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The Changing Landscape of Medicaid Fraud Compliance

As every health care provider is acutely aware, federal and state-sponsored programs pay for a significant portion of health care on which many providers heavily depend. Exclusion from participation in federal health care programs due to a finding of fraud, as well as significant civil penalties, can have a devastating impact. Providers are well advised to be vigilant with respect to their compliance programs in the emerging environment of enhanced fraud detection and stronger enforcement.

There is a fundamental transformation presently occurring in the area of Medicaid fraud detection and enforcement on both the federal and state levels. This transformation is necessitated in large part by the fact that the 41-year-old program, funded by both federal and state monies, grew to an estimated $300 billion in 2006, $192 billion of which was funded by the federal government.

Federal Initiatives

Section 6034 of the Deficit Reduction Act of 2005 (DRA) established the Medicaid Integrity Program (MIP) and implemented the newly created Medicaid Integrity Group (MIG). The purpose of the MIP is to increase the resources available to the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) to detect and combat Medicaid fraud and abuse. There are two general operational responsibilities under the new MIP. The first is to review the actions of those providing Medicaid services, and second is to provide support and assistance to the States to combat Medicaid fraud, waste, and abuse.

This mandate will be accomplished in several ways including the issuance of a comprehensive Medicaid integrity plan every five years, the hiring of contractors, increased field operations and increased funding for enforcement efforts.

• ***Comprehensive Medicaid Integrity Plan.*** The first five-year Comprehensive Medicaid Integrity Plan (CMIP) for fiscal years 2006-2010 was issued on July 18, 2006.[1] Congress mandated that CMS consult with many other agencies in the development of each CMIP including "the Attorney General, the Federal Bureau of Investigation, the Comptroller General of the United States, the Inspector General of the Department of Health and Human Services, and State officials with responsibility for controlling provider fraud and abuse under State plans under this title."[2] Presumably, for the state of New York that "official" will be the inspector general of the newly created Office of Medicaid Inspector General, described in detail below.

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• ***Medicaid Integrity Contractors.*** Congress specifically required the use of contractors to review the actions of those seeking payment from Medicaid, conduct audits, identify overpayments and educate providers and others on payment integrity and quality of care.[3] The Division of Medicaid Integrity Contracting (DMIC) is charged with the procurement, functional administration and oversight of all Medicaid Integrity Contractors.[4]

• ***Field Operations.*** Further mandated are field operations to conduct state program integrity oversight reviews and provide training and technical assistance to the states. These operations will be part of the Division of Field Operations (DFO) and will be divided among the division office and up to five teams whose staff will be strategically located throughout the country.[5] The CMIP states that an outcome-oriented review guide will be developed in consultation with the states. The DFO will identify best practices guidance and offer other technical assistance such as training in key fraud and abuse areas.

• ***Infusion of Funding to Enhance Enforcement Efforts.*** To implement the MIP Congress appropriated $5 million in fiscal year 2006 with an additional $50 million in each of fiscal years 2007 and 2008 and $75 million annually in fiscal year 2009 and each year thereafter.[6] Moreover, Congress provides the Office of Inspector General with $25 million annually for each fiscal year 2006 to fiscal year 2010 to expand its Medicaid fraud activities.[7] The Medi-Medi program received $12 million in fiscal year 2006 and will receive increases each year thereafter in $12 million increments until fiscal year 2010 when it will receive $60 million. The Medi-Medi program will receive $60 million annually thereafter.[8]

To assist in the expansion of these efforts Congress mandated that CMS employ 100 full-time employees to provide support to the states. As stated above, Congress specifically requires CMS to use contractors in the effort to reduce Medicaid waste and improve program integrity.

New York State Initiatives

New York State has also been undergoing a significant shift toward a more robust system to combat Medicaid fraud. On June 23, 2006, the New York State Legislature agreed to codify and expand the independent Office of Medicaid Inspector General (the Medicaid IG) within the New York State Department of Health. This office had previously been created by Governor George Pataki in July 2005 by executive order. The legislation was signed into law on July 26, 2006.[9] The Medicaid IG's office was created to serve as the state's single state agency with respect to (a) prevention, detection and investigation of fraud and abuse within the Medical Assistance Program, (b) referral of appropriate cases or criminal prosecution, and (c) recovery of improperly expended Medicaid funds through a variety of administrative and civil mechanisms. The head of the office will be the Medicaid Inspector General appointed by the governor with the advice and consent of the Senate. The inspector general must

submit an annual report summarizing the activities of the office during the preceding calendar year.[10] The legislation does not include a "qui tam" provision, for which many had advocated, that would have provided a financial incentive to whistleblowers.

The New York State Department of Health, in consultation with the Medicaid IG, is directed to develop, test and implement new methods to strengthen the capability of the Medicaid payment information system to detect and control fraud and improve expenditure accountability. It is authorized to develop new methods using current information technology. Such methods must, at a minimum, address the following areas: (i) automatic claims review process prior to payment, (ii) coordination of benefits, (iii) comprehensive review of paid claims, and (iv) targeted claims and utilization review.[11]

• ***Mandatory Provider Compliance Program.*** The new legislation requires that certain providers who wish to participate in the Medical Assistance Program must adopt an effective compliance program.[12] As stated above, unlike the Voluntary Federal Compliance Program issued by the HHS OIG with which most providers are familiar, the program established by this legislation is mandatory. It should be noted, however, that if a compliance program complies with the standards of the HHS OIG, it will be deemed in compliance with the New York state requirements.[13] Also, the New York Medicaid IG is directed by statute to create and make available guidelines which may include a model compliance program.

Each provider is responsible for implementing a program that is appropriate to its characteristics (e.g., provider's size, complexity, resources, and culture). The program must, at a minimum, be applicable to (i) billings to and (ii) payments from the Medical Assistance Program. Similar to federal OIG compliance program guidelines, the New York legislation requires a compliance program to include the following elements: (1) Written policies and procedures, (2) Compliance officer, (3) Employee training, (4) Clear lines of reporting, (5) Disciplinary policies, (6) A system of monitoring, (7) A system for responding to compliance issues, and (8) A policy of nonintimidation and nonretaliation.[14]

• ***Regulations, Sanctions, Penalties and Revocation of Participation.*** The Medicaid Inspector General is authorized and directed to promulgate regulations to establish those categories of providers that must have a compliance program. The legislation states that such group must include any provider of care, services and supplies under the Medical Assistance Program for which the Medical Assistance Program is a "substantial portion" of their business operations. Specifically mentioned as part of this group of providers are hospitals which are subject to Article 28 of the Public Health Law, entities that provide home care services which are subject to Article 36 of the Public Health Law, as well as entities that are subject to Articles 16 and 31 of the Mental Hygiene Law. If the Commissioner of Health or the Medicaid Inspector General finds that a provider does not have a compliance program within 90 days after the effective date of the regulations then the provider may be subject to sanctions or penalties, which may include revocation of the provider's agreement to participate in the Medical Assistance Program.[15]

While the effective date of the legislation is the date on which the governor signed it into law, the effective date of the mandatory compliance program provisions is Jan. 1, 2007.[16] After that, upon enrollment in a new Medical Assistance Program, a provider must certify to the Department of Health that the provider satisfactorily meets the requirements for an effective compliance program.[17] It should be noted that there is no grandfathering provision with respect to the compliance program mandate. Therefore, the mandatory compliance program applies to existing entities as well.

Medicaid fraud detection is changing, necessitated by the fact that the 41-year-old program grew to about $300 billion in 2006, $192 billion of which was funded by the federal government.

• ***Advisory Opinions.*** The legislation grants authority to the commissioner of the Department of Health to issue advisory opinions with respect to the provision of medical items or services pursuant to the Medical Assistance Program. As in the case of opinions issued by the HHS OIG, an advisory opinion issued by the commissioner will only apply with respect to the provider to whom the advisory opinion is rendered.[18]

• ***Allocation of Medicaid Recoveries.*** The Medicaid IG will establish a schedule for the allocation of amounts recovered after Jan. 1, 2006 between the state and local social service districts. Moreover, if a local social services district is responsible for an investigation, it will be entitled to share up to 15 percent of the recovery.[19]

• ***New Criminal Penalties for Healthcare Fraud.*** In addition to the increased enforcement efforts listed above, the New York State Penal Law was amended to add new Article 177 entitled "Health Care Fraud."[20] Health Care Fraud has the following elements: (i) Intent to defraud a health plan,[21] (ii) knowingly and willfully providing materially false information or omitting material information, for the purpose of requesting payment, and (iii) payment is received for health care items or services by a recipient not entitled to such payment. Crimes range from a Class A misdemeanor to a Class B felony, depending on the amount of the fraudulent payment.

Conclusion

Each participant in the Medical Assistance Program should be aware of the new wave of Medicaid fraud detection and enforcement initiatives on both the federal and the state levels. Each such provider should take proactive steps to ensure that it and its staff are in compliance. The Comprehensive Medicaid Integrity Plan issued in July 2006 provides that CMS will issue guidance and that the Division of Field Operations will identify best practices guidance. Providers and their counsel should expect a much higher level of scrutiny with respect to providers' billings to and payments from the Medical Assistance Program. Likewise, providers should be prepared to adopt a compliance program that meets the requirements of the new statute and to offer to the Office of the Medicaid Inspector General evidence of such compliance program at the appropriate time.

In order to be adequately prepared to implement and comply with the new requirements, providers should consider putting into place internal controls and audit mechanisms. In particular, they should evaluate areas within their organization where fraud and abuse are likely to occur such as: the procurement of managed care contracts, marketing, enrollment and disenrollment, underutilization, claims submission and billing procedure, embezzlement, and theft. With the influx of millions of dollars to fund the policing and enforcement of the Medical Assistance Program, the enhancements to existing federal programs, the establishment of the new federal Medicaid Integrity Program and the new authority for the Medicaid IG in New York State, such internal controls will assist providers in achieving the ability of more closely monitor compliance efforts and prevent compliance violations in the evolving Medicaid fraud enforcement environment.

1. http://www.cms.hhs.gov/DeficitReductionAct/.
2. Section 6034(a) of the Deficit Reduction Act of 2005.
3. Id.
4. CMIP July 2006, page 17.
5. Id.
6. Section 6034(a) of the DRA.
7. Section 6034(c) of the DRA.
8. Section 6034(d) of the DRA.
9. See A12015, 229th Ann. Leg. Sess. (June 23, 2006) (identical to S8450) (N.Y. 2006).
10. Id. at §1.
11. Id. at §3.
12. Id. at §4.
13. Id.
14. Id.
15. Id.
16. Id. at §14.
17. Id. at §4.
18. Id. at §6.
19. Id. at §8.
20. Id. at §9.
21. "Health plan" is defined as any publicly or privately funded health insurance or managed care plan or contract under which any health care item or service is provided, and through which payment may be made to the person who provided the health care item or service. The New York State's Medicaid Program is considered a single health plan for these purposes.

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