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Providence Settles Cases Over Exclusions for $536K; Screening Metrics May Be Helpful

By Nina Youngstrom

In a reminder that there's a price to pay when excluded people are on your payroll, Providence Health System-Southern California and an affiliated entity agreed to settle three civil monetary penalty cases for a total of $536,148. The settlements with the HHS Office of Inspector General (OIG) stem from self-disclosures in connection with the employment of three excluded people in different facilities.

The largest dollar settlement, which is for $362,342, centered on Jennifer Lynn Watson Jenkins, who was employed by Providence Health System-Southern California from Jan. 4, 2016, to Sept. 3, 2019. OIG's List of Excluded Individuals and Entities (LEIE) has a Jennifer Lynn Watson in Modesto, California, as a pharmacy technician who is excluded from Medicare because she lost her license. However, OIG spokesman Donald White said Jenkins was employed as a talent recruiter at Providence. A search by an exclusion screening vendor, ProviderTrust, shows Watson's license was cancelled, with an expiration date of July 31, 2007. She was excluded from Medicare in August 2007. It's unclear whether it is the same person.

After reporting Jenkins's employment, Providence was accepted into OIG's Self-Disclosure Protocol (SDP) on Oct. 15, 2019. The settlement said OIG contends Providence should have known Jenkins was excluded from participation in federal health care programs, and therefore no payments could be made for items or services she provided.

Providence Settles Exclusion Case

Excluded employees don't have to provide direct care to trigger civil monetary penalties, according to OIG's 2013 special advisory bulletin on exclusions.[1] The prohibition is sweeping. As OIG explained, no federal health care program payment will be made for goods or services provided by an excluded person, whether it's direct care, such as physicians' services, or indirect care, such as reviewing treatment plans, and "excluded persons are prohibited from furnishing administrative and management services that are payable by the Federal health care programs. This prohibition applies even if the administrative and management services are not separately billable," the bulletin states. "For example, an excluded individual may not serve in an executive or leadership role (e.g., chief executive officer, chief financial officer, general counsel, director of health information management, director of human resources, physician practice office manager) at a provider that furnishes items or services payable by Federal health care programs. Also, an excluded individual may not provide other types of administrative and management services, such as health information technology services and support, strategic planning, billing and accounting, staff training, and human resources, unless wholly unrelated to Federal health care programs."

The other two Providence settlements don't identify the names of the employees because they are no longer excluded from federal health care programs, White said. They are:

- Providence Health System-Southern California, doing business as Providence Little Company of Mary

Medical Centers, which includes two hospitals, agreed to pay $141,562 in connection with the employment of an excluded emergency services technician from Aug. 8, 2016, to June 5, 2019. Providence Little Company of Mary was accepted into the SDP Oct. 22, 2019.

- St. Joseph Health Personal Care Services, doing business as Nurse Next Door, agreed to pay $32,244 in connection with the employment of an excluded constant care attendant from Nov. 2, 2017, to Aug. 8, 2019. St. Joseph was accepted into the SDP Oct. 22, 2019.

Providence didn't admit liability in the settlements, which were obtained through the Freedom of Information Act. In a statement, Providence said it agreed to the settlements after voluntarily disclosing it failed to identify three employees who were on the LEIE before they were employed by Providence. "The employees worked at three separate locations in Los Angeles and Orange counties. None of the services provided by these employees were billed separately to Federal health care programs," the statement said. "After learning of gaps in its process for identifying excluded employees, Providence engaged a new third-party vendor to re-screen all workforce members. This is how we discovered the three employees on the LEIE. Providence voluntarily disclosed its non-compliance, worked with the OIG to timely resolve these issues and is satisfied that the new screening process will help ensure we do not inadvertently employ individuals on the LEIE in the future."

'A Nightmare Waiting to Happen'

With the help of software, Baptist Memorial Health Care Corp. in Memphis, Tennessee, screens all its employees, vendors and volunteers monthly, said Corporate Compliance Officer Kim Danehower. "You check everybody—[volunteers] are an area people don't realize" should be included. "Volunteers can play an important role and may have access to protected health information, and we believe it is a good practice to ensure the safety of our data. In addition, if a health care system provides hospice, volunteer involvement is a requirement for Medicare, so it is important to screen them."

It's tedious, with Baptist Memorial Health running 38,000 people through the LEIE, another federal database and state databases. "It is a massive amount of data we have to go through, and that's what's most challenging," Danehower said.

Exclusion screening is not performed only to satisfy the federal government, she noted. "A lot of commercial payers and Medicare Advantage plans expect you to screen monthly." Screening also serves a greater purpose than meeting payer requirements. "Our motto is we want to get every penny we deserve and not one penny more," Danehower said. "The ones who really disturb me are ones who have been excluded for abuse. That's a nightmare waiting to happen. It's so terrifying you could have someone in your system who has actually tried to hurt a patient."

One of the metrics used to evaluate the compliance program's effectiveness is the length of time between the OIG's LEIE updates, which occur around the 20th of every month, and compliance running monthly exclusion checks. "Do we do it within 10 days or 15 days of when the list comes out? And how effective and efficient are we?" She said the screening metrics are reported to senior leadership and the board on a regular basis. "It allows us to track that we are consistently hiring the appropriate people to staff and provide care at our facilities," Danehower explained.

Baptist Memorial Health doesn't get a ton of hits. Sometimes physicians turn up as excluded, often because they didn't repay student loans. If they repay and apply for reinstatement to Medicare, the physicians may resume working at the health system.

Danehower said some of the classic challenges of exclusion screening persist, such as common names showing

up on the LEIE or state databases. Is employee Mary Smith the same Mary Smith who was excluded? "You have to check all the data and make sure it's not the same one," Danehower said. "If you let one or two slide through, the government will fine you."

There's also a potential "weak link" with orders from physicians who don't have privileges. Physicians with privileges have been screened, but if the physicians don't have privileges, and patients present with an order from them, the hospital does an on-the-spot exclusion check. "But sometimes the timing is not as accurate as it should be," she noted.

Vendors are the most challenging aspect of exclusion screening, because they don't have Social Security numbers, and they might have managers or owners who are excluded, or you might sign a contract with a related entity that's excluded. "You just have to weed through it," Danehower said. "You check and you use your best judgment. This is where you say a prayer." Baptist Memorial Health also has clauses in its contracts with vendors that require them to screen their own employees for exclusions.

Medicaid Can Be More of a Problem

The exclusion arena is rife with mistakes and misunderstandings, said attorney Judy Waltz, with Foley & Lardner in San Francisco. One of her clients bought a confusing screening system that left them with the wrong impression about how to enter employee names. When the client figured it out, an excluded employee was identified. OIG was sympathetic because it understood the client's interpretation of the vendor's instructions. Some excluded parties also continue to think they are back in Medicare automatically when the exclusion term ends, but they have to apply to OIG for reinstatement.

She thinks organizations are pretty good about Medicare screening. The cracks are in screening for Medicaid exclusions. "If you have sites across multiple states, there isn't one list you can look up," Waltz explained. Also, the California Medi-Cal exclusion database matches names but has limitations in terms of additional identifying information, so you have to ask the employee or vendor for verification. "I don't know how reliable that approach is," she said. And unlike the HHS OIG, there's still no formal procedure for Medicaid reinstatement when the Medi-Cal suspension period ends. Providers seeking reinstatement are advised to write a letter to attorneys at the state Department of Health Care Services (DHCS).

Meanwhile, against the backdrop of the COVID-19 pandemic, health care organizations and the government may be vulnerable to excluded people who have found a new way to make money, said Michael Rosen, founder of ProviderTrust. "When dollars are doled out by the government in the CARES [Coronavirus Aid, Relief, and Economic Security] Act is when the fraudsters come out," he said. He predicts the government will find excluded people "behind the corporate veil." Already there have been fraud cases related to COVID-19 and the CARES Act. For example, Carlos Belone of Coconut Creek, Florida, was charged in a Medicare fraud scheme for allegedly submitting fraudulent Paycheck Protection Program loan applications for R&S Pharmacy, which he owned, and billing Medicare for durable medical equipment that wasn't medically necessary or authorized by the patient, the Department of Justice said July 10.[2]

CMS also is auditing Medicare Advantage plans with an eye on the requirements for their first tier, downstream and related entities (FDRs), including hospitals, Rosen said. They are required to do exclusion screening, among other things. CMS wants to know what the Medicare Advantage plans know about the FDRs they do business with, including the owners and whether they have been screened for exclusions, he said.

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1 Office of Inspector General, *Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs*, HHS, May 8, 2013, https://bit.ly/315u9DJ.
2 Department of Justice, "Florida Man Charged with COVID Relief Fraud and Health Care Fraud," news release, July 10, 2020, https://bit.ly/337UhQY.