

# The Medicaid Fraud and Abuse

## Provisions of the Deficit Reduction Act of 2005



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**O**n February 8, 2006, President Bush signed the Deficit Reduction Act of 2005<sup>1</sup> (DRA). As its title suggests, the DRA makes massive cuts in a variety of federal budget line items, including Medicaid program benefits. At the same time, however, it contains new mandates and increased spending aimed at combating Medicaid<sup>2</sup> fraud, waste, and abuse. This article addresses the economic and political climates in which the Medicaid-oriented mandates of the DRA were passed, and explores their practical impacts on healthcare providers.

### Medicaid Spending

Medicaid is the largest health benefit program in the United States. It is jointly funded by the federal government and the states. The federal government regulates the Medicaid program through the Centers for Medicare and Medicaid Services (CMS) and pays the states between 50% and approximately 76% of their annual Medicaid program costs.<sup>3</sup> Why is the Medicaid program now coming to the forefront in the political and enforcement arenas? The simple and compelling answer is that Medicaid spending, like Medicare spending, is growing at a very high rate. Medicaid spending grew 7.7% just last year. The state portion of Medicaid spending is estimated to grow faster than the federal portion. With CMS reporting that the healthcare share of the Gross Domestic Product will likely rise from 16% in 2004 to 20% in 2005,<sup>4</sup> the government has an urgent need to contain such astronomical costs through increased fraud and abuse enforcement.

### The State False Claims Act Incentive

Section 6032 of the DRA provides financial incentives for states to enact laws dealing with false or fraudulent claims that parallel the federal False Claims Act (Federal FCA).<sup>5</sup> This provision was included in an effort to contain the perceived escalation in Medicaid fraud, waste, and abuse, as addressed in two days of Medicaid fraud hearings before the Senate Committee on Finance on June 28-29, 2005.<sup>6</sup> Three themes developed in those hearings: (1) there is rampant fraud, waste, and abuse associated with the Medicaid prescription drug benefit; (2) the federal government was not doing enough to fight it; and (3) the Federal FCA was an important and effective tool for doing so. At the same time, the Government Accountability Office (GAO) issued a report critical of CMS entitled, *Medicaid Fraud and Abuse: CMS's Commitment to Helping States Safeguard Program Dollars Is Limited*,<sup>7</sup> which clearly put significant pressure on CMS and gave Congress the basis it needed to encourage CMS to effectively address Medicaid program excesses. Here are some of the more compelling findings in the GAO Report:

- (1) In fiscal year 2003, Medicaid covered nearly 54 million people and the program benefit payments totaled about \$261 billion, of which the federal share was about \$153 billion.
- (2) The resources CMS expended to support and oversee states' Medicaid fraud and abuse control activities remained out of balance with the amount of federal dollars spent annually to

provide Medicaid benefits. In fiscal year 2005, CMS' total staff resources allocated to these activities was about 8.1 full-time equivalent employees.

- (3) CMS lacked specific goals for Medicaid fraud and abuse control, which raised questions about its level of commitment to improve states' activities in this area.
- (4) Federal oversight of a state's Medicaid program safeguards would not occur, at best, more than once every seven years.
- (5) Despite the millions of dollars CMS received annually from a statutorily established fraud and abuse control fund, it did not allocate resources to sufficiently fund initiatives to help states increase the effectiveness of their Medicaid fraud and abuse control efforts.

Against this backdrop, Senator Charles Grassley (R-IA), Chairman of the U.S. Senate Committee on Finance, authored Section 6032 of the DRA. Senator Grassley has been at the forefront of the government's healthcare anti-fraud efforts for several years.

Section 6032(a) of the DRA provides that states are eligible for a 10% increase in their share of Medicaid fraud recoveries if they have False Claims Acts (State FCAs). Section 6032(b) specifies four requirements for determining whether a State FCA supports this financial incentive:

- (1) It must establish liability to the state for false or fraudulent claims described in the Federal FCA with respect to any expenditure described in the Medicaid Program;
- (2) The law must contain provisions that are at least as effective in rewarding and facilitating qui tam (whistleblower) actions for false or fraudulent claims as those described in the Federal FCA;
- (3) The statute must allow whistleblowers to file actions under seal, with a sixty-day review period by the State Attorney General; and
- (4) There must be a civil penalty that is not less than that authorized by the Federal FCA.

Importantly, Section 6032(d) of the DRA, entitled *No Preclusion of Broader Laws*, states that the DRA shall not be construed as prohibiting a state from having a law that is broader than the Federal FCA, as long as it meets the foregoing requirements. States generally have until January 1, 2007 to enact such a law to be eligible for the financial incentive. Under Section 6035(e) of the DRA, however, if state legislation is needed in order for the state's Medicaid state plan (State Plan) to meet the DRA requirements, the State Plan will not be deemed to be out of compliance until the first day of the first quarter after its next regular legislative session after February 8, 2006.

Section one of 6032(b) of the DRA contemplates that the Department of Health and Human Services Office of Inspector General (DHHS OIG), in consultation with the U.S. Attorney General, will determine whether a State FCA complies with the DRA's mandates. On March 17, 2006, slightly over a month after the DRA became law, Senator Grassley sent a letter relating to the DRA to DHHS Inspector

General Daniel R. Levinson and U.S. Attorney General Alberto Gonzales. In the letter,<sup>8</sup> Senator Grassley urged the federal government to help states qualify for the new financial incentive in Section 6032 of the DRA. He also expressed concern over the second element listed above: that the state law be at least as effective as the Federal FCA in rewarding and facilitating whistleblower actions for false claims. Senator Grassley indicated that it had come to his attention that many state legislatures are in the process of enacting State FCAs in accordance with Section 6032 of the DRA, and that they are attempting to modify and deviate from the Federal FCA provisions. He expressed concern that the changes would ultimately undermine whistleblowers' ability to file complaints on behalf of the government. He therefore requested that the DHHS OIG and the U.S. Attorney General ensure that the State FCAs contain qui tam provisions, as intended by Congress.

On April 26, 2006, Senator Grassley sent another letter<sup>9</sup> to the DHHS OIG and the U.S. Attorney General. The press release announcing the letter states:

"If states want to collect a greater share of the recoveries, then states need to let whistleblowers be part of the process as specified in the Medicaid legislation just passed by Congress," Grassley said. "Whistleblowers have proven to be the key to the success of the federal False Claims Act over the last 20 years. They stick their necks out and put themselves in very risky situations to do the right thing on behalf of taxpayers, and their courage and sacrifice deserves to be recognized and rewarded."

In the second letter, Senator Grassley raised a new concern about the states' legislative efforts to enact State FCAs. He observed that some states were drafting legislation that would not permit qui tam actions to proceed once a State Attorney General declined to intervene in the matter. Senator Grassley pointed out that this variation is contrary to the requirements of section 6032 and will not entitle a state to receive enhanced matching funds under the DRA. He reasoned that the success of the Federal FCA lies with the qui tam provisions. The adjudication of any State or Federal FCA case should not hinge solely upon intervention by a government agency, but rather should be based on judicial action in the courts.

These letters make it even more clear that Congress intends to go to great lengths to ensure that people who are aware of potential Medicaid fraud can proceed as whistleblowers under both State and Federal FCAs. These circumstances, however, also raise some questions:

- (1) Will a whistleblower be allowed to forum-shop? For example, if a whistleblower had information against a healthcare provider with operations in more than one state, he or she could bring his or her case under the Federal FCA, while at the same time pursuing State FCA claims in the state or states with the most favorable statute. Also, if a State Attorney General declined to intervene in a qui tam case, the whistleblower could shop his or her case in another forum.
- (2) Will there be cooperation or competition between state and federal authorities? The current political and

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fiscal pressure is such that each respective enforcement agency will be endeavoring to boost its own results.

- (3) Will there be inconsistent results, overlapping recoveries, and needless duplication of efforts? Ironically, healthcare providers faced with a whistleblower case under any FCA, whether State or Federal, might actually seek to join additional states or agencies as parties in an effort to avoid such outcomes.

## The Education Requirement

Section 6033 of the DRA, entitled *Employee Education About False Claims Recovery*, will have a considerable impact on healthcare providers and their compliance programs. It effectively makes compliance programs and education about the Federal FCA and State FCAs mandatory for entities that receive or pay \$5 million or more in Medicaid funds annually. It does so by amending Section 1902(a) of the Social Security Act<sup>10</sup> to require state Medicaid programs to enact certain provisions by January 1, 2007.<sup>11</sup> As a condition of receiving Medicaid funding, the states must now require such entities to:

- (1) Establish written policies for all employees of the entity (including management), and any contractor or agent of the entity, that provide detailed information about:
  - a. the Federal FCA;
  - b. administrative remedies for false claims and statements under 31 U.S.C. Chapter 38;
  - c. any state laws pertaining to civil or criminal penalties for false claims and statements;
  - d. the whistleblower protections under the Federal FCA and the state laws; and
  - e. the role of such laws in preventing and detecting fraud, waste, and abuse in Federal healthcare

programs, as defined in Section 1128B(f) of the Social Security Act.<sup>12</sup>

- (2) Include, as part of their written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.
- (3) Include, in any employee handbook for the entity, a specific discussion of:
  - a. the state and federal laws referenced above;
  - b. the rights of employees to be protected as whistleblowers; and
  - c. the entity's policies and procedures for detecting fraud, waste, and abuse.

There are several notable impacts on healthcare providers, covered payer entities, and their compliance programs:

- (1) Meeting these requirements are prerequisites to reimbursement. In other words, if a provider that receives more than \$5 million in annual Medicaid reimbursement does not comply with the DRA, it will risk losing all of its Medicaid funding, along with any other funding under state-administered, federal healthcare programs covered by the Social Security Act.
- (2) Because the financial stakes are so high, there may be increased compliance buy-in by senior leaders, directors, and other stakeholders.
- (3) Before the DRA became law, compliance programs were voluntary. Now, however, compliance programs are mandatory for entities covered by the DRA. The "entity's policies and procedures for detecting fraud, waste, and abuse" are obviously the components of its compliance program.
- (4) The written policies and procedures must cover not only employees, but agents and contractors as well. This is an extremely broad and diverse population for most organizations that are covered by the DRA. Even identifying all contractors of an entity may be an enormous undertaking.
- (5) Organizations will need to understand the details of all of the referenced state and federal civil, criminal, and administrative provisions, and figure out ways to efficiently educate the population mentioned above on those details.
- (6) Organizations will have to adopt consistent and verifiable processes for confirming that they have provided the required education.
- (7) Entities will have to balance the details contained in their policies, procedures, educational materials, and employee handbooks against the risk of unjustifiably creating whistleblowers in their ranks.
- (8) Time is short. For some entities subject to the DRA, both the State Plan provisions and the State False Claims Acts will be in place by January 1, 2007. Even if others will have more time because of the unique characteristics of their State Plans and legislative process, they will nonetheless have to comply with these provisions in the very near future.

- (9) There has not yet been any rulemaking relating to these DRA mandates, at either the state or federal level. While these provisions are sweeping, there is no guidance as to the federal government's and states' practical expectations toward healthcare entities under the DRA.

### The Medicaid Integrity Program

Section 6035 of the DRA establishes a new Medicaid Integrity Program, modeled after the long-standing Medicare Integrity Program. The DHHS will promote integrity in the Medicaid Program by entering into contracts to carry out the following activities:

- (1) Review of actions of individuals or entities furnishing items or services for which payment may be made under a State Plan, to determine whether:
  - a. fraud, waste, or abuse has occurred or is likely to occur; or
  - b. such actions have any potential for expenditure of Medicaid funds in an inappropriate manner.
- (2) Audit of claims for payment for items or services furnished, or administrative services rendered, under a State Plan, including:
  - a. cost reports;
  - b. consulting contracts; and
  - c. risk contracts.
- (3) Identification of overpayments to individuals or entities receiving federal funds pursuant to the Medicaid program.
- (4) Education of providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care.

Section 6035(d) of the DRA orderd HHS to develop a five-year comprehensive plan for ensuring the integrity of the Medicaid program by combating fraud, waste, and abuse. The plan must be developed in consultation with the U.S. Attorney General, the Federal Bureau of Investigation, the Comptroller General, the DHHS OIG, and state officials with responsibility for controlling provider fraud and abuse under State Plans.

In section 6035(e) of the DRA, Congress provided immediate funding for the Medicaid Integrity Program: \$5 million for the remainder of fiscal year 2006; \$50 million in fiscal years 2007 and 2008; and \$75 million in subsequent fiscal years. It also increased CMS staffing devoted to protecting Medicaid program integrity by 100 full-time equivalent employees. Their duties will consist solely of protecting the integrity of the Medicaid program by providing effective support and assistance to states as they endeavor to combat provider fraud and abuse.

In keeping with the federal initiative to oversee the states' administration of their Medicaid programs, the DRA requires states to cooperate with these federal efforts. Congress is also holding DHHS accountable. It is now required to report to Congress within 180 days of the end of each fiscal year. The report will identify the use of the fund-

ing referenced above, and the effectiveness of the use of such funds.

The DHHS OIG has also received increased funding under the DRA. It received \$25 million per fiscal year, from 2006 to 2010, in connection with combating fraud, waste, and abuse in the Medicaid program. The DHHS OIG also must make an annual report to Congress as to its use of this funding and the effectiveness of its efforts.

Further, the DRA provides, in Section 6035, for increased funding for the Medicare-Medicaid Data Match Program (the "Medi-Medi Program"). This program identifies Medicaid program vulnerabilities through the use of computer algorithms to look for payment anomalies. Such anomalies have historically included billing patterns regarding services, time, or patients that appear to be suspect or implausible. Congress allocated \$12 million in funding for this program for fiscal year 2006; \$24 million in 2007; \$36 million in 2008; \$48 million in 2009; and \$60 million in every fiscal year thereafter.

### The Post-DRA GAO Report

On March 28, 2006, in the wake of the DRA's passage, the GAO testified before a Senate Subcommittee<sup>13</sup> that the DRA provides opportunities for federal leadership to combat fraud and abuse. The GAO found that the most immediate challenge will be for CMS to develop the congressionally

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mandated comprehensive plan to provide strategic direction for CMS, the states, and law enforcement partners. To call this undertaking a challenge is an understatement. CMS has to recruit and train an additional 100 employees, identify risk areas, establish priorities, and gain an understanding of the many differences between the fifty-six separately administered state Medicaid programs.

## Conclusion

Congress is putting pressure on CMS and the states. CMS will be increasing its historically minimal oversight of state Medicaid programs' efforts to combat fraud, waste, and abuse. About a third of the states have False Claims Acts, and many of the remaining states are currently in the midst of legislative efforts to enact them. Providers are required to educate their employees, agents, and contractors about the details of State and Federal FCAs and similar laws, with specific focus on the whistleblower provisions. The impact on healthcare providers is easily discernable:

- (1) A burgeoning number of investigations and enforcement actions;
- (2) More whistleblower cases;
- (3) Additional, tougher interpretations and expectations as the DRA takes root; and
- (4) The need to dedicate substantially more resources, both human and financial, toward compliance.

The coming years promise to be exhilarating for Medicaid providers.

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## Endnotes

<sup>1</sup> S. 1932 (Feb. 8, 2006). Note that due to a clerical error, the President signed the wrong version of the applicable DRA bill. There is a pending lawsuit challenging the validity of the DRA. Note that the signed version had the exact provisions discussed here as the bill passed by Congress.

<sup>2</sup> Medicaid is a healthcare benefit program jointly financed by the states and the federal government. Medicaid is administered directly by the states under State Plans. Within broad federal guidelines, each state program establishes its own eligibility standards; determines the type, amount, duration, and scope of covered services; and sets payment rates. The federal government matches state Medicaid spending for medical assistance according to a formula based on each state's per capita income. In fiscal year 2004, the federal contribution ranged from 50 to 76 cents for every state dollar spent on medical assistance. The federal match rate for administrative costs is generally 50%. See *Medicaid Fraud and Abuse: CMS's Commitment to Helping States Safeguard Program Dollars is Limited*, GAO-05-855T, June 28, 2005, available at <http://www.gao.gov/new.items/d05855t.pdf>. The fifty-six separately administered Medicaid programs include one for each of the fifty states, plus the District of Columbia,

Puerto Rico, and the U.S. territories of American Samoa, Guam, Northern Mariana Islands, and the Virgin Islands.

<sup>3</sup> *Leveraging Partnerships to Maximize the Medicaid Dollar*, by Daniel R. Levinson, Inspector General, Department of Health and Human Services, THE JOURNAL OF PUBLIC INQUIRY, Fall/Winter 2005, p. 15.

<sup>4</sup> For these and additional detailed statistics and discussion about cost trends, see *Health Spending Projections Through 2015: Challenges on the Horizon*, HEALTH AFFAIRS - Web Exclusive, available at

<http://content.healthaffairs.org/cgi/content/abstract/hlthaff.25.261>.

<sup>5</sup> 31 U.S.C. § 3729 et seq.

<sup>6</sup> Witness statements from the hearings, entitled *Medicaid Waste, Fraud and Abuse: Threatening the Health Care Safety Net*, available at <http://finance.senate.gov/sitepages/hearing062905.htm>.

<sup>7</sup> GAO-05-855T, June 28, 2005, available at <http://www.gao.gov/new.items/d05855t.pdf>.

<sup>8</sup> Available at <http://www.senate.gov/~finance/press/Gpress/2005/prg032106.pdf>.

<sup>9</sup> Available at [http://grassley.senate.gov/index.cfm?FuseAction=PressReleases.Detail&PressRelease\\_id=5043](http://grassley.senate.gov/index.cfm?FuseAction=PressReleases.Detail&PressRelease_id=5043).

<sup>10</sup> 42 U.S.C. § 1396a(a).

<sup>11</sup> As with the grace period for enactment of State FCAs, states will be given until the first day of the quarter following their next legislative session after February 8, 2006 to the extent complying with these provisions under a State Plan requires legislative action.

<sup>12</sup> 42 U.S.C. § 1320a-7b(f), entitled *Criminal Penalties for Acts Involving Federal Health Care Programs*. Note that the definition of "federal health care program" is much broader than just Medicaid. It states:

(f) For purposes of this section, the term "Federal health care program" means —

(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code); or

(2) any State health care program, as defined in section 1128(h).

Under Social Security Act Section 1128(h), 42 U.S.C. § 1320a-7(h), the term "State health care program" means —

(1) a State plan approved under title XIX,

(2) any program receiving funds under title V or from an allotment to a State under such title,

(3) any program receiving funds under title XX or from an allotment to a State under such title, or

(4) a State child health plan approved under title XXI.

<sup>13</sup> Statement of Leslie G. Aronovitz, Director, Health Care, Government Accountability Office, *Testimony Before the Subcommittee on Federal Financial Management, Government Information, and International Security, Committee on Homeland Security and Government Affairs*, U.S. Senate; GAO-06-578T, March 28, 2006, available at <http://www.gao.gov/new.items/d06578t.pdf>.