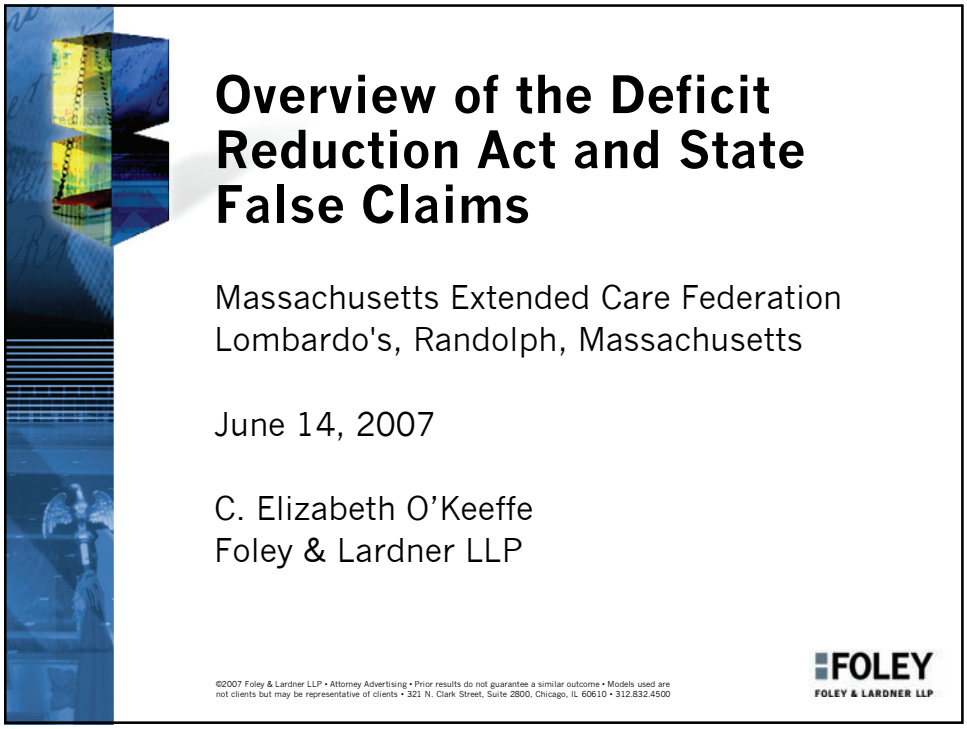

Overview of the Deficit Reduction Act and State False Claims

Massachusetts Extended Care Federation
Lombardo's, Randolph, Massachusetts

June 14, 2007

C. Elizabeth O'Keeffe
Foley & Lardner LLP

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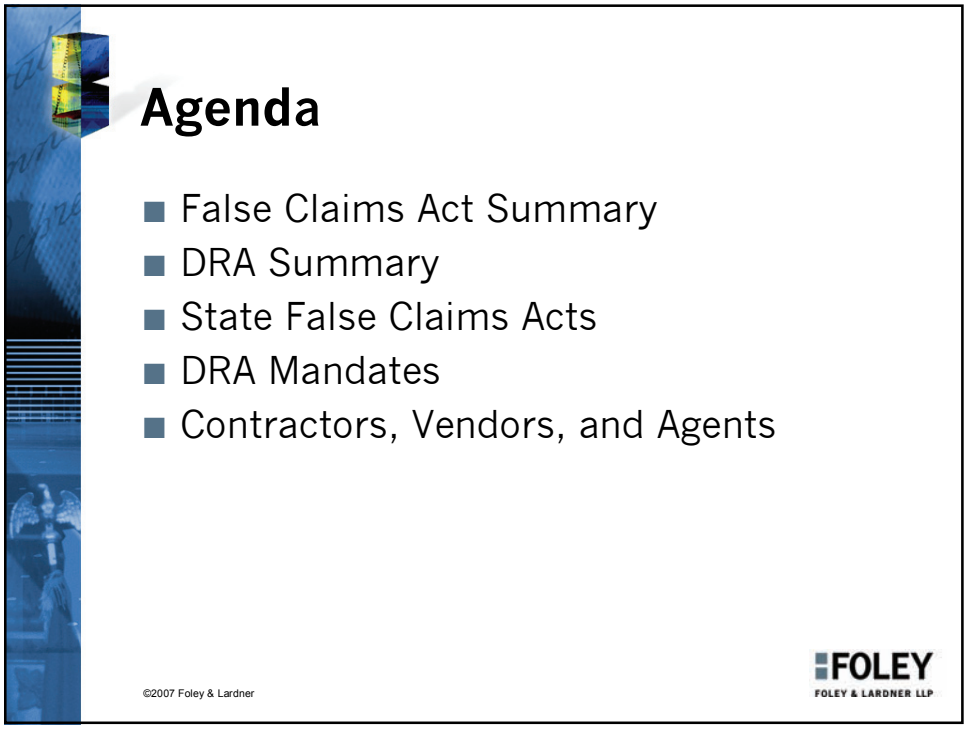

Agenda

- False Claims Act Summary
- DRA Summary
- State False Claims Acts
- DRA Mandates
- Contractors, Vendors, and Agents

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Focus on Medicaid

- Medicaid is the largest health insurance program in the US.
- It is jointly funded by Federal and state governments.
- Federal contribution in Fiscal Year 2004 topped $176 billion and is expected to exceed $193 billion in Fiscal Year 2007.

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Focus Continued…

- In Fiscal Year 2004, Medicaid covered 43.7 million low-income children and adults and expected to exceed 46 million in Fiscal Year 2007.
- Bottom line = Medicaid spending, which grew 7.7% alone last year.
- Fraud and abuse enforcement is aimed at containing the rise in Medicaid spending.

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Examples of Medicaid Fraud

- Billing for services not rendered.
- Billing for undocumented services.
- Double billing for items or services.
- Making false statements.
- Participating in kickbacks.
- Including improper entries on cost reports.
- Billing for medically unnecessary services.
- Assigning incorrect codes to secure higher reimbursement.
- Poor quality

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Federal False Claims Act (31 USC § 3279)

- Federal statute that covers fraud involving any Federally funded contract or program (i.e., Medicare/Medicaid) and establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

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False Claims Act Liability

- Subject to Civil monetary penalties (CMP) ranging from $55,000 to $11,000 for each false claim submitted.
- In addition to the CMP, can be required to pay three times amount of damages sustained by U.S. government.
- Office of Inspector General (OIG) may seek to exclude the provider or supplier from participation in Federal health care programs.

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Qui Tam "Whistleblower" Provisions

- Purpose = to encourage people to come forward and report misconduct involving false claims.
- Allows any person (with actual knowledge of allegedly false claims) to file a lawsuit on behalf of the U.S. government.
- Persons often referred to as "relators."

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No Retaliation

- The False Claims Act also grants relators protection from retaliation from employers for filing a lawsuit or assisting (i.e., providing testimony) in a False Claims Act action.
- Relief may include: employee reinstatement, back pay, or any other damages arising from retaliatory conduct.

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DRA Summary

- Signed by President Bush on February 8, 2005
- Establishes a federal Medicaid Integrity Program
- Provides increased Medicaid enforcement funding for states (100 new federal FTEs; Texas from 37 ->200)
- Increases audit initiatives, and state-federal collaboration
- Provides incentives to states to have state False Claims Acts (FCA)
- Provides funding for data sharing between Medicare and Medicaid
- Requires recipients of $5 Million or more in Medicaid funds to implement certain requirements

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State False Claims Acts

- Incentive for states to adopt FCA modeled after the Federal FCA
- 10% of Federal share of any recovery of Medicaid funds litigated under qualifying state FCA
- Examples (Bayer 1&2, GSK, Pfizer and TAP)
  - California - $8.9 Million
  - New York - $9.5 Million
  - Texas - $7.4 Million
- Section 6032 of the DRA specifically outlines four requirements for a state to be FCA compliant

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State FCA Requirements

- Section 6032 of the DRA specifically outlines four requirements a state FCA must meet to be compliant:
  - The law establishes liability to the state for false or fraudulent claims described in [the federal FCA] with respect to any expenditure described in [Title 19, the Medicaid Program];
  - The law contains provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in [the federal FCA];
  - The law contains a requirement for filing an action under seal for 60 days with review by the State Attorney General; and
  - The law contains a civil penalty that is not less than the amount of the civil penalty authorized by [the federal FCA].

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OIG Review of State FCAs

- The OIG invited States to request OIG's review of State laws to determine if the laws meet the requirements of additional 10% incentive.
- Specific State Laws Reviewed by OIG:

- California
- Florida
- Hawaii
- Illinois
- Indiana
- Louisiana
- **Massachusetts (Approved)**
- Michigan
- Nevada
- Tennessee
- Texas
- Virginia

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Additional State Requirements

- DRA also requires states to amend their state Medicaid Plans
- The state Medicaid plan addresses the areas of state program administration, Medicaid eligibility criteria, service coverage, and provider reimbursement.
- The official plan is a hard-copy document that includes a range of materials in different formats, ranging from federally-defined "preprint" pages on which states check program options to free-form narrative describing detailed aspects of state Medicaid policy.
- Thus far, according to CMS, only Idaho, Kansas, Kentucky, Virginia and West Virginia have amended their State Plans

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Mandates in the DRA

- Entities that receive $5 million or more in Medicaid reimbursement, as a condition of payment, shall:
  - (A) Establish written policies for all employees of the entity and any **contractor or agent** of the entity, that provide detailed information on:
    - The Federal False Claims Act;
    - Administrative remedies;
    - Any state laws pertaining to civil or criminal penalties for false claims and statements;
    - Whistleblower protections;
    - The role of such laws in preventing and detecting fraud, waste and abuse.

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Mandates in the DRA, cont.

- Entities that receive $5 million or more in Medicaid reimbursement, as a condition of payment, shall:
  - (B) Include, as part of such written policies, information regarding the entities policies and procedures for detecting and preventing fraud, waste and abuse; and
  - (C) Include in any employee handbook for the entity, a specific discussion of the laws described in (A) above, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste and abuse.
- Please note that amendments to State Medicaid Plan and/or state False Claims Acts may require additional action steps or the adoption of specific language

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CMS Issues Further Guidance, or Do They?

- "It is the responsibility of each entity to establish and disseminate written policies which must also be adopted by its contractors or agents." However, the next sentence then states that the policies must be "readily available" to the contractors.
- The previously-quoted language suggests that the new policies must be "adopted" by the contractors and agents. It is not clear what such "adoption" must entail, particularly for contractors that work with multiple entities. It is difficult to see how the entities are expected to enforce a contractor's adoption of such policies - and nowhere in the text of Section 6032 is such adoption mandated.
- CMS limited the application of the Section 6032 to three categories of contractors. "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 health care items or services, **performs billing or coding functions**, or is involved in monitoring of health care provided by the entity."
- The letter is silent on any duty to undertake "education" of employees or contractors. Not mandating education is consistent with the straightforward reading of the statute that no special education efforts are required under Section 6032.

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CMS Issues Further Guidance, or Do They?

- March 22, 2007 Guidance
- Establish policies for contractors' and agents' employees
- Contractors include physicians and supply vendors, even if the contract has not been reduced to writing
- No requirement (yet) to amend services contract language
- Electronic form allowed
- States may require specific language or compliance actions

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Contractors, Vendors and Agents

- CMS defined contractor to include any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs **billing or coding functions**, or is involved in monitoring of health care provided by the entity."

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DRA: Open Issues

- Promote internal reporting
- CMS providing mixed messages
- Field response has been varied
- No guidance on adoption of policies
- How to disseminate to/from vendors and contractors?
  - Oversight issues
  - Educating about other entities policies
- Uncertain universe of contractors
- Onus on states to provide further guidance
- Compliance date; no uniform response

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Helpful Links

- Text of the DRA: http://thomas.loc.gov/cgi-bin/query/D?c109:5:./temp/~c109AE40Ay::
- OIG's State False Claims Acts Review: http://www.oig.hhs.gov/fraud/falseclaimsact.html
- CMS Deficit Reduction Act Resources: http://www.cms.hhs.gov/DeficitReductionAct/
- Civil False Claims Acts/Qui Tam Resources http://www.ffhsj.com/quitam/cfc.htm
- Taxpayers Against Fraud http://www.taf.org/
- **Text of Massachusetts FCA: http://www.oig.hhs.gov/fraud/docs/falseclaimsact/Massachusetts.pdf**

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