



**HCCA's  
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**Practical Effects of the DRA:  
Medicaid Enforcement Developments  
and Compliance Strategies**

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**Today's Panel**

- **Doug Colburn**
  - Inspector General to the Georgia Department of Community Health, Office of Inspector General
- **Jeffrey Oak, PhD**
  - Vice President/Corporate Responsibility Officer, Bon Secours Health System Inc.
- **Sara Kay Wheeler**
  - Partner, Powell Goldstein LLP

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## Objectives

- **View Medicaid enforcement initiatives in context**
- **Review impact of Deficit Reduction Act on Medicaid enforcement**
- **Discuss current state initiatives and identify risk areas**
- **Explore Medicaid compliance strategies**

## Why Medicaid?

- **Federal False Claims Act enforcement has dominated the field**
  - 1998-2005: \$6.6 billion in health care qui tam recoveries
  - Largest segment of FCA actions relate to health care
    - Example - 2006: 72% of all recoveries were generated by health care matters
  - Cases often involve conduct in multiple states

## Why Medicaid? (cont'd)

- **State Medicaid costs mushrooming**
- **Conduct affecting Medicaid reimbursement but not other federal programs**
- **Wide disparity between the level of staff and financial resources expended by CMS to support and oversee state enforcement compared to dollars at stake**
- **Important component of strengthening Medicaid's long-term financial security**

## DRA of 2005

- **DRA provisions are expected to cut Medicare and Medicaid spending by \$13 billion... savings accomplished by:**
  - Instituting new Medicaid fraud and abuse detection and prevention initiatives
  - Encouraging states to adopt state false claims acts
  - Mandating employee education provisions regarding fraud, waste and abuse

## Medicaid Integrity Program

- **DRA takes partnership between CMS and states to a new level**
- **Medicaid Integrity Program (MIP) is CMS's first national strategy to detect and prevent Medicaid fraud and abuse in the program's history**
- **Within CMS, the Center for Medicaid & State Operations (CSMO) is organizationally responsible for administration of the MIP**

## Medicaid Integrity Program Key Components

- **Increased Funding**
  - Annual funding for MIP to increase in stages up to \$75 million per year
  - Additional \$25 million in funding to OIG for Medicaid-related activities
  - President Bush's 2008 budget (released February 5, 2007) includes \$183 million in new discretionary funding to support Health Care Fraud and Abuse Control program initiatives, including the MIP.



## Medicaid Integrity Program Key Components (cont'd)

- **Audit Program Development Contractors**
  - Review of provider activity for fraud, waste & abuse
  - Audit claims for payments under state Medicaid programs
  - Identification of overpayments
  - Education of providers regarding program integrity and quality of care

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## Medicaid Integrity Program Key Components (cont'd)

- **State Program Integrity Assessment Contractors**
  - Identifying State program integrity baselines
    - Current activities
    - States' perceived ROI
    - States' level of commitment to program integrity
  - Recommending performance metrics and standards against which States' performance may be measured in the future

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## Medicaid Integrity Program Collateral Themes

- **Collaboration and Communication**
  - Avoid conflicts with state audits and other enforcement activity
- **Medi-Medi**
  - Matching Medicare and Medicaid claims underway in 9 states
  - Efforts provide insights into overall practices that may be abusive
  - Data will be used to strengthen the MIP
  - Office of Financial Management (OFM) administers

## Medicaid Integrity Program Collateral Themes (cont'd)

- **Payment Error Rate Measurement (PERM) Project**
  - Improper Payments Information Act (IPIA) of 2002
  - OMB identified Medicaid and the State Children's Health Insurance Program (SCHIP) as programs at risk for significant improper payments
  - To address, CMS developed PERM to reduce national program error rates

- **PERM reviews**
  - Fee-for-service
  - Managed care
  - Program eligibility
- **States will be reviewed on a rotating basis... once every three years**

- **States selected for 2007 review include:**
  - North Carolina, Georgia, Tennessee, West Virginia, Kentucky, Maryland, Alabama, South Carolina and Nebraska
- **Contractors and sampling methodologies will be major issues with which state Medicaid agencies must contend**

- **DRA also encourages enactment of state false claims act**
  - Incentives for states to enact and enforce false claims act modeled after the federal FCA
    - Whistleblower provisions
    - Relaxed intent standards
    - Treble damages plus civil monetary penalties per claim

- **Incentive for State False Claims Act**
  - State must return to the federal government a percentage of any monies recouped by the state due to Medicaid fraud
  - Under the DRA, states with qualifying false claims acts will retain 10% more of the recouped monies

▪ **Employee Education**

- First law that requires non-public health care providers to adopt specific compliance measures
- Applies to entities that receive or make annual Medicaid payments of at least \$5 million
- Became effective on January 1, 2007

▪ **Employee Education**

- Must create written policies for employees, contractors and agents with information about the federal and state false claims provisions including whistleblower protections
- Policies must also address entity's efforts and procedures for detecting and preventing fraud, waste and abuse

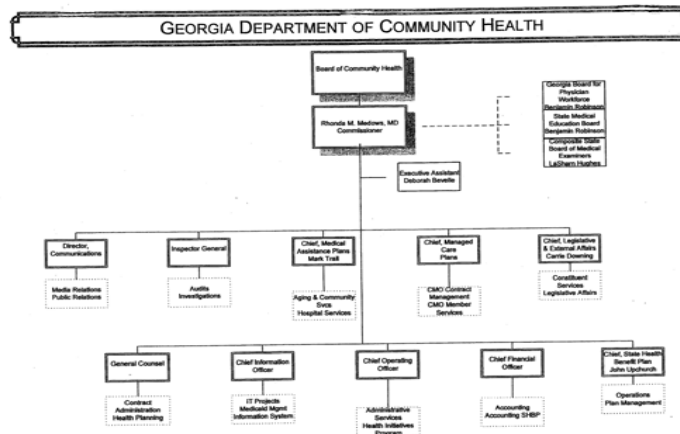
- **Employee Education**
  - Employee handbooks must also be revised to discuss false claims acts, right of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, waste and abuse
  - Training strategies are under debate

- **What does the DRA mean for Medicaid providers?**
  - Increased resources for Medicaid fraud enforcement at federal and state levels
  - Increased whistleblower activity at state level
  - Increased awareness by potential relators of rights and remedies for whistleblowers

# Georgia Inspector General And MIP Initiatives

## What is the DCH OIG

- **Created by the DCH Commissioner, Rhonda M. Meadows, MD, in February of 2006**
  - Purpose: Reduce fraud and abuse in state Medicaid program, PeachCare and the State Health Benefit Plan
  - DCH IG reports directly to the DCH Commissioner and Governor
  - Distinct from state Inspector General whose mission is to foster and promote accountability and integrity in state government



## Context: The DCH Budget

- **DCH Budget Now Exceeds \$10 Billion!**
  - The federal government is applying increased pressure on states to tighten their health care spending
  - The states are responding. For example, recoveries from providers to the Georgia Medicaid program have increased:
    - 2004 - \$12.5 million
    - 2005 - \$14.0 million
    - 2006 – estimated to surpass 2005 recoveries

## DCH OIG Program Integrity

- **DCH OIG will work closely with the State Health Care Fraud Control Unit (FCU), Georgia Bureau of Investigation (GBI), the HHS (federal) Office of the Inspector General (OIG) and other state and federal offices to prevent and uncover fraud and abuse. Efforts include**
  - Investigations
  - Audits

## Current Initiatives Self-Disclosure Protocol

- **Issuance of Georgia Self-Reporting Protocol**
  - See Ga. DCH Policy and Procedure Manual (Part 1), section 304.10 (issued in October of 2006).
    - Clear and defined method of self-reporting
    - Self-disclosure will not preclude criminal liability but will allow DCH OIG to treat self-reporting entity with leniency
    - Self-disclosure is greatly encouraged

## Current Initiatives Self-Disclosure Protocol

- **Manual outlines basic information that must be included in any self-disclosure letter**
  - Information includes the “methodology used... in determining the amount of the overpayment”
  - Letter should be accompanied by a Corrective Action Plan (CAP)
  - DCH must approve the disclosure and CAP
  - Appeal rights may be implicated
- **Compare to federal OIG Self Disclosure Protocol (1998; April 2006)**

## Current Initiatives Areas of Interest

- **Prevention – Self Disclosure**
- **Long Term Care – Skilled Nursing Facilities**
- **Generic Physician Code for Prescriptions**
- **Waiver Reviews**

## State False Claims Activity

## State Medicaid Enforcement

- **Where have the states been?**
  - Wide disparities in state laws and enforcement activity
    - Medicaid fraud statutes without false claims acts
    - False claims acts without qui tam provisions
    - False claims acts with qui tam provisions
  - Medicaid Fraud Control Units with differing enforcement priorities
    - Billing for services not provided/covered/medically necessary
    - Criminal fraud
    - Elder abuse
    - Pharmaceutical/device fraud

## State Medicaid Enforcement

- **Sample Medicaid Settlements/Single State**

- December 2005, Georgia: Lifecare of Lawrenceville (\$2.5 million) (nursing home patient neglect) (joint investigation by Ga. MFCU and U.S. Attorneys Office, Northern District of Georgia)
- May 2005, New York: Staten Island University Hospital (\$76.5 million) (billing services at full-time clinics at part-time rates)
- 2003-2005, Texas: Boehringer Ingelheim, Dey Inc., Schering-Plough (\$55.5 million) (inflating AWP to “market the spread”)
- May 2005, Florida: University of Miami (\$3.89 million) (charging facility fee for non-covered primary care at hospital clinics)
- August 2006, Louisiana: Our Lady of Lourdes Regional Medical Center (\$3.8 million) (medically unnecessary heart procedures)

## State Medicaid Enforcement

- **Sample Medicaid Settlements/Multistate**

- November 2005: King Pharmaceuticals (\$124 million) (failure to report drug “best prices” to Medicaid)
- September 2005: Gambro Healthcare (\$37.5 million) (kickbacks by dialysis provider)
- February 2006: Tenet Healthcare (\$820,000) (unbundling Medicaid billings for outpatient laboratory services)
- September 2005: AdvancePCS (\$137.5 million) (kickbacks by PBM to drug manufacturers)

- **Where are the states going?**
  - Increased uniformity in state laws
  - Increased recoveries/enforcement activity
    - California: \$274.4 million in 2005 recoveries, \$78.1 million in 2004 recoveries
    - New York: \$273.5 million in 2005 recoveries, \$62.5 million in 2004 recoveries
  - Increased coordination between state and federal enforcement agencies
  - Increased coordination among states

- **Increased coordination between federal and state agencies**
  - Joint training initiatives (MFCUs sharing experience with HHS OIG)
  - Cooperation on cases of mutual interest
    - "Traditional" billing cases (billing for services not rendered, covered or medically necessary, upcoding, unbundling, improper billings for prescription drugs)
    - Kickback cases (including hospital/supplier and hospital/physician relationships)

- **Coordination among states**
    - National Association of Medicaid Fraud Control Units
      - Process for reviewing multistate qui tam cases
    - 1993-2006: 34 global multistate settlements through NAMFCU
    - Traditionally, pharmaceutical cases or cases involving large provider/supplier chains
    - In the future, cases will involve Medicaid billing issues that could affect multiple states
      - Communication among states
      - Qui tam plaintiffs (“marketing the spread” litigation)
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**Status of State FCA in Georgia**

## Compliance Strategies

- **An effective compliance program is the best way to mitigate heightened legal risks for Medicaid providers**
- **Recognition of heightened Medicaid risks should be addressed at the executive compliance committee level and integrated into 2007 work plans**

## Compliance Strategies (cont'd)

- **Identify and Prioritize Potential Risks**
  - OIG 2007 Workplan
  - 2006 hotline calls
  - Patterns of denial
  - Trade publications
  - Networking sessions

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