Ready for the Deficit Reduction Act?: Effective 2007, the Federal Government is Raising the Bar on Anti-Fraud Compliance

by Frank Sheeder, Esq.

Large providers dozing on January 1 will put their Medicaid reimbursement at risk. But it will not take long before new federal anti-fraud mandates become universal requirements or voluntary practices for providers of all sizes.

On February 8, 2006, the president signed the Deficit Reduction Act of 2005 (DRA), which seeks to control federal spending on entitlement programs such as Medicare and Medicaid. The act is significant to healthcare providers because:

- It has transformed the nature of compliance programs from voluntary to mandatory.
- Certain employee handbook content and policies are now mandatory for recipients of $5 million or more in Medicaid reimbursement.
- States without statutes that parallel the federal False Claims Act will now likely adopt them.
- The government has been granted additional resources to combat fraud and abuse in Medicare and Medicaid programs.

Compliance aspects of the DRA become effective January 1, 2007, so providers have very little time to comply with its mandates.

Why the Focus on Medicaid?

Why is the Medicaid program coming to the forefront of the enforcement arena? The simple and compelling answer is that Medicaid is the largest health insurance program in the United States. The number of eligible beneficiaries is projected to exceed 46 million this year. Further, Medicaid spending is growing at a very high rate. Spending on the program grew nearly 8 percent alone last year, and federal contributions are expected to exceed $192 billion this year. The government has an urgent need to contain costs through increased fraud and abuse enforcement.

The federal government administers the Medicaid program through the Centers for Medicare and Medicaid Services (CMS). CMS pays the states between 50 and 83 percent of their annual Medicaid program costs.[1] The state portion of spending is projected to grow faster than the federal portion. This is especially significant when it comes to reining in Medicaid fraud, because state governments are trailing the federal government on fraud enforcement.

States have traditionally had the responsibility of conducting payment screens, detecting inappropriate billing, and investigating and prosecuting Medicaid fraud and abuse. But Congress feels not enough has been done about Medicaid fraud and abuse, and Congress is probably right. Only 15 states and the District of Columbia currently have laws that parallel the federal False Claims Act. Not surprisingly, Congress has stepped in to encourage states to curb healthcare fraud.

Fraudulent and abusive activity by Medicaid providers has taken the traditional forms:

- Billing for services not rendered
- Billing for undocumented services
- Including improper entries on cost reports
- Billing for medically unnecessary services
- Assigning incorrect codes to secure higher reimbursement
- Characterizing noncovered services or costs in a way that secures reimbursement

- Not seeking payment from beneficiaries who may have other primary payment sources
- Participating in kickbacks[2]

Congress also has allocated funding for the new Medicaid Integrity Program, issued on July 18, 2006. The secretary of Health and Human Services developed this program to:

- Review the actions of individuals or entities who receive Medicaid reimbursement to determine whether fraud, waste, or abuse has occurred
- Audit claims for payment for items or services furnished
- Identify overpayments to individuals or entities receiving federal Medicaid funds
- Educate providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care

There is also enhanced funding for the Medicare-Medicaid Data Match Program, which uses data mining software to identify cross-program fraud and abuse. Clearly, Medicaid enforcement is going to be a high priority in the near future.

An Increase in State False Claims Laws

The DRA gives states a significant economic incentive to adopt laws that model the federal False Claims Act. Even among the minority of states that have similar laws, some of those laws may need to be revised to more closely parallel the federal False Claims Act, which is what the DRA requires.

Congress has given the states an incentive to adopt such laws by allowing them to keep 10 percent of the federal recoveries obtained on behalf of their respective Medicaid programs. To take advantage of the incentive, a state must have such a law in place by January 1, 2007. Several states have already begun the process. In order to support the incentive, the state law must:

- Establish liability to the state for false or fraudulent claims as described in the federal False Claims Act
- 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
- Contain a civil penalty not less than the amount authorized by the federal False Claims Act

States can go further if they choose. Congress states in the DRA that it has not precluded states from enacting laws that are more stringent or broad than the federal False Claims Act.

Once states have false claims laws available to them, there will certainly be more whistleblower cases at the state level and more cases brought by the states themselves. Providers may even find themselves defending against false claims allegations simultaneously in federal and state courts.

A New Prerequisite: Policies and Training

Effective January 1, 2007, entities that receive $5 million or more in annual Medicaid reimbursement will need to establish written policies for all of their employees, contractors, and agents that provide details about the federal False Claims Act and the applicable parallel state laws. Doing so is a prerequisite to receiving Medicaid funds. In other words, noncompliance with the DRA's mandates will put 100 percent of the entity's Medicaid reimbursement at risk.

Organizations' employee handbooks and written policies must include detailed information about the administrative remedies for violations of the federal False Claims Act and corresponding state laws, civil and criminal penalties, and whistleblower protections. They must address the roles of federal and state laws in preventing and detecting fraud, waste, and abuse in federal healthcare programs.

The materials must also include detailed information about the organization's own policies and procedures for detecting and preventing fraud, waste, and abuse. Implicit in this requirement is the assumption that organizations to which the DRA applies will have compliance programs.

Organizations will also need to enact processes to provide education to their employees, contractors, and agents on the previously mentioned issues. They also should have processes in place to consistently confirm that the education has taken place.

Creating a New Compliance Standard

Healthcare entities that do not receive more than $5 million in annual Medicaid reimbursement may be breathing sighs of relief. These organizations should not relax for long, though. Remember that before the DRA, compliance programs were voluntary. The OIG Compliance Program Guidances, for example, are suggestions, not statutory requirements. Despite this fact, prudent providers would not even entertain the idea of neglecting compliance programs in today's environment.

The same holds true for the Sarbanes-Oxley Act, whose application is generally limited to publicly traded entities. Nonetheless, even nonprofit and non-publicly traded entities have voluntarily adopted Sarbanes-Oxley principles.

For healthcare organizations, the case for developing mechanisms to detect fraud and abuse is even stronger. Congress has mandated compliance policies and education for certain recipients of Medicaid reimbursement. It will not take long before the DRA's mandates become universal requirements or practices that providers undertake voluntarily. Either way, providers that want to diminish their risk in this highly charged enforcement environment should adopt the DRA's requirements.

Organizations that receive more than $5 million in annual Medicaid funding should prepare now for DRA's January 1, 2007, effective date. They should review their employee handbooks, compliance programs, and policies and procedures and add to or modify them as necessary to ensure compliance with the DRA. Failure to do so will put the entity's entire Medicaid reimbursement at risk.

Clearly, compliance and anti-fraud activities are HIM issues. HIM professionals should understand the mandates and take roles in the review of compliance programs, policies, and procedures. They should also undertake roles in education and training programs.

Notes

1. Levinson, Daniel R. "Leveraging Partnerships to Maximize the Medicaid Dollar." *The Journal of Public Inquiry*, Fall/Winter 2005: 15.
2. "Health Spending Projections through 2015: Changes on the Horizon." *Health Affairs* 2006. Web exclusive, available at http://content.healthaffairs.org/cgi/content/abstract/ hlthaff.25.w61.

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