

Deficit Reduction Act: Recent Developments and Implications for Providers

By Frank Sheeder, Esq. and Keri Tonn, Esq.

Executive Summary

The Deficit Reduction Act (DRA) seeks to combat fraud, waste and abuse in Medicare and Medicaid programs. The idea of the DRA is to curb inappropriate program expenditures through new initiatives and funding. Entities receiving \$5 million annually from Medicaid must establish certain policies for all employees, contractors and agents in order to receive Medicaid reimbursement. Providers, if they haven't, should consider actions needed to comply with the employee education section and other applicable DRA sections.

Ongoing integrity program funding has been established along with hiring of new fraud fighters. The Payment Error Rate Measurement program has been expanded and state error rates are being established. In some instances, providers must pay back reimbursement for each error found, with no appeals available.

States will likely focus on charges, record keeping, quality failure and worthless services. Data mining is under development. Providers will need to ensure their compliance programs align with the DRA requirements and remain consistently effective.

as Medicare and Medicaid. The idea behind the DRA is to decrease the deficit, but with it has come a surge in efforts and funding to help curb Medicaid waste, fraud and abuse. Since the DRA's enactment, healthcare compliance programs have gained increased attention and are no longer voluntary. The DRA set forth conditions with which many entities must comply as a prerequisite to receiving Medicaid reimbursement. These conditions are set forth in Section 6032 of the DRA, entitled "Employee Education about False Claims Recovery." The DRA also provided funding for the creation of a Medicaid Integrity Program and provided incentives for states to have false claims acts that parallel the federal False Claims Act. As a result, there is now unprecedented attention and directed resources toward combating Medicaid fraud, waste and abuse.

Employee Education: Policies and Training

Effective January 1, 2007, DRA Section 6032, entitled "Employee Education About False Claims Recovery" mandates that each state Medicaid plan require entities that receive or make annual Medicaid payments of at least \$5,000,000 to establish certain written policies

Background

Historically, the federal government has not been heavily engaged in efforts to combat Medicaid fraud, waste and abuse. This is due to a variety of factors, such as a lack of federal funding and data mining capabilities. States were solely responsible for Medicaid enforcement activities. Across the nation, states' attention varied, but typically, Medicaid enforcement activities received low priority.

Within the past five years, however, the economic climate has changed and Medicaid enforcement activities are now a top issue for lawmakers, the government and healthcare providers. There are many reasons for this shift. First, Medicaid spending is growing faster than Medicare spending. In the first half of 2007, there was a 10.7% jump in Medicaid costs. Medicaid is the largest health insurance program in the United States and it represents approximately one-third of many states' budgets. Second, many people thought that the transition to a Medicaid managed care environment

would decrease the opportunity for fraud and abuse, but this has not proven true. Third, the underinsured and the uninsured increasingly place significant demands on the Medicaid system.

In light of the changing economic climate, Congress grew concerned about what states were doing to curb Medicaid fraud, waste and abuse and it stepped in to encourage states to take action. The rules and policies that states implement over the next few years will impose substantial legal risks to healthcare providers.

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Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005¹ (DRA) was signed by the President on February 8, 2006 and it seeks to control federal spending on entitlement programs such

for all of their employees, contractors and agents. Entities must make these changes as a prerequisite to receiving Medicaid reimbursement. States must require such entities to establish written

¹ Deficit Reduction Act of 2005, 42 U.S.C. §§ 1396 et seq. (2007).

policies that the entity provides to all employees (including management) and any contractor or agent of the entity. The policies must contain detailed information about state and federal laws (including whistleblower protection) and the role of these laws in preventing waste, fraud and abuse in federal healthcare programs. The DRA left many organizations wondering whether this Section applied to them and how far Congress intended it to stretch. The DRA provides an expansive definition of an entity. A “contractor” or “agent” includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity furnishes or otherwise authorizes the furnishing of Medicaid healthcare items or services, performs coding or billing functions, or is involved in monitoring of healthcare provided by the entity. It is the responsibility of each entity to establish and *disseminate* written policies. If a healthcare provider to which this provision is applicable has not already identified or created these necessary policies, it should do so immediately.

The entity must also have a specific section in its employee handbook that describes applicable state and federal fraud, waste and abuse laws. The handbook should contain an explanation of employees’ rights to be protected as whistleblowers and a specific discussion of the entity’s policies and procedures for detecting and preventing fraud, waste and abuse. Although the DRA refers to “any employee handbook,” there is no requirement that an entity *create* an employee handbook.

As entities continue to make organizational changes in response to the employee education requirement of the DRA, they will want to ask themselves the following questions:

- Are we an “entity”?
- What level of detail do we need to include in our policies?
- How do we disseminate the information?
- How do we get our contractors to adopt our policies?
- How do contractors adopt policies of multiple providers?
- Are there any state plan amendments about which we need to be aware?

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There are no clear-cut answers to any of these questions. In fact, the Centers for Medicare and Medicaid Services (CMS) has acknowledged that there are many

open questions in the DRA. This begs the question of what actions healthcare providers should make to comply with the employee education section in the DRA. Providers should, at a minimum, make good-faith efforts, collaborate with contractors, consider including education in training courses and seek guidance from the applicable Medicaid agency.

Medicaid Integrity Program

The DRA also created the Medicaid Integrity Program (MIP) with \$50 million in funds for 2007 and up to \$75 million in 2009 and each year thereafter. According to a CMS press release, the MIP is based on four key principles:

- National leadership in Medicaid program integrity
- Accountability for the program’s own activities and those of its contractors and the states
- Collaboration with internal and external partners and stakeholders
- Flexibility to address the ever-changing nature of Medicaid fraud

The MIP has multiple roles. First, according to CMS, it will shine a powerful spotlight on any entity seeking inappropriate payment from the Medicaid program. Under the MIP, regulators will suspend payments to suspect providers while simultaneously seeking recovery of identified overpayments. Second, the MIP will include referrals of suspected fraudulent practices and providers to federal and state enforcement agencies. Third, according to the MIP strategic plan, the MIP will serve as a “bully pulpit” to encourage states to enhance their program integrity efforts. Congress provided funding for at least 100 new federal full time staff designated to fight Medicaid fraud, waste and abuse.

With some of the funds appropriated to CMS through the DRA, CMS entered into contracts with Medicaid Integrity Contractors (MICs). The MICs will play a large role in Medicaid enforcement efforts; in turn, healthcare providers will need to take necessary steps to enhance their compliance programs continually. MICs will review the actions of those seeking payment from state Medicaid plans and audit claims. MICs began performing audits in September 2007. MICs will also provide education to providers and others with respect to payment and quality of



² CTRS. FOR MEDICARE & MEDICAID SERVS., Press Release: CMS Launches Comprehensive Effort to Combat Medicaid Fraud and Abuse, www.cms.hhs.gov/apps/media/press/release.asp?Counter=1900 (last visited Jan. 10, 2008)

care and they will perform Medicaid cost report audits.

Audit priorities will be based on not only the potential value of individual provider overpayments, but also the potential for prevention-oriented guidance for the states. By identifying the states' vulnerabilities, CMS will be able to make recommendations and directives to the states to prevent future improper payments to providers. We expect to see an increased emphasis on data mining and analysis as MICs and the states try to identify potential audit and review targets.

Other New and Expanded Processes

Providers should also be aware of some additional and expanded initiatives that focus on Medicaid enforcement. CMS expanded the Payment Error Rate Measure (PERM) program, which is to measure improper payments to the Medicaid program and the State Children's Health Insurance Program. As part of the PERM initiative, CMS uses contractors to perform statistical calculations, medical records collection and data process of Medicaid and managed care claims. PERM is rolling out nationwide under the auspices of CMS and it will be in every state within the next three years. The PERM program received funding and became permanent under federal law.

As part of the PERM programs, CMS will ask healthcare providers to supply various records. It is critical that providers respond promptly to requests for records and provide additional information as necessary. A provider's failure to respond to PERM requests for records drives up error rates. The PERM program will establish a state error rate and for each error it finds against a provider, the provider will have to pay money back to the government. The PERM program does not contain a provision for a provider to appeal or negotiate with respect to a claim found to be erroneous under the PERM program.

Another project about which healthcare providers should be aware is the Medi-Medi project, whereby Medicare and Medicaid claims data are shared to help detect billing issues and analyze utilization patterns. In 2001, CMS, in partnership with the State of California, initiated the Medi-Medi project to improve coordination between the Medicare and Medicaid programs and to analyze data from the two programs. Since 2001, Medi-Medi projects have expanded to other states and they continue to roll out nationally.

With the DRA, the Medi-Medi project will receive enhanced funding and by fiscal year 2010 it will receive \$60 million annually and for each year thereafter.

State Action

The DRA requires each state to determine the manner by which it will ensure that Medicaid providers are complying with program requirements. In a state's "State Plan," the state must include a description of the methodology of compliance, oversight and the frequency with which the state will re-assess compliance on an ongoing basis. However, states are not completely independent in the process. CMS may, at its discretion, independently determine compliance through audits of entities or other means. CMS may also review a state's procedures through its routine oversight of states' activities.

Some states have already made significant strides in expanding Medicaid enforcement efforts. Texas led the way with its Medicaid enforcement enhancements. Within the first two years of creating an Office of Inspector General and increasing its Medicaid enforcement efforts, Texas recovered \$1.5 billion and its return on investment was 17:1 against budget expenditures. The Texas model also includes a voluntary disclosure program.

Recently, New York has enhanced its Medicaid enforcement initiatives because of pressure through OIG reports, U.S. Senate Finance Committee Hearings, a State Senate report, a *New York Times* series and a CMS audit. New York adopted the "Texas model," hired its first Inspector General and initially created 170 new positions. By the middle of 2008, New York intends to increase its staff to 640 people. This large staff includes auditors, investigators and data mining analysts. In addition, New York has made specific recovery commitments. It has committed to recover \$644 million per year by fiscal year 2011. New York's model also includes a voluntary disclosure program that is substantially simpler than the voluntary disclosure process at the federal level.

Other states continue to gear-up in a similar fashion. Many states will probably create a position for an independent Medicaid Inspector General and have unprecedented staffing levels. Some states might institute mandatory compliance programs. We have seen many states enact or amend state False Claims Acts, and this will probably continue to happen. Some states will enact new penal statutes. Also, states might make heavy use of their exclusion authority.

States are also placing an emphasis on quality of care issues.

This is not an easy path for healthcare providers or for the states. State action will have to be coordinated to avoid overlapping of processes and turf wars. For example, the MICs are auditing the same universe of information as the states. States will also struggle over the DRA education requirements.

As we see states develop programs to detect Medicaid fraud, waste and abuse, CMS and the states will likely target providers that have not historically had compliance issues. Large providers, hospitals, long-term care facilities, mental health, substance abuse and disability providers and managed care programs will probably be the primary targets.

States will probably focus their efforts on some key areas. Healthcare providers should monitor these areas within their own organization. These include:

- Excessive services and charges
- Unacceptable record keeping
- Quality failures as false claims
- "Worthless services" and errors as a basis for criminal indictment

States are also placing an emphasis on quality of care issues. Regulators have opined that quality of care issues tend to develop in organizations that are not in compliance with program requirements. Healthcare providers should endeavor to focus on patient centered care throughout the organization.

Another key trend is expanded mandatory data reporting and data accuracy, as well as "data prospecting" for outliers in performance and cost. In order to prepare for the future, healthcare providers should evaluate their data analysis capabilities. For example, does the organization have reliable data (financial data, quality of care data, etc.) and how does it routinely monitor the reliability of the data?

State False Claims Act Legislation

The DRA gives states an economic incentive to adopt laws that model the federal False Claims Act (FCA). If a state has a FCA that parallels the federal FCA, it may keep up to 10 percent

of the federal recoveries obtained in actions against providers. Before the DRA became effective, only 17 states had FCAs. Most of these state FCAs did not map to the federal FCA. There are now about 34 state FCAs. Several states created state FCAs in response to the DRA and others modified their FCAs to parallel the federal FCA. This should cause concern to healthcare providers for a variety of reasons. The state FCAs have whistleblower provisions and provide

whistleblower protection. With the presence of state FCAs and the federal FCA, providers may find themselves defending against false claims allegations simultaneously in federal and state courts and there might be turf wars between state and federal agencies.

Summary

DRA Section 6034 provides for increased funding for Medicaid enforcement. The increased Medicaid enforcement initiatives

are not just talk; they are backed by the funding to detect non-compliance and to control Medicaid fraud, waste and abuse. Compliance is not an option. Providers should evaluate whether their compliance programs comply with the new DRA requirements and providers must make sure their compliance program is effective. As states develop programs and compliance requirements, healthcare providers will need to take protective measures to limit their exposure. **NP**

Authors



Frank Sheeder, Esq. is a Partner in the healthcare practice of Jones Day in Dallas. He is a nationally recognized expert, and frequent lecturer and writer on healthcare compliance and litigation. He may be reached at fesheeder@jonesday.com.



Keri Tonn, Esq. is an Associate with Jones Day in Dallas. She may be reached at kltonn@jonesday.com.



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