m-settlement-asbury-health-center-resolves-false-claims-act-allegations>.

⁹⁴ Ibid, Press Release. July 13, 2013. <https://www.justice.gov/usao-wdpa/pr/956590-settlement-upmc-resolves-false-claims-act-allegations>.

⁹⁵ Pietragallo, Gordon, Alfano, Bosick & Raspanti LLP. *United States Government Gets \$12 Million Settlement From the Hospital of the University of Pennsylvania over Allegations of Medicare Billing Fraud*. <https://www.falseclaimsact.com/case/united-states-government-gets-12-million-settlement-from-the-hospital-of-the-university-of-pennsylvania-over-allegations-of-medicare-billing-fraud>.

Summary of Federal Government FCA Cases

Since 1987, \$38.8 billion in remedies have been a result of false claims settlements and judgments related to the health care industry. This accounts for 48.6% of all judgments under the FCA.⁹⁶ Likewise, \$5.9 billion resulted from false claims involving the Department of Defense (16.6% of all judgments) and another \$14.3 billion have been for other false claims cases (34.7% of all judgments).⁹⁷

Since 1986, the number of lawsuits filed under qui tam provisions have grown – 645 in 2018 alone averaging 12 new cases a week.⁹⁸ According to the United States Department of Justice, the department brought in over \$2.8 billion from FCA claims in the fiscal year 2018. Of this amount, over \$2.1 billion arose from FCA lawsuits filed by whistleblowers. The government paid out \$301 million to these individuals for filing the actions.

Of the amounts recovered in 2018, \$2.5 billion involved the health care industry which encompasses managed care providers, hospitals, drug and medical device manufacturers, pharmacies, laboratories, hospice organizations and physicians. This total is for federal losses only and does not include the additional millions of dollars for state Medicaid programs.⁹⁹

Some of the largest recoveries came from drug and medical device false claims. \$625 million was paid by the AmerisourceBergen Corporation (ABC) over allegations they improperly repackaged injectable drugs into pre-filled syringes and then distributed the syringes to cancer patients. States received \$43.2 million in recoveries for Medicaid.¹⁰⁰ The settlement resolves three FCA cases filed.

In another case involving drug and medical devices, the manufacturer Alere paid \$33.2 million to resolve allegations it sold unreliable point-of-care testing devices, marketed as Triage, intended to be used to diagnosis drug overdoses, acute coronary syndrome and other serious conditions. States received \$4.8 million in recoveries for Medicaid. The settlement resolved an FCA allegation filed by a former employee who was a senior quality control analyst. She received \$5.6 million.¹⁰¹

The federal government also investigated fraud matters relating to procurement fraud. In one example, Toyobo Co. Ltd. Of Japan agreed to pay \$66 million to settle claims it sold defective

⁹⁶ The U.S. Department of Justice, Civil Division. Fraud Statistics. Health and Human Services. October 1, 1986-September 30, 2018.

⁹⁷ The U.S. Department of Justice, Civil Division. Fraud Statistics. Department of Defense. October 1, 1986-September 30, 2018.

⁹⁸ The U.S. Department of Justice. Press Release. December 21, 2018. <https://www.justice.gov/opa/pr/justice-department-recovers-over-28-billion-false-claims-act-cases-fiscal-year-2018>.

⁹⁹ The U.S. Department of Justice. Press Release. December 21, 2018.

¹⁰⁰ The U.S. Department of Justice. Press Release. October 1, 2018.

https://www.justice.gov/opa/pr/amerisourcebergen-corporation-agrees-pay-625-million-resolve-allegations-it-illegally?utm_medium=email&utm_source=govdelivery.

¹⁰¹ The U.S. Department of Justice. Press Release. March 23, 2018. https://www.justice.gov/opa/pr/alere-pay-us-332-million-settle-false-claims-act-allegations-relating-unreliable-diagnostic?utm_medium=email&utm_source=govdelivery.

Zylon used in bullet proof vests purchases for federal, state, local and tribal law enforcement agencies in the United States. The settlement resolves two lawsuits, one brought by the United States and another filed by a law enforcement officer. The law enforcement officer received \$5.8 million.¹⁰²

In another case, 3M Company of St. Paul Minnesota agreed to pay \$9.1 million to resolve allegations it sold defective dual-ended Combat Arms Earplugs to the military without disclosing the defects. The settlement resolves a lawsuit brought by its competitor, Moldex-Metrics. The whistleblower will receive \$1.9 million plus nearly \$645,000 in attorney fees.¹⁰³

Deloitte & Touche LLP paid \$149.5 million to settle FCA claims involving the outside audit of Taylor, Bean & Whitaker Mortgage Corp (TBW). TBW was authorized to originate and underwrite mortgage loans insured by the FHA. TBW was engaged in a fraudulent scheme involving the sale of fictitious or double-pledged mortgage loans. As the independent outside auditor, Deloitte was alleged to knowingly deviate from auditing standards which failed to detect the fraudulent activity and detecting false and misleading financial statements.¹⁰⁴

Former professional cyclist Lance Armstrong agreed to pay \$5 million to resolve FCA allegations arising from his use of performance-enhancing drugs resulting in the submission of millions of dollars in false claim payments for the USPS sponsorship. The suit was originally brought forward by a former teammate (Floyd Landis) in June 2010 under the whistleblower provisions of the FCA. Landis received \$1.1 million.¹⁰⁵

Over \$114 million was awarded to the federal government against three defendants for FCA allegations they paid physicians for referring patients to two blood testing laboratories, Health Diagnostic Laboratory and Singulex Inc. Evidence also showed physicians were referring patients to the laboratories for medical unnecessary test and billing federal health care programs. The claim was originally brought in three lawsuits under the whistleblower provisions of the FCA.¹⁰⁶

Prime Healthcare Services agreed to pay \$65 million to settle FCA allegations that 14 hospitals knowingly submitted false claims to Medicare by admitting patients who required outpatient care and billing for more expensive diagnosis. The suit was brought through the whistleblower

¹⁰² The U.S. Department of Justice. Press Release. March 15, 2018. https://www.justice.gov/opa/pr/japanese-fiber-manufacturer-pay-66-million-alleged-false-claims-related-defective-bullet?utm_medium=email&utm_source=govdelivery.

¹⁰³ Whistleblower News Review. *Defense Contractor 3M Settles Defective Earplug Lawsuit at \$9.1 million, \$1.9 million to Whistleblower*. August 7, 2018. https://www.whistleblowergov.org/government-contracts.php?article=3m-pays-9.1-million-on-alleged-military-contract-scam-1.9m-to-whistleblower_130.

¹⁰⁴ Eastin, Parker. *Deloitte & Touche Agrees to Pay \$149.5 Million to Settle Claims Arising from Its Audits of Failed Mortgage Lender Taylor, Bean & Whitaker*. The Whistleblower Resource. March 1, 2018. <http://thewhistleblowerresource.com/deloitte-touche-agrees-to-pay-149-5-million-to-settle-claims-arising-from-its-audits-of-failed-mortgage-lender-taylor-bean-whitaker/>.

¹⁰⁵ The U.S. Department of Justice. Press Release. April 19, 2018. https://www.justice.gov/opa/pr/lance-armstrong-agrees-pay-5-million-settle-false-claims-allegations-arising-violation-anti?utm_medium=email&utm_source=govdelivery.

¹⁰⁶ The U.S. Department of Justice. Press Release. May 29, 2018. <https://www.justice.gov/opa/pr/united-states-obtains-114-million-judgment-against-three-individuals-paying-kickbacks>.

provisions of the FCA by a former Director of performance Improvement at Alvarado Hospital Medical Center (one of the hospitals owned by the defendants). She received \$17.2 million.¹⁰⁷

Summary of Relevant Existing Law

While Pennsylvania has no false claims legislation akin to the federal False Claims Act, most false claims are pursued under the criminal statute, 18 Pa.C.S. § 3922, of theft by deception.

§ 3922. Theft by deception.

(a) Offense defined. --A person is guilty of theft if he intentionally obtains or withholds property of another by deception. A person deceives if he intentionally:

(1) creates or reinforces a false impression, including false impressions as to law, value, intention or other state of mind; but deception as to a person's intention to perform a promise shall not be inferred from the fact alone that he did not subsequently perform the promise;

(2) prevents another from acquiring information which would affect his judgment of a transaction; or

(3) fails to correct a false impression which the deceiver previously created or reinforced, or which the deceiver knows to be influencing another to whom he stands in a fiduciary or confidential relationship.

(b) Exception. --The term "deceive" does not, however, include falsity as to matters having no pecuniary significance, or puffing by statements unlikely to deceive ordinary persons in the group addressed.

Pennsylvania's Whistleblower Law (43 P.S. §§ 1421-1428), provides that: "No employer may discharge, threaten or otherwise discriminate or retaliate against an employee regarding the employee's compensation, terms, conditions, location or privileges of employment because the employee or a person acting on behalf of the employee makes a good faith report or is about to report, verbally or in writing, to the employer or appropriate authority an instance of wrongdoing or waste by a public body or an instance of waste by any other employer..."

Other instances in which the Commonwealth provides whistleblower protection are:

- The Hazardous Sites Cleanup Act (35 P.S. §§ 6020.101 et seq.).
- The Low-Level Radioactive Waste Disposal Act (35 P.S. §§ 7130.101 et seq.).
- The Municipal Waste Planning, Recycling and Waste Reduction Act (53 P.S. §§4000.101 et seq.).

The following statutes address "false claims" in various situations, via criminal or civil sanctions:

- Insurance fraud (18 Pa.C.S. § 4117).
- Unlawful acts (34 Pa.C.S. § 547).

¹⁰⁷ The U.S. Department of Justice. Press Release. August 3, 2018. https://www.justice.gov/opa/pr/prime-healthcare-services-and-ceo-pay-65-million-settle-false-claims-act-allegations?utm_medium=email&utm_source=govdelivery.

- Discharge of insolvent; forced insolvent (39 P.S. § 100).
- Frauds against government (51 Pa.C.S. § 6041).
- Provider prohibited acts, criminal penalties and civil remedies (62 P.S. § 1407).
- Penalty for false claims (71 P.S. § 1689.205).
- Penalties (72 P.S. § 3761-521).
- Crimes (72 P.S. § 7353).
- Warning notice on application for insurance and claim forms (75 Pa.C.S. § 1822).
- Offenses (77 P.S. § 1039.2).

False Claims Conclusion

Given the number of cases being pursued against individuals, companies or industries, within Pennsylvania, by the federal government, the enhanced financial incentive offered by the federal government to states with a state-specific FCA, the history of legislation being passed by the House during two previous legislative sessions, and actual state-specific FCA civil recoveries made by other states, we believe there is ample evidence to support the consideration of enacting a state-specific False Claims Act.

We acknowledge the benefit of pursuing these remedies is not measured over a short period of time. The task of investigating and conducting a civil remedies case can take three to five years, but we believe the payoff to taxpayers is one that the Commonwealth has the endurance to undertake. If an industry is making money from taxpayer dollars, then the state should have the ability to go after wrongdoers and recover civil remedies. It is our duty to protect taxpayer dollars, ensure the integrity of programs and make sure the state can be adequately repaid in full by those who try to cheat the system.

Improper Payments

Similar to the instances of fraud unveiled in the Attorney General’s Grand Jury Report, are the circumstances resulting in improper payments.

The Improper Payments Information Act (IPIA) of 2002 (amended by the Improper Payments Elimination and Recovery Act of 2010 and the Improper Payments Elimination and Recovery Improvement Act of 2012) requires federal government agencies to review programs and identify those susceptible to significant improper payments, estimate the improper payments, submit the estimates to Congress and a report on actions taken to reduce those payments. As a result of the Children’s Health Insurance Program (CHIP) and Medicaid as being programs at

greatest risk of improper payments, CMS developed the Payment Error Rate Measurement (PERM) program.¹⁰⁸

PERM measures improper payments of Medicaid and CHIP and establishes error rates based on reviews of three components: fee-for-service, managed care, and eligibility. These are not “fraud rates” but rather a measurement of payments that did not meet statutory, regulatory, or administrative requirements. Improper payments cover a broad category of errors not necessarily fraudulent which can be lack of documentation, incomplete documentation, procedure error coding or number of units error. CMS and HHS report improper payments annually in the Agency Financial Report (AFR) <http://www.hhs.gov/afr/>.

As part of the PERM review, a CMS contractor requests medical records from a selection of providers. This requires cooperation between CMS and the states. Medicaid Fee-For-Service (FFS) payments undergo two reviews: (1) A Data Processing Review to determine if the state processed the claim correctly; and (2) A Medical Review of provider records to ensure there is documentation that support the claim billed, coding accuracy and medical necessity of the service. Managed Care payments involve only a Data Processing Review to determine if the state accurately process the capitation payment (premium); there is no Medical Review because the managed care organizations do not provide a medical service. In March of 2019, the United States Government Accountability Office (GAO) released a report entitled, “Medicare and Medicaid: CMS Should Assess Documentation Necessary to Identify Improper Payments” citing FFS improper payments were \$41.2 billion nationally.¹⁰⁹

CMS uses a 17-state rotation for PERM which allows each state to be reviewed once every three years. Pennsylvania is a cycle 1 state.¹¹⁰ PERM audits take approximately 2.5 years to complete.¹¹¹

- **Cycle 1:** Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, **Pennsylvania**, Virginia, Wisconsin, and Wyoming.
- **Cycle 2:** Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, and West Virginia.

¹⁰⁸ Centers for Medicare & Medicaid Services. Payment Error Rate Measurement (PERM). <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/index.html>.

¹⁰⁹ United States Government Accountability Office. *Medicare and Medicaid: CMS Should Assess Documentation Necessary to Identify Improper Payments*. March 2019. <https://www.gao.gov/assets/700/697981.pdf>.

¹¹⁰ Centers for Medicare & Medicaid Services. *Payment Error Rate Measurement (PERM)*. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/PERMOVERVIEWFORPROVIDERS.pdf>.

¹¹¹ PA Department of Human Services. *Payment Error Rate Measurement (PERM)*. <http://dhs.pa.gov/provider/paymenterrortatemeasurement/index.htm>.

- **Cycle 3:** Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, and Washington.

The last PERM audit for Pennsylvania was in 2015. It is important to note that one of the three PERM components -- eligibility determinations and any resulting improper payments -- was not measured in the audit. Eligibility components of PERM were put on hold beginning with 2014 due to the changes in requirements and expanded eligibility made through the Patient Protection and Affordable Care Act of 2010, known as the Affordable Care Act (ACA). The 2015 PERM audit only reviewed FFS claims and managed care capitation payments.¹¹²

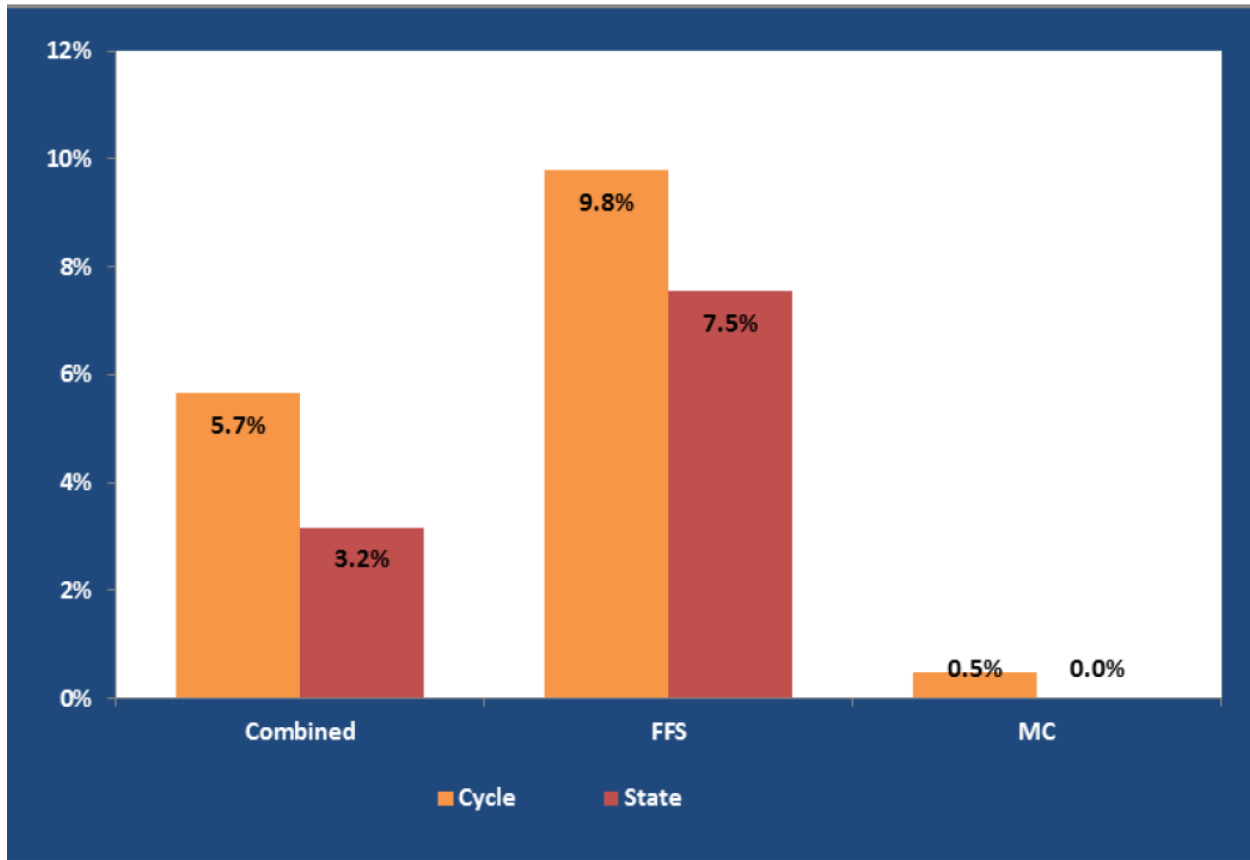
According to the U.S. Department of Health and Human Services 2015 Payment Error Rate Measurement for Pennsylvania Summary Report, “the FFS component improper payment rate measured under PERM is usually higher than the managed care component improper payment rate, primarily due to non-compliance with HIPAA transaction standards requiring National Provider Identifiers (NPI) to be included on electronically submitted claims and new regulations under ACA, such as risk-based screening of providers prior to enrollment. Additionally, the FFS improper payments include errors cited when providers fail to comply with record requests or fail to maintain documentation required by state policies. For the managed care measurement, PERM only reviews the payments made by states to managed care organizations and not claims submitted by providers for services rendered. Therefore, the managed care measurement does not include some errors observed in the FFS component, such as violations of claim transaction standards and provider failure to submit requested medical records.”¹¹³

The following chart shows the 2015 error rates reported for Pennsylvania (labeled “State”) and the overall error rates for all 17 states audited in Cycle 1 (labeled “Cycle”). Pennsylvania was lower on all three improper payment rates (FFS, Managed Care and Combined) when compared to the overall Cycle 1 error rates.

¹¹²United States Department of Health and Human Services. *Fiscal Year 2015 Pennsylvania Medicaid Payment Error Rate Measurement (PERM) Cycle 1 Summary Report*. November 16, 2016. p. 1.
http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_278846.pdf.

¹¹³ Ibid, p. 4.

Cycle 1 States vs. Pennsylvania Combined and Component Improper Payment Rates:



As the above figure from the Report shows, Pennsylvania’s Error Payment Rate for FFS is 7.5% while the Cycle 1 FFS error rate is 9.8%. The improper payment rate for managed care is 0.5% while Pennsylvania’s is 0.0% (again, it is important to note the claims submitted by providers for services rendered are not reviewed, therefore the measurement rate does not include some errors measured in FFS).¹¹⁴ Pennsylvania had a combined Medicaid improper payment rate of 3.2 percent compared to 5.7 % for the Cycle. While DHS would submit Pennsylvania achieved a successful audit outcome in part due to its lower combined improper payment rate than the Cycle, we suggest an error over 3% is not one to cause for celebration. Five states had combined error rates below Pennsylvania – their combined improper payment rates ranged from 0.3% to 2.9%.

To understand the possible fiscal impact of this error rate, we look at the total amount of the sample dollars in error which is an estimate of the total dollars paid incorrectly by the state across the program. The Report shows Pennsylvania’s projected dollars in error is \$694.1 million for FFS. While Medicaid is one state program, states have yet to fully engage to

¹¹⁴ United States Department of Health and Human Services. *Fiscal Year 2015 Pennsylvania Medicaid Payment Error Rate Measurement (PERM) Cycle 1 Summary Report*. November 16, 2016. p. 3. http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_278846.pdf.

eliminate improper payments which can reduce costs and provide more freed up state dollars to reallocate to other critical programs such as education funding or the Department of Corrections.

The following table summarizes the Report findings in the Fee-For Service component of Pennsylvania’s 2015 PERM audit.

Medicaid Program Component	State				Cycle			
	Sample # of Errors	Sample Dollars in Error	Projected Dollars in Error	% of Total Projected Dollars in Error	Sample # of Errors	Sample Dollars in Error	Projected Dollars in Error (\$Millions)	% of Total Projected Dollars in Error
Medicaid FFS	24	\$48,938	\$694,150,441	100.0%	1,563	\$4,067,319	\$7,579	96.1%
Medicaid Managed Care	0	\$0	\$0	0.0%	15	\$8,752	\$306	3.9%

Note: Details do not always sum to the total due to rounding.

**Pennsylvania PERM Audit: Fee-For-Service
Sample Medicaid Findings and Projected Dollars in Error**

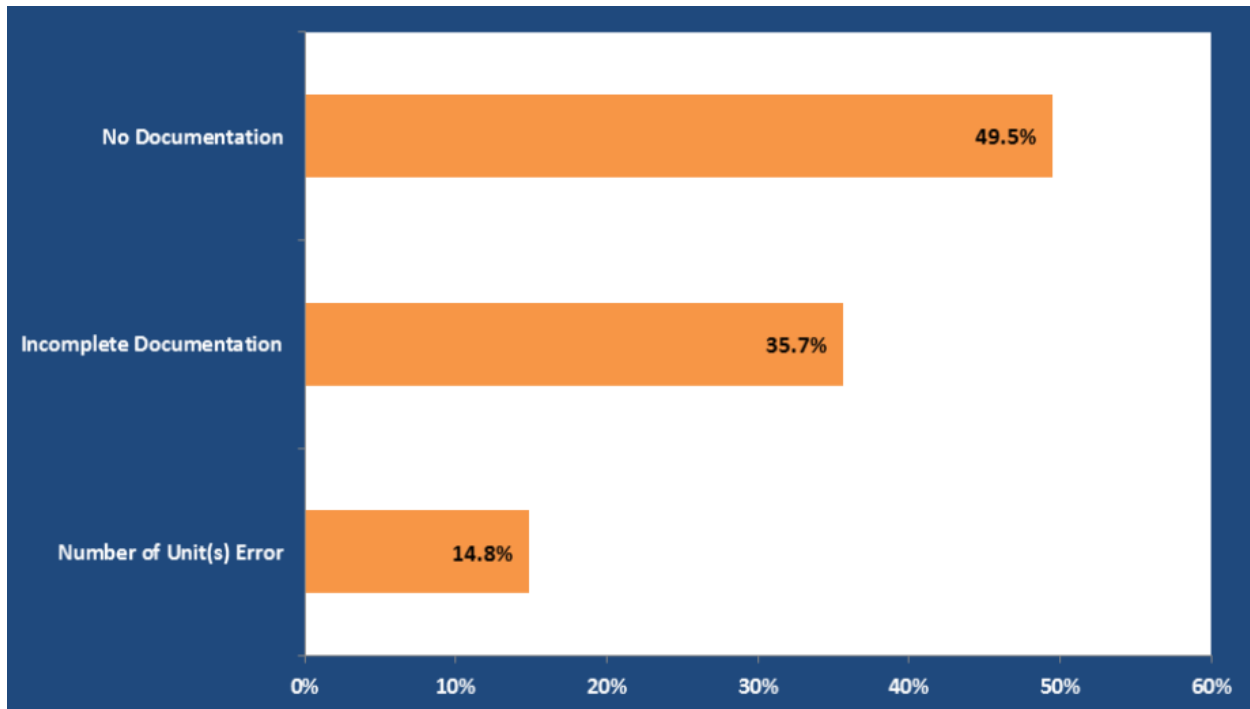
	Number of Errors in Sample	Sample Dollars in Error	Projected Dollars in Error	Percent of Projected Dollars in Error
Total FFS Errors	24	\$48,936	\$694,150,441	100%
Medical Review Errors	5	\$8,152	\$79,874,662	11.5%
Data Processing Errors	19	\$40,786	\$614,275,779	88.5%

Source: Pennsylvania PERM Medicaid FY 2015 Findings, Table 1 (page 5) and Table 2 (pages 5-6)

The audit reviewed a sample of FFS claims and found 24 errors with resultant improper payments totaling \$48,936. Based on these findings, the Report projected \$694 million payments may have been made in error across Pennsylvania’s Fee-For-Service program which includes inpatient, outpatient and long-term care services. (The projected dollars in error is calculated by multiplying the improper payment rate in the sample by the projected payment amounts listed on reports Pennsylvania filed with the Centers for Medicare & Medicaid Services.)

- Errors discovered in the Medical Review accounted for nearly \$80 million (or 11.5 percent) of total projected dollars in error. All errors were associated with long-term care claims (i.e., nursing facility, intermediate care facilities /group homes for individuals with intellectual disabilities, and home health services).
- Data Processing errors made up the lion’s share of projected improper payments, accounting for \$614 million (or 88.5 percent) of the total projection.

The Medical Review errors included: no supporting documentation to support the payment claim submitted to DHS, incomplete documentation to support the payment claim, and the incorrect number of units were billed. The following chart from the Report shows the percentage of Medical Review improper payments by error type. For example, almost half of the projected \$80 million dollars in error is attributed to claims that had no supporting documentation and more than one-third is due to claims with incomplete documentation.



It is both interesting and cause for concern to realize some of the error types given regarding the medical review errors that resulted in improper payments **echo the very issues detailed in the Attorney General’s Grand Jury’s Report regarding proper documentation.** Providers billed for the wrong recipient, providers shared that the recipient was not seen, the state could not locate the provider and the wrong units of service were billed. These are all provider information errors.

Findings from the Data Processing Review show 99.7% of improper Fee for Service payments are a result of provider information/enrollment errors. The majority of the errors are cited because providers were not screened using ACA risk based criteria as set forth 42 CFR 455.414, 42 CFR 455.436 and 42 CFR 450.¹¹⁵ Another strong sampling of the errors cited were because they did not include the provider’s NPI. **These are the same issues contained in the Attorney General’s Grand Jury Report detailing how provider fraud is being carried out in MA.** In total, the Pennsylvania Medicaid FFS data processing review error type review shows projected dollars in error for overpayments to be \$612.4 million.

¹¹⁵ Ibid p. 15.

State Level Improper Payments Law

As discussed earlier in this report, the payment of errors measurement conducted by CMS for managed care is not a complete picture. It only reviews the payments made by states to managed care organizations and not claims submitted by providers for services rendered. Therefore, we conclude the Commonwealth does not have an accurate picture of how many payments are improper. The argument that the MCOs independently maintain program integrity mechanisms does not assist us in being able to measure payment errors or detect forms of fraud, waste or abuse. We simply are unable to determine the amount of improper payments made to providers through the MCOs. After realizing comprehensive reviews are not occurring and error payments remain unknown, despite the fact that federal law may require MCOs to establish a Fraud, Waste, and Abuse Unit,¹¹⁶ we support a stronger review and audit of payments made to providers through MCOs.

Given the amount of payment errors made and disclosed through the PERM audit, primarily for FSS as the Managed Care review was unable to examine some of the causes leading to increases in improper payments made through FSS, **the Commonwealth should create a more efficient means to reduce costs attributed to errors of payment through the development of its own baseline analysis of improper payments across state agencies.**

Seeking the benefit of being able to provide more needed services to the most vulnerable, a cooperative team involving the Office of Inspector General, the Auditor General and the Treasury could create a Pennsylvania specific improper payment review for programs and services across every agency that is allocated taxpayer dollars. An improper payment elimination plan should be developed for each state agency with the target of achieving between 0 and 0.03 improper payment rate. Within five years of adopting an improper payment elimination plan for an agency, an audit should be completed by the Legislative Budget and Finance Committee to verify the effectiveness of the improper payment elimination plan. Going forward, reports of error should be performed every five years for every agency.

Considering the number of contracts, payments, and agreements between various state agencies and non-public entities, take for example the level of payments made through the Department of Corrections, it would be beneficial for a review of improper payments at the state level for all agencies and payments made by those agencies. Not having error payment rate to reference is not the same as the error payment not occurring. The Commonwealth needs to have an adequate and thorough understanding of the amounts of improper or error payments made across the board in order to protect the integrity of government programs, services, and the taxpayers who provide the funding for agencies to continue operating.

¹¹⁶ 42 CFR §438.608 (a)(1)(vii).

Other Wrongful Payments: Office of Inspector General

The ACA and federal regulations prohibit federal payments for health-care-acquired conditions and authorize States to identify other provider-preventable conditions (PPCs) that would prohibit Medicaid payments.¹¹⁷ State plans require state agencies to meet federal requirements related to nonpayment of PPCs. Furthermore, federal regulations require contracts with MCOs to comply with the prohibition of payments for PPCs.¹¹⁸ Ultimately, the state is responsible for ensuring our contracts with MCOs comply with both federal and state requirements.

The Office of Inspector General conducted an audit for the time period between October 1, 2013 through September 30, 2015. The purpose of the audit was “to determine whether the Pennsylvania Department of Human Services (State agency) ensured that its MCOs complied with Federal and State requirements prohibiting payments to providers for inpatient hospital services related to treating certain PPCs.”¹¹⁹ The Office of Inspector General has conducted similar audits on at least 11 other states since 2016 (New York, Massachusetts, Rhode Island, Louisiana, Nevada, Iowa, Missouri, Oklahoma, Illinois, Washington, and Idaho).

The audit only reviewed 10 physical health MCOs and 2 private-sector behavioral health MCOs. The state agency contracts with 32 county governments who subcontract with private sector behavioral health organizations were not included in the audit. The audit found the state was not ensuring contracts complied with both federal and state requirements prohibiting payments for inpatient hospital services related to PPCs. In fact, the audit reveals MCOs paid providers \$43.5 million for 576 claims involving PPCs. This is problematic since those payments were included in the calculation of capitation payment rates for 2016, 2017, and 2018. The audit suggests the Commonwealth did not have proper internal controls in place to ensure compliance. Specifically, there was no policy or procedure to determine whether an MCO complied or if the payment rates were based on services covered in the state plan. In addition, because of lacking information it could not be determined on whether MCOs were paying for additional services related to treating the PPCs.¹²⁰

It is worth noting, that in a response to the Office of Inspector General, the Department of Human Services suggests the \$43.5 million amount represents payments post-PPC adjustments

¹¹⁷ United States Department of Health and Human Services, Office of Inspector General. Pennsylvania Did Not Ensure That Its Managed-Care Organizations Complied With Requirements Prohibiting Medicaid Payments For Services Related To Provider-Preventable Conditions. August 2019. P. 4.

¹¹⁸ Ibid, p. 5.

¹¹⁹ Ibid, p. 1.

¹²⁰ Ibid, p. 6.

and unallowable expenditures. The Office of Inspector General disputes this statement and stands by its Report.¹²¹

Under federal regulations, payments are not denied when they contain a PPC, but rather the payment is reduced to the amount attributed to the PPC. This was not done according to the audit. Instead, payments were paid in full. There were no reductions in payments to providers for any of the 576 claims containing PPCs. Likewise, there were no policies or procedures in place that would have allowed the MCO determine a reduced payment for claims that included PPCs.¹²²

The audit unveiled the lack of proper monitoring by the state agency to ensure MCOs were compliant and the absence of a provision in the contract to require MCOs be compliant with federal requirements. The lack of oversight provided an avenue for a missed opportunity for the state to impose sanctions on the MCOs for compliance failure. There is no provision that allows the state agency to recoup funds from the MCOs.

In all, seven recommendations were made in the audit. Most involved greater oversight by the state agency. For the purposes of this report, the reliance on the state to allow the MCOs to police themselves in making payments only further supports our request for measures to be taken to reduce improper payments and other wrongful payments. These involve audits that were conducted and unknown. We are not certain how widespread such errors are actually being committed and paid.

United States Treasury: Do Not Pay Program

In 2002, the U.S. Treasury started the Do Not Pay program¹²³ which was codified in federal law with the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA).¹²⁴ The Do Not Pay program uses data analytics to verify eligibility and to identify and prevent fraud and waste associated with improper payments. Its purpose is to reduce improper payments by providing national agencies, state agencies or local governments who are disbursing federal funds access to critical information to identify fraud and prevent improper payments. It is a portal that provides information collected previously from agencies or publicly available information.¹²⁵

¹²¹ Ibid, p. 14.

¹²² Ibid, p. 7.

¹²³ U.S. Department of the Treasury. *Do Not Pay*. <https://fiscal.treasury.gov/dnp/>.

¹²⁴ U.S. Government Printing Office. 112th Congress 2D Session. *H.R. 4053*. December 17, 2012. <https://fiscal.treasury.gov/files/dnp/IPERIA.pdf>.

¹²⁵ Bureau of the Public Debt, U.S. Department of the Treasury. *Do Not Pay*. Privacy Impact Assessment (PIA). June 15, 2012. p. 4. <https://www.treasurydirect.gov/DoNotPayPIA.pdf>.

Data sources are constantly being added. The federal agencies providing information to the system include the Social Security Administration, General Services Administration, Department of Treasury and the Department of Health and Human Services. Publicly available sources (both on the internet or purchased from third-party providers, and others) are collected and used.¹²⁶ Those who use the system will use the reports to identify payments that need to be investigated to determine if the payments are indeed improper.¹²⁷

In discussing the federal program with the Pennsylvania Treasury, we were informed that Treasury does not currently actively participate in this program. Treasury further explained 90 percent of the contracts it comes across are from vendors approved by the Department of General Services.

While the Department of General Services also indicated they do not use the Do Not Pay program, they indicated that they utilize the Contractor Responsibility Program. This program was mandated by Executive Order 1990-3 by Governor Robert P. Casey to be administered by the Office of the Budget, with the assistance of the Department of General Services, Office of General Counsel, and Office of Inspector General.¹²⁸ Under the Executive Order, the program was designed to “identify, evaluate, and sanction appropriately, contractors that do not meet the standards of responsibility, which render deficient performance, or that engage in wrongdoing, or other activity adversely affecting their fitness to contract with Commonwealth agencies.”¹²⁹

According to the Management Directive for the program, dated October 25, 2010, agencies are required to only enter into contracts with responsible contractors.¹³⁰ Agencies are prohibited from awarding, renewing, extending, amending or assigning contracts to persons who are currently suspended or disbarred. In determining if a contractor is deemed responsible, agencies access the Contractor Responsibility Program (CRP) System which is an internet-based system to collect and disseminate information on contractor obligations; suspensions and debarments and performance issues.¹³¹ The CPR system is administered by the Office of the Administration.

In determining if a contractor is deemed responsible, some of the evaluating factors considered include suspension or disbarment, obligations to the Commonwealth; capacity to perform the task; performances of past or current contracts; financial stability; and any other information, act, or omission indicating they are not responsible.¹³²

The contractor is required to certify they are not suspended or disbarred by the Commonwealth, the federal government, or any governmental entity, they have no tax liabilities or other

¹²⁶ Ibid. p. 5.

¹²⁷ Ibid. p. 7.

¹²⁸ PA Office of the Budget. Contractor Responsibility Program.

<https://www.budget.pa.gov/Programs/Pages/ContractorResponsibilityProgram.aspx>.

¹²⁹ Executive Order 1990-3. June 29, 1990. https://www.oa.pa.gov/Policies/eo/Documents/1990_3.pdf.

¹³⁰ Management Directive. Commonwealth of Pennsylvania Governor’s Office. Contractor Responsibility Program. 215.9 Amended. October 25, 2010, p. 6. https://www.oa.pa.gov/Policies/md/Documents/215_9.pdf.

¹³¹ Ibid. p. 3.

¹³² Management Directive. Commonwealth of Pennsylvania Governor’s Office. Contractor Responsibility Program. 215.9 Amended. October 25, 2010. p12-13.

Commonwealth obligations, and they have filed timely appeals or are in a deferred payment plan if such liabilities exist. If during the time of the contract such liabilities arise, the contractor is required to inform the contracting agency.¹³³ The typical time span of a contract is two years with the possibility of being extended an additional year for up to three extensions. It appears that the only CPR system reviews conducted are during the awarding of the contracts and upon contract renewals.

A CRP Oversight Committee comprising of members of the Administration is tasked with monitoring, maintaining, and evaluating the program. Agency heads and the Office of General Counsel have the ability to waive any contract provision regarding contractor responsibility.¹³⁴

In addition to the CRP program, the Governor's office has established the Keystone Offset Program (KOP). Through the KOP, the existing tools in the CRP are leveraged against payments to collect certain eligible, delinquent debt owed to the Commonwealth.

MA Providers

Instead, for providers who wish to participate in the MA program, DHS uses an enrollment process that "screens" providers for participating in the program. Providers are required to be licensed and registered by the appropriate state agency. Providers can complete an on-line application and submit supporting documentation. Each provider enrolls in the MA program based on their provider type (physician, nurse, mental health and substance abuse provider, case manager...etc.) and each has different requirements. All providers must be screened according to the ACA screening requirements.¹³⁵

Providers are assigned a categorical risk level (limited, moderate, high). Those assigned as "high" risk are required by the ACA to obtain fingerprint-based criminal background checks which include a Federal Bureau of Investigation criminal background check and a Pennsylvania State Police Criminal Record check.¹³⁶ These are implemented through the DHHS regulations at 42 CFR 455, Subpart E-Provider Screening and Enrollment. This section also requires a person with 5% or more direct or indirect ownership interest in a "high" risk provider to submit a set of fingerprints. Failure to do so results in the termination or denial of the application.

The screening requirements of the ACA require all providers to undergo a federal database check. These checks are also to be done on a monthly basis as well as a check against pertinent licensing database. Databases include the Provider Enrollment, Chain and Ownership System (PECOS); Social Security Administration Database; OIG-US Office of Inspector General's List of Excluded Individuals/Entities (LEIE); MEDI-CHECK- Pennsylvania Precluded Provider Database; System for Awards Management (SAMS); and the National Plan & Provider

¹³³ Ibid. p. 7.

¹³⁴ Ibid. p. 8.

¹³⁵ Department of Human Services. Welcome to the Pennsylvania (PA) Department of Human Services (DHS). Medical Assistance (MA) and Children's Health Insurance Program (CHIP) On-line Provider Enrollment Application. <https://provider.enrollment.dpw.state.pa.us/>.

¹³⁶ Pennsylvania Department of Human Services, Medical Assistance Bulletin. 99-17-03. March 6, 2017. http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_259400.pdf.

Enumeration System (NPPES). In addition, site visits are conducted on “moderate” and “high” categorical risk providers to verify the information submitted is accurate and determine enrollment requirements are met. A revalidation of enrollment is conducted on every provider every five years. The department does not participate in the U.S. Treasury’s Do Not Pay program.

In addition, the department has established the Department of Human Services’ Bureau of Program Integrity (BPI) to identify and eliminate fraud, waste and abuse within the MA program. A toll-free fraud hotline (1-844-DHS-TIPS) is established to report suspected cases of fraud. Members of the public may use the tip line to report suspected fraud related to the provision or receipt of public assistance benefits.¹³⁷ The bureau not only monitors potential health care fraud and abuse, but it also manages the federally mandated cost containment program and administers the Estate Recovery Program and the Health Insurance Premium Payment Program.

The law requires DHS to publish an annual report on its activities relating to fraud prevention. The report for fiscal year 2017-2018 shows 282 calls were made to report incidents of suspected fraud.¹³⁸ The Bureau determined 178 of those calls required further investigation. In addition, 796 reports of suspected fraud were reported via the website and the united states mail, which resulted in 117 investigations. The department reclaimed \$842,626.20 from providers as a result of the investigations and reports of fraud.¹³⁹

Based on these reclamations, the existence of the Do Not Pay Program and the Commonwealth’s nonparticipation, and the levels of improper payments known and reported by the federal government, we believe efforts should be taken to examine or re-examine the utilization of the Do Not Pay program by all agencies and Commonwealth entities that spend taxpayer dollars, especially those who have contracting relationships. A full review of improper payments throughout state agencies has never been performed. We suggest building upon what is currently in place so such reviews can finally be performed.

Likewise, the system of provider screening should be expanded and built upon to be used on a continuous basis for processing payment reviews. We suggest a better data analytical system be developed to review these payments, on a continual basis, before actual disbursements are made. The Office of the State Treasurer could develop further state specific analytics to enhance the federal Do Not Pay program or develop one that meets or exceeds the federal program. Not utilizing this program to further protect taxpayer dollars is a concern, especially in light of the amount of reported fraud, abuse and waste within the MA program.

¹³⁷ Pennsylvania Department of Human Services, Report of Tips of Suspected and Confirmed Provider Fraud Received by the Medical Assistance Fraud Hotline. Act 132 of 2014. 2017-2018 Fiscal Year.

¹³⁸ Section 1418(b) of Act 132 of 2014 amended Act 132 of June 13, 1967 (P.L. 31, No. 21).

¹³⁹ Pennsylvania Department of Human Services, Report of Tips of Suspected and Confirmed Provider Fraud Received by the Medical Assistance Fraud Hotline. Act 132 of 2014. 2017-2018 Fiscal Year.