Issue Brief

New Medicaid Compliance Issues from the Deficit Reduction Act

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A lot of "noise" accompanied the passage of the 2006 Deficit Reduction Act and it appeared to be divided between several potential areas of impact. One concern was, seriously, about a typo's impact on the bill's enforceability. Another was the effect on Medicaid beneficiaries who would be challenged by more difficult access and payment procedures. Still another was the impact on Medicaid providers and managed care organizations that generate or pay out more than $5 million a year in reimbursement from that federal healthcare program.

Many providers will feel the impact of the DRA almost immediately. They have new legal provisions to be concerned about. There are additional risks that must be assumed or avoided. With this in mind let's look at some of the background of this law, and the additional risks that accompany some of its lesser-known provisions.

The Medicaid program has been a source of great frustration for the enforcement arm of the Centers for Medicare and Medicaid Services and for Congress as well. Although funded by the federal government in part, the day-to-day management of Medicaid and its primary enforcement efforts have largely been the responsibility of the states. Various studies by the OIG (Office of the Inspector General for HHS) and the General Accounting Office have noted the high level of compliance risk in the Medicaid program and bemoaned the lack of consistent enforcement efforts by the states, cross-fertilization of best investigatory practices, and cooperation in joint investigations. Various techniques have been used to try and entice the states into more active efforts; these include federal incentives and funding as well as humiliation in the form of audit findings and bad publicity about wasting the taxpayer's dollars through lax oversight. For example, recent bad publicity about Medicaid fraud in New York State has yielded bipartisan agreement about the need for a state OIG reporting directly to the governor.

The DRA will make some major changes to the enforcement landscape that increase federal oversight of Medicaid anti-fraud efforts and provides new and very attractive incentives for states to ramp up their efforts as well. The only reasonable conclusion is that after years of significant and impressive funding for enforcement efforts directed toward Medicare compliance, the tide has turned and now (to the delight of many at the federal level) it is now Medicaid's turn.

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The new "Medicaid Integrity Program"

The first major change to the enforcement landscape in the DRA is the creation of the Medicaid Integrity Program. This program modeled after a similar one in Medicare will allow the government to bring private contractors into the business of Medicaid oversight. The program's financial goals are ambitious. Congress expects to get back the money it appropriated for the program and more from provider paybacks, recoupments, and fines. (Remember this law is intended to reduce the deficit, not add to it.) The appropriation for 2007 and 2008 is $50 million each year. In 2009 and thereafter the appropriation is $75 million. In three years that amounts to recoveries of over $175,000,000 in federal program costs alone. Add in the state's share and you are over $350 million in potential cost savings (read provider paybacks and billing reductions).

The Medicaid Integrity Program will give the feds at least part of what they have wanted for years: a standard approach to compliance and integrity that bypasses at least some of the variations among state enforcement, communications, and training efforts. The program's activities will encompass four areas:

(1) Reviewing the actions of Medicaid providers under any type of payment system (FFS, capitation, etc) to determine if their actions have produced fraud, abuse or waste, are likely to, or may potentially result in unintended expenditures on the part of the Medicaid program.

(2) Auditing of claims for payment of Medicaid services, items, or administrative services rendered including cost reporting, consulting contracts, and various risk contracts.

(3) Identification of overpayments to individuals or entities receiving Medicaid Federal funds.

(4) Education of providers, managed care companies, beneficiaries, and others with respect to payment integrity and quality of care.

Providers should watch the development of this program closely to see how the MIP contractor(s) identify and then subsequently deal with risk or non-compliance. For compliance officers who monitor the efforts and priorities of the various healthcare watchdogs, your job has just become more difficult and complex.

Incentives for States to Create False Claims Acts

The federal False Claims Act is one of the most well-known and powerful weapons in the arsenal of the OIG and the Department of Justice. The federal FCA is notable for three provisions:

- Prosecutions on the civil side do not require proof of fraud but only proof that the provider acted in "reckless disregard" or "deliberate ignorance" of the fraud and abuse going on in their organizations. Those who watched or read about the Enron trial may remember the judge denying the defendants request to be judged using a so-called "ostrich" defense – i.e. could the defendants simply claim ignorance of the activities under scrutiny and be found

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not guilty. The False Claims Act has been most powerful in those cases where specific intent to defraud is difficult to prove but where management can be shown to have acted without proper internal controls and other safeguards in place to prevent fraud, abuse and waste.

- Qui tam or "whistleblower" provisions that allow for private citizens to bring suit against providers for false claims and to collect a portion of the monies recouped by the government in a successful prosecution or action against that provider.
- Very high penalties assessed on a per claim basis for violators. The government can get triple damages on monies it should not have paid and per claim fines of between $5,500 to $11,000 each.

A number of states have false claims acts but very few contain one or all of these provisions, which the federal government believes makes the federal law so successful at uncovering fraud and abuse. Now under the DRA, states which pass false claims laws that are as tough as the federal law will be able to keep an additional 10% of their recovery.

Is 10% enough to entice states to act? Remember the feds have always given states back their share of any Medicaid recovery. Most states, therefore, have some experience with the financial windfall that comes with a big healthcare fraud or abuse recovery. This provision of the DRA seems likely to get some significant attention.

Additional Funding for the Office of the Inspector General (OIG)

The OIG is one of the big dogs in the healthcare enforcement landscape. Their public profile has grown along with their funding over the past two administrations primarily through a trust created under the HIPAA Act that gives back to enforcement a percentage of everything collected from providers, suppliers, MCOs, and other healthcare related entities in fines and take backs.

The DRA adds to the rather spectacular funding trajectory of the OIG by appropriating an additional $25 million per year over the next ten years dedicated solely to the OIG's efforts to uncover Medicaid fraud.

The OIG works each year from an Annual Work Plan that details their areas of interest and presumed high risk. Behavioral health has had a prominent place in the last two work plans of the OIG and will likely continue to be a target for some time. See articles on Behavioral Health Collaborative Solutions website: http://bhcollaborativesolutions.com/Page4.html.

100 New Employees for CMS

CMS is required to hire 100 new staff persons to work more closely with the states on their Medicaid integrity programs and efforts. The expectation is that these new employees will provide some coordination of efforts, cross-fertilization of ideas, and, of course, oversight and insight into each state's efforts to reduce fraud, abuse and waste in Medicaid.

Providers Required to Have Compliance Programs
The federal government has for many years, strongly encouraged all health care providers, managed care organizations, and suppliers of health care goods and services to design and implement compliance programs. These programs, built on the Federal Sentencing Guidelines, provide for activities and oversight designed to uncover and deal with instances of fraud, abuse and waste within an individual organization and its contractors and agents.

With the passage of the DRA, encouragement has been replaced with requirement. All providers or organizations who receive or pay out $5 million or more in Medicaid funds will be required in essence to have a compliance program as of January 1, 2007. The required compliance related activities are a "condition of payment". This means that on January 1, 2007, without a compliance program in place, providers risk the possibility of a false claims action for every claim they submit. Is this likely? Unknown at this time and there are no specific penalties for non-compliance actually listed in the Act. However, most consultants are cautioning providers to take these provisions of the Act seriously and to comply.

The provisions of the DRA are very specific as to what eligible health care entities must do:

- ☐ Implement employee, contractor and agent education containing "detailed" information about the federal and any state False Claims Acts, any other administrative remedies for false claims under federal law, any and all whistleblower provisions, and information on the roles of such laws and provisions in preventing and detecting fraud, abuse and waste in the federal healthcare programs.
- ☐ Develop written policies that include "detailed provisions" regarding the policies and procedures of the entity for detecting and/or preventing fraud, abuse and waste within the organization.
- ☐ Include in any employee handbook a discussion of the fraud and abuse laws, the whistleblower provisions and whistleblower rights, and the organization's policies and procedures for detecting and/or preventing fraud, abuse and waste in the federal healthcare programs.

What You Must Do Now
If you already have a compliance program:

- ☐ Check to make sure that educational efforts include contractors and agents as well as all employees.
- ☐ Check the curriculum – you may need to add specific information about the federal False Claims Act and any similar state acts, other civil remedies available, and whistleblower provisions and rights.
- ☐ Check your employee handbook – do the portions about the compliance program need to be rewritten?
- ☐ Start thinking about your annual employee, contractor and agent compliance training – you want the required information out there before January 1, 2007 if possible.

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- ☐ Look at your policies and procedures – do you need to include information about employee rights to contact the federal and/or state government regarding potential fraud, abuse and waste?
- ☐ With all the discussion staff will now hear about whistle blowing – check to make sure your internal hotline works and is well advertised, your supervisors are ready and willing to hear and discuss complaints, questions and concerns
- ☐ Make sure your compliance officer is out, visible, and accessible.

If you do not have a compliance program:

- ☐ Get a hold of the federal sentencing guidelines.
- ☐ Read one or more of the OIG compliance guidances found on their website – for mental health centers think about a combination of the Third Party Billing Company guidance and the Small and Independent Physician Practice guidance. http://oig.hhs.gov
- ☐ Appoint a compliance officer and committee
- ☐ Get to work!

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