

The Deficit Reduction Act and Trends in Medicaid Fraud Enforcement

Spencer D. Levine
Senior Vice President/
Chief Administrative, Compliance and Ethics Officer
North Broward Hospital District
Ft. Lauderdale, Florida

Paul W. Shaw
Brown Rudnick Berlack Israels LLP
One Financial Center
Boston, MA 02111

Enforcement Trends in Medicaid Fraud

- Spiraling costs
- Nearly 25% of state budget in many states
- Within 10 years could be over half to nearly 60% of state's budget
- Congress puts Medicaid front and center
- As a result, Congress acts and the resulting pressure on all the stakeholders

Deficit Reduction Act (DRA)

- GAO found that Medicaid enforcement was lacking
- Convergence of issues
- Results in the passage of the DRA
- Various components of the section regarding “Eliminating Fraud, Waste and Abuse in Medicaid”

Deficit Reduction Act

- Improved Federal Financial Participation (FFP) for states with False Claims Acts that comply with HHS standards
 - Key question
 - Several states notified, including Florida, as to non-compliance
 - Those states that comply will receive an extra 10% in their share of the recoveries
 - Increased pressure on states to pass compliant False Claims Acts

Employee Training in Reporting Fraud and False Claims Acts

- Those providers who receive at least \$5 Million in Medicaid payments must have training and written policies regarding fraud and abuse and the Federal or relevant state False Claims Act
 - Includes employers, vendors and agents of the provider
 - Increased visibility of “whistleblower” or Qui Tam statutes
 - Observations

Establishment of Medicaid Integrity Program

- CMS significantly increased its resources in this area
- Medicaid Integrity Program (MIP) will audit, “data mine”, etc.
- Establishment of a comprehensive five year plan for ensuring the integrity of Medicaid

Establishment of Medicaid Integrity Program

- Scope of auditing and data mining (whether all of the effort will be focusing on individual provider or to include trends nationally, regionally or state by state)
- Priorities for the MIP Staff
- How will they interact with MFCUs?
- Will it expand or duplicate what is presently being done?
- What will their investigative priorities be?

Medicaid Integrity Plan

- Beginning in 2006 and every five years, HHS required to establish a comprehensive Medicaid Integrity Plan.
- First MIP issued in July 2006.
- Initial program enforcement priorities will include:
 - fraud related to long term care facilities and home health agencies;
 - issues relating to prescription drugs;
 - durable medical equipment and other medical suppliers;
 - improper claims for payment from hospitals and individual practitioners.

Medicaid Integrity Contractors

- The DRA also authorizes CMS to hire private companies to engage in a broad range of enforcement activities. These include:
 - Reviewing individual Medicaid providers;
 - Auditing claims for payment as well as cost reports, consulting contracts and risk contracts;
 - Identifying and recovering Medicaid overpayments.

Enforcement Priorities For MFCUs

- The mission of the Medicaid Fraud Control Units is to investigate and prosecute fraud and abuse committed by providers as well as abuse and neglect in long term care facilities
- MFCUs have, with permission of regional offices, to investigate Medicare fraud under extended authority provision
- MFCUs presently housed in Attorney General's office, have investigative and prosecutorial power, as well as criminal and civil jurisdiction
- Working closely with HHS/OIG, they are the "front line" in Medicaid Fraud enforcement

Enhanced Funding

- HHS/OIG will receive an additional \$25 Million annually from 2006 to 2010 for Medicaid Fraud enforcement
- Significant increase of funding, especially when considering what is already spent on MFCUs
- Increased scrutiny
- Increased expectations for results?

Expansion of Medicare-Medicaid Data Match Pilot Program (“Medi-Medi” Project)

- Pilot project to match Medicare and Medicaid databases
- Funding will increase significantly annually
- Will expand the project throughout the states
- Increased scrutiny to correlate data between the two projects, to find double billing, “impossible” billing, among other schemes
- What will their investigative priorities be?

State False Claims Acts

- DRA provides states with financial incentive to enact false claims laws.
- Will likely see an increase in state “whistleblower” actions as more states enact their own false claims statutes.

The Perfect Storm

- The emergence of the following trends:
 - Out of control state Medicaid budgets
 - Federal budgets
 - Increased money for data mining and other investigative tools
 - Increased cooperation between Medicare and Medicaid databases
 - Every provider (over \$5 Million) training their employees on the elements of the False Claims Act with the potential of creating new “whistleblowers”

The Perfect Storm

- The emergence of the following trends:
 - The growing influence of the plaintiff’s bar [Taxpayers Against Fraud (TAF), etc.]
 - Legislative Leaders taking the lead in scrutinizing Medicaid Fraud enforcement
 - U.S. Senate Hearings on Medicaid Fraud
 - States passing Qui Tam statutes and aligning their statute with the Federal statute

The Perfect Storm

- The emergence of the following trends:
 - All the prior elements result in challenging times for both providers and regulators and “Medicaid Fraud” enforcement
 - Increased focus

Future Trends in Enforcement

- Increased coordination between enforcement and oversight agencies
- Emergence of MIP demonstrates the erosion of the old demarcation between “primary” Federal and state responsibilities
- “Part D” is another illustration of the increased overlap between Medicare and Medicaid
- For example, in Florida, 20% of recipients are dual-enrollees that previously accounted for over 40% of all pharmaceutical expenditures

Future Trends in Enforcement

- Increased integrated approach to enforcement, such as “task forces” like the “Medi-Medi” project
- Increase number of Qui Tam suits in more states; speedier adjudication of claims and shorter “Seal” periods

What Should the Healthcare Compliance Officer Do?

- Medicaid enforcement become just as critical to your work plan as Medicare
- Stop looking at both programs as separate and district silos and acknowledge the increased “ties” between the two programs
- Re-look and revitalize your fraud and abuse policies, not just for compliance with DRA, but to have a robust compliance plan