

MEDICAID INTEGRITY: EVERYONE IN THE POOL

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The world of Medicaid compliance is about to experience a sea change: The Deficit Reduction Act of 2005 created the Medicaid Integrity Program and provided unprecedented levels of funding for a variety of enforcement initiatives including, the Payment Error Rate Measurement and Medicare-Medicaid Data Matching Programs, Medicaid Integrity Contractors and the Recovery Audit Contractor Program. This paper will review the federal origin of each of these new Medicaid enforcement programs.

The unprecedented scope and uncoordinated nature of the various federal efforts to curtail Medicaid fraud and abuse has resulted in communication gaps among both the various new federal Medicaid compliance programs, and the federal and State Medicaid integrity efforts. Providers who participate in State Medicaid Programs should expect to be audited by multiple agencies within the federal and state government. The communication gaps among the agencies are likely to lead to overlapping audits, inconsistent standards and a myriad of procedural traps. These increased risks can be managed, but certainly not eliminated, by diligent oversight of the provider organization's audit response processes.

I. Background: The Deficit Reduction Act of 2005 and Medicaid Compliance

Historically, state agencies have been responsible for oversight and enforcement activities relating to State Medicaid Programs. The Deficit Reduction Act of 2005 ("DRA") changes the enforcement dynamics.² The Act was intended to improve Medicaid fraud and abuse enforcement on both the state and federal level. The Act imposes specific requirements on State Medicaid Programs and encourages states to adopt their own false claims acts. The DRA also establishes a federal Medicaid Integrity Program, to be staffed with 100 new federal employees and funded with \$50 million to \$75 million per year.

This new focus on Medicaid is not surprising. According to some estimates, within five years Medicaid will be the single biggest federal expenditure. Moreover, Medicaid spending is currently dominating many state budgets, soaking up as much as a third of total expenditures. The need to control costs is apparent and Congress believes increasing enforcement dollars will pay off. The \$160 million investment in Medicaid fraud enforcement under the DRA is projected to result in recoveries of over \$1 billion.

One component of the DRA obligates State Medicaid Programs to require Medicare providers who receive at least \$5 million in annual Medicaid payments to establish written policies for all employees, contractors, and agents explaining the federal False Claims Act, other administrative remedies for false claims under federal law, and any state civil or criminal penalties for false claims. Medicaid providers in most states are in a precarious position. Under the DRA, State Programs were required to amend their State Medicaid Plans to impose the DRA

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² The Deficit Reduction Act of 2005 (Pub. L. 109-171), was signed onto law on February 8, 2006 by President Bush.

false claims act policy obligations by March 13, 2007. Most states have not acted. See http://www.cms.hhs.gov/DeficitReductionAct/03_SPA.asp for copies of the State Plan Amendments. The Centers for Medicare and Medicaid Services (“CMS”) is suggesting, however, that entities were required to comply with the DRA by January 1, 2007. This seems wrongheaded. The State Medicaid Plan -- not the provisions of the DRA -- impose obligations on Medicaid providers. Moreover, if the State Plan has not been amended it is not clear what specific requirements providers are obligated to meet.

A second component of the DRA provides an incentive for States to enact their own False Claims Act analogous to the federal False Claims Act, by offering a 10 percent increase in its share of Medicaid false claim act recoveries.³

Finally, the DRA directs CMS to establish and staff a new Medicaid Integrity Program (“MIP”). The MIP is perhaps the most significant Medicaid compliance aspect of DRA, and we devote an entire section to the MIP below.

II. The Medicaid Fraud Control Unit

Historically, the federal government primarily relied on the individual State Medicaid Programs and the state Medicaid Fraud Control Units (“MFCUs”) to protect Medicaid from fraud, waste and abuse.⁴ More specifically, the State Medicaid agency is responsible for ensuring proper payment, recovering misspent funds, identifying suspected Medicaid fraud, and making referrals to its MFCU. The MFCU is responsible for reviewing the referrals it receives from the State Medicaid agency and other sources to determine if the issues involved merit criminal and/or civil investigation. The MFCUs were established in 1977 by the Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. No. 95-142, § 17(c) (Oct. 25, 1977), creating SSA §1903(q), codified at 42 U.S.C. § 1396(b)(q). MFCUs are granted the authority to investigate Medicaid fraud and to review recipient abuse in licensed facilities receiving Medicaid funds under 42 C.F.R. Part 1007.

The MFCU was initially established in Washington State in 1978 as part of DSHS, and became part of the DSHS Office of Special Investigations in 1982. Then, in 1988, MFCUs were required to become distinct entities from State Medicaid Agencies.

The MFCU investigates contracted providers who defraud the Medicaid program, where the State of Washington is considered to be the victim. The MFCU also assists law enforcement with incidents of resident abuse in licensed facilities which receive Medicaid funds, even if the victim is not a Medicaid recipient. 42 C.F.R. § 1000.11. Fraud is defined as the willful and knowing misrepresentation of material fact for the purpose of obtaining reimbursement for goods

³ On August 21, 2006, the Office of Inspector General (OIG) for the Department of Health and Human Services published in the Federal Register a list of specific guidelines that it will consider in determining whether a state's false claims act satisfies the above requirements. DRA §6031, codified at 42 U.S.C. § 1396h.; OIG guidelines for reviewing State false claims acts published at 71 Fed. Reg. 48552 (Aug. 21, 2006). The OIG has since reviewed thirteen State Acts. The following eight State false claims laws were in compliance with DRA requirements: Hawaii, Illinois, Massachusetts, Nevada, New York, Tennessee, Texas and Virginia. The following five State false claims laws failed to pass muster: California, Florida, Indiana, Louisiana, and Michigan. The OIG's reviews can be found at <http://www.oig.hhs.gov/fraud/falseclaimsact.html#1> (Website last checked October 17, 2007).

⁴ The MFCU Annual Reports and Contact Directory are available at <http://www.oig.hhs.gov/publications/mfcu.html>.

or services that the provider would not be entitled to, or in an amount greater than the provider would have been entitled to, had the claim reflected true information.

According to 42 C.F.R. § 455.14, if DSHS receives a complaint of Medicaid fraud or abuse from any source or identifies questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation. If the findings of the preliminary investigation give DSHS reason to believe that an incident of Medicaid fraud and abuse by a provider has occurred, the agency must refer the case to the MFCU. 42 C.F.R. § 455.15.

MFCU investigations may include: requests for documents pursuant to Medicaid rules, obtaining and executing search warrants, interviewing of staff, patients and other witnesses, seizure of records, computer equipment (MFCU often takes images of computer hard drives and returns the equipment), and interviews of accused providers. The consequences of a criminal conviction may include: incarceration, civil penalties with treble damages, loss of Medicaid provider number, loss of professional license, restitution and court costs, court-ordered conditions, and negative publicity.

III. New Medicaid Integrity Program

The Government Accounting Office (“GAO”) has conducted a number of studies that identified significant weaknesses in the state’s MFCU efforts to detect and control fraud and abuse. In 2005, a GAO report indicated that CMS’s oversight of Medicaid State agencies was lacking. The GAO found CMS’s efforts “disproportionately small relative to the risk of serious financial loss.” *Medicaid Fraud and Abuse: CMS’s Commitment to Helping States Safeguard Program Dollars is Limited* (2005).

Congress evidently agreed with the GAO and grew increasingly concerned with ever-rising Medicaid costs. The establishment of a Medicaid Integrity Program (“MIP”) at the federal level reflects both a shift in policy to increased federal enforcement and an increase in federal resources devoted to Medicaid oversight. Through the MIP the federal government will take on a much more active role in monitoring the State Medicaid Programs.

Section 6034 of the DRA describes some of the specific functions of the MIP. CMS must develop a comprehensive five-year plan for ensuring the integrity of the Medicaid program and combating fraud and abuse. Specifically, CMS must enter into contracts with qualified entities to (a) perform reviews of providers that furnish items or services under the Medicaid program to determine whether fraud, waste or abuse has occurred, (b) audit claims made under a state Medicaid program, including cost reports and risk contracts, (c) identify overpayments to individuals or entities receiving federal funds and (d) educate providers and managed care entities regarding payment integrity and quality of care.

Congress also put both money and manpower behind this initiative. The Medicaid Integrity Program will receive \$5 million in 2006, \$50 million in 2007 and 2008, and \$75 million per year thereafter. Historically, CMS had fewer than 10 individuals devoted to Medicaid oversight. The DRA requires CMS to hire 100 additional full-time employees to support and assist the states in combating Medicaid fraud and abuse.

In 2006, CMS published the “Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program for FY 2006-FY 2010.” This Plan identified the following initial enforcement priorities: long-term care facilities and home health agencies; prescription drug costs; durable medical equipment and other medical suppliers; and improper claims for payment by hospitals and individual providers.⁵

IV. Payment Error Rate Measurement (PERM) and Medicare-Medicaid Data Matching (Medi-Medi) Programs

The DRA is not Congress’s only Medicaid-specific fraud control measure. Two other important Medicaid fraud control programs are the Payment Error Rate Measurement program (“PERM”) and the Medicare-Medicaid Data Matching (“Medi-Medi”) programs. Enacted by Congress as part of the Improper Payment Act of 2002⁶, the PERM program is designed to target improper Medicaid and State Children’s Health Insurance Program payments. The Medi-Medi program, which was started in 2001 by CMS and California, matches Medicare and Medicaid claims data to find patterns of fraud previously undetectable to the programs individually.⁷ Medicare program integrity staff has the responsibility for both the PERM and Medi-Medi data matching programs. Section 6034 of the DRA provides both the OIG and the Program Integrity Group with enhanced funding for these additional Medicaid fraud efforts, above and beyond the Medicaid Program Integrity allocation.

The PERM auditors are housed within the CMS Office of Financial Management (“OFM”) within the Medicaid Integrity Group. Interim final regulations published in August 2006 provide for contractors to audit states and providers and require states to recover from providers payments identified as errors. *See* 71 Fed. Reg. 51050 (Aug. 28, 2006). To make matters more difficult, payment errors under PERM based on a claims sample are extrapolated to the universe of claims and only the state, not the provider, may appeal. *Id.* at 51082-51084; 42 C.F.R. § 431, Subpart Q.

The Medi-Medi program will be expanded nationally using funds from the DRA, which provides OIG with \$25 million annually from 2006 to 2010 to expand its Medicaid fraud activities, and also provides the Medicaid Integrity Program with funding for a national expansion of the Medi-Medi pilot project. The additional Medi-Medi program funding starts at \$12 million in 2006, and increases in \$12 million increments until 2010, after which it will receive \$60 million annually. This is significant because prior to the Medi-Medi program, there had been no crosswalk between the Medicare and Medicaid codes, and Medi-Medi data analysis has already revealed multiple pharmacies that either inappropriately billed Medicaid first for Medicare-covered drugs or had double-billed both programs.⁸ CMS recently created a new

⁵ “Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program for FY 2006 – FY 2010” (2006), available at www.cms.hhs.gov/DeficitReductionAct/Downloads.

⁶ Pub. L. 107-300, enacted on Nov. 26, 2002.

⁷ The Medi-Medi program has since expanded to at least nine states, and had resulted in initiation of 335 investigations and 42 referrals to law enforcement through 2005, as explained in the Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program for FY 2006 – FY 2010 (2006).

⁸ See CMS Press Release dated March 28, 2006, “Bolstering the Safety Net: Eliminating Medicaid Fraud, Dennis Smith, Director, Center for Medicaid and State Operations, available at <http://www.cms.hhs.gov/apps/media/press/testimony.asp?Counter=1822&intNumPerPage>.

system of records, the One Program Integrity Data Repository (“ODR”), to facilitate the Medicare Integrity Program and the Medi-Medi Program data comparisons. 71 Fed. Reg. 64530 (Nov. 2, 2006). The primary purpose of the ODR system “is to establish an enterprise resource that will provide a single source of information for all CMS fraud, waste, and abuse activities.” *Id.* at 64531.

V. Recovery Audit Contractor (RAC) Program

The Medicare Modernization Act of 2003 (“MMA”) §306 directed CMS to investigate Medicare claims payment using Recovery Audit Contractors (“RACs”) to identify underpayments and overpayments and to collect the overpayments so that they may be returned to the Medicare Trust Fund. CMS pays the RACs on a contingency basis; that is, the RACs receive a portion of what they identify and collect. On March 28, 2005, CMS announced that California, Florida, and New York are the states that were chosen for this three-year demonstration.⁹ The most recent CMS RAC Status Document for FY 2006 (2006 RAC Status Document) was published on November 22, 2006.¹⁰ During 2006, CMS hired three RACs to perform claim review functions (Claim RACs) and three RACs to perform Medicare Secondary Payer (“MSP”) functions (MSP RACs). According to the 2006 RAC Status Document, 4.4 percent of Medicare fee-for-service (“FFS”) dollars paid did not comply with one or more Medicare coverage, coding, billing or payment rules, which equates to \$10.8 billion in Medicare overpayments and underpayments. Of that, the RACs identified over \$303 million in improper payments, with a high percentage linked to inpatient claims.

While the RAC Program’s mission is to reduce Medicare improper payments through the efficient detection and collection of overpayments, this mission includes audits of dually eligible patients (Medicare and Medicaid), similar to the Medicaid Integrity Program’s Medi-Medi Program discussed above. RACs make use of proprietary automated review software algorithms to identify overpayments and underpayments that may be detected without medical record review, and RACs may also subject some of these claims identified by algorithms to medical record review. CMS compensates the RACs on a contingency fee basis, with the RACs entitled to keep their fee if denials are upheld at the first level of Medicare appeals. This fee arrangement will likely encourage private contractors to aggressively deny claims.

The RAC demonstration project ends in March 2008, and CMS plans to release a RAC Demonstration Project Report to Congress in September 2008. Meanwhile, the Tax Relief and Health Care Act of 2006 (“TRHCA”) § 302 makes the RAC Program permanent and requires the Secretary to expand the program to all 50 states by no later than 2010. CMS has announced a RAC Expansion Strategy, in which it will procure 4 RAC contractors in a competitive bidding process by 2010, and these four new RAC jurisdictions will match the DME MAC jurisdictions.¹¹ CMS plans to move forward quickly with the expansion, with nationwide auditing as soon as spring 2008.

⁹ See CMS Press Release available at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1405>.

¹⁰ A link to the CMS RAC Status Document for FY 2006 is available at http://www.cms.hhs.gov/RAC/01_Overview.asp.

¹¹ See http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp.