THE DEFICIT REDUCTION ACT AND ITS IMPACT ON MEDICAID FRAUD ENFORCEMENT

Paul W. Shaw
Brown Rudnick Berlack Israels LLP
One Financial Center
Boston, MA 02111
pshaw@brownrudnick.com
(617) 856-8200

Spencer D. Levine, Esq.
Senior Vice President
Chief Administrative, Compliance and Ethics Officer
North Broward Hospital District
Ft. Lauderdale, FL
sdlevine@nbhd.org
(954) 355-4555

I. INTRODUCTION.

On February 8, 2006, President George W. Bush signed the Deficit Reduction Act of 2005 (DRA) into law. The DRA contains many provisions reforming Medicare and Medicaid that are estimated to reduce program spending by $11 billion over five years. The DRA takes a multi-faceted approach to cracking down on Medicaid fraud, waste and abuse. The law creates a federal Medicaid Integrity program, expands funding for Medicaid fraud enforcement, provides incentives for states to adopt whistleblower programs similar to the federal False Claims Act, and requires that certain providers "self-police" potential Medicaid fraud, waste and abuse by adopting new policies and educating employees.

Before the enactment of the DRA, the fight against Medicaid fraud, waste and abuse was largely left to the states. There was little to no coordination on the national level. In fact, the General Accounting Office reported in 2005 a wide disparity between the level of staff and financial resources that CMS expended to support and oversee state activities to control Medicaid fraud and abuse as compared to the amount of federal dollars at risk in Medicaid benefit payments. The GAO concluded there were insufficient resources being expended to protect the integrity of the Medicaid program. *Medicaid Fraud and Abuse: CMS's*

Commitment to Helping States Safeguard Program Dollars is Limited, (2005) (found at www.gao.gov/new.items/d05855t.pdf).

In response, the DRA establishes and funds a federal Medicaid Integrity Program to coordinate efforts to safeguard the Medicaid program, insure that Medicaid funds are properly spent, and recover Medicare funds when they have not been spent properly. The Department of Health and Human Services (HHS) is also authorized to hire contractors to audit Medicaid claims and identify and collect overpayments from entities receiving federal Medicaid funds.

II. MEDICAID INTEGRITY PROGRAM.

A. Background

The DRA created the Medicaid Integrity Program ("MIP") within CMS. The MIP drastically increases both CMS' obligations and resources to combat Medicaid fraud at the federal level:

- $5 million was appropriated in FY 2006 with an additional $50 million in both FY 2007 and 2008, and $75 million annually in FY 2009 and each year thereafter.
- the OIG is budged an additional $25 million per year for Medicaid fraud activities.
- additionally, the DRA requires CMS to hire 100 new employees whose duties consist solely of protecting the integrity of the Medicaid program.

Given these funding initiatives, health care providers can expect significantly more federal involvement in policing Medicaid fraud and abuse.

B. MIP Integrity Plan

Beginning in FY 2006 and every five years, the Secretary of HHS – in consultation with the Attorney General, the FBI Director, the Comptroller General, the HHS Inspector General, and responsible state officials – must establish a comprehensive plan for ensuring Medicaid program integrity. States must comply with any requirements deemed necessary to effectuate the Medicaid Integrity Program.

In July 2006, CMS issued a *Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program* for FY 2006 – FY 2010. (available at www.cms.hhs.gov/DeficitReductionAct/Downloads/). Apart from discussing the organizational structure of the new Medicaid Integrity Program, CMS identified specific program enforcement issues that will be addressed at the outset of the MIP. These include: a) nursing and personal care such as fraud related to long term care facilities and home health agencies; b) the provision of prescription drugs to beneficiaries and the underlying costs of those drugs as reported to the States; c) durable medical equipment and other medical suppliers; and d) improper claims for payment from hospitals and individual practitioners.

III. STATE FALSE CLAIM INVESTIGATION AND ENFORCEMENT.

Under the federal False Claims Act, providers who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim. The False Claims Act empowers the federal government to file civil lawsuits alleging fraud against federal contractors, including providers of health care services. It also contains qui tam or "whistleblower" provisions that allow private citizens to bring civil lawsuits alleging fraud on behalf of the government. In exchange, the whistleblower receives a portion of the funds recovered if the suit is successful.

In contrast, prior to the DRA, when states identified overpayments to providers, they were required to repay the federal share of the identified overpayment to the federal government. Section 6032 of the DRA encourages states to enact state false claims laws by establishing a financial incentive: states that enact false claims acts modeled after the federal False Claims Act can keep an extra 10% of the federal Medicaid share of any funds recouped in a Medicaid enforcement action brought under the state's false claims law that otherwise would have gone to the federal government.

In order to qualify for the financial incentive, the state law must be at least as stringent as the federal False Claims Act. This means that the law must:

- establish liability to the state for false or fraudulent claims described in the federal False Claims Act with respect to Medicaid expenditures;
- contain provisions that are at least as effective in rewarding and facilitating qui tam (whistleblower) actions as those in the federal False Claims Act;
- contain a requirement for filing an action under seal for 60 days with review by the state attorney general; and
- contain a civil penalty that is no less than the amount authorized by the federal False Claims Act.

The financial incentives in the law are significant, and states are already responding. A number of state legislatures have passed or have proposed state false claims acts. At the same time, the DRA requires the OIG review state false claim laws to determine if they meet the requirements for the incentive payment. The OIG in Auugust 2006 published guidelines it would use for its reviews. As of December 29, 2006, of the ten state laws that the OIG has evaluated since it released the review guidelines, only three (Illinois, Massachusetts and Tennessee) were approved for the DRA incentive bonus. For example, in reviewing California's false claims legislation, the OIG found that the civil penalty is less than the minimum federal penalty of $5,000.

As health care cases currently comprise 60% of all federal False Claims Act cases involving the largest damages, penalties and whistleblower payments, it is expected that there will be an increase in state false claims cases as individual states enact their own state statutes.

IV. AUDITS BY 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 to determine whether fraud, waste, or abuse has occurred, is likely to occur, or has the potential for occurring;
- Auditing claims for payment for items or services furnished or for administrative services rendered including cost reports, consulting contracts and risk contracts;
- Identifying and recovering overpayments to individuals or entities receiving federal Medicaid funds; and
- Educating providers, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care issues.