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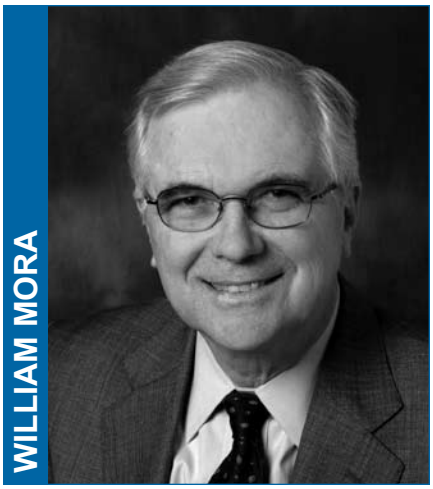
Medicare and Medicaid enforcement: The planned surge

William Moran; Rita Isnar, JD; and Sessily Watt



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Not since Richard Kusserow, former Inspector General (IG) of Health and Human Services, redirected the resources of the Office of the Inspector General (OIG) from welfare to health care has there been such a major shift in Medicare/Medicaid enforcement as is occurring today. The planned surge in enforcement, being implemented now, will be particularly noticeable to providers in 2008.

This article will address what some of the basic problems were with Medicare (Part A and B) and Medicaid enforcement in the past; what major administrative and legislative initiatives are currently being implemented; what future enforcement efforts will look like; and what significant impact these changes may have on health care providers.

Previous and current environment

Medicare's fiscal agents did not have the resources or incentives to properly address fraud and abuse issues, and Medicaid fraud efforts were dependent on State initiatives.

Medicare. At the onset of the Medicare program, Medicare's fiscal agents were not well structured for oversight and enforcement initiatives. The Fiscal Intermediaries (FI) and the Carriers had inadequate budgets to process bills and to ensure that bills were for medically necessary services or otherwise devoid of fraud. A number of edits were utilized and efforts were made to process bills appropriately, but Medicare's fiscal agents were not sufficiently funded or organized to properly address fraud and abuse issues. In addition, because of conflict-of-interest concerns with the FI and Carriers, CMS created Program Safeguard Contractors to focus on fraud and abuse initiatives and redirected the Quality Improvement Organizations (QIO) to focus on aberrant providers and quality-of-care issues.

Given the concerns associated with Medicare fraud and abuse, Medicare was authorized by provisions of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) to contract with other agents to process provider claims. Medicare has begun to implement this new contracting strategy by selecting new claims processing agents called Medicare Administrative Contractors (MAC). The initiative for change also includes a new consolidated Program Safeguard Contractor strategy driven by the fact that Congress has become accustomed to getting more than $11 return on investment for every dollar they appropriate for fraud and abuse activities. Congress knows there is a lot of fraud, waste, and abuse and wants to retrieve as much of the overpayments as they can.

Medicaid. Historically, Medicaid enforcement of fraud, waste, and abuse issues has been the responsibility of state agencies and largely dependent on state initiatives. As such, Medicaid enforcement has remained uncharted territory for the federal government. The OIG and others at the federal level did not want to intervene in State matters on Medicaid issues, so they relied predominantly on Medicaid Fraud Control Units to handle fraud and abuse at the State level. In the past, there were no federally led Medicaid enforcement initiatives. State-led initiatives include Program Integrity Units, State Auditors, Comptroller or IG, and the Medicaid Fraud Control Units. These will be discussed in greater detail below.

In response to reports that the cost of Medicaid is estimated to overtake Medicare, the Deficit Reduction Act of 2005 (DRA) enabled the Centers for Medicare and Medicaid Services (CMS) to develop and implement its first national strategy in the program's history to detect and prevent Medicaid fraud and abuse. The Center for Medicaid and State Operations (CMSO) within CMS has been directed to carry out the major responsibilities under this new program.

Future status

Medicare and Medicaid providers will experience much closer scrutiny under new Federal initiatives addressing fraud and abuse concerns.

Medicare. This new major administrative shift of selecting MACs will replace both the FIs and Carriers as the primary source of payment for providers. For the first time, a single Medicare contractor will be processing both Medicare Part A and Part B claims. They will also be strengthened by several functional contractors. Four different functional contractors will assist and feed information into the MACs.

- **Enterprise Data Centers** (EDC) will house claims-processing software systems for Medicare claims. The EDC is consolidating the large number of data centers currently servicing Medicare Fee-For-Service contractors.
- **Health care Integrated General Ledger and Account System** (HIGLAS) is the new general ledger accounting system that will replace the Contractor Administrative Budget and Finance Management System, also known as CAFM. Where possible, the transition to the HIGLAS accounting system is aligned to the MAC implementation schedule to avoid having the MAC use multiple systems in reporting and tracking financial data.
- **Beneficiary Contact Center** (BCC) is assuming the duties traditionally held by FI and Carriers. In the BCC environment, beneficiaries have a single Medicare point of contact – a 1-800-MEDICARE call center operated by CMS that will connect them to a seamless network of customer service entities that can answer Medicare and related questions and resolve problems.
- **National Medicare Banking Contractor** will provide reimbursement to MACs to cover all costs incurred in the administration of the Medicare program and for the payment of all checks/electronic funds transfer items presented to the Bank for covered Medicare services.

MACs will also be coordinating activities with four entities that will be dealing directly with Medicare providers. These four entities are:

- **Program Safeguard Contractors (PSCs)** perform functions to ensure the integrity of the Medicare Program, such as identifying outlier patterns and other claims data abnormalities that suggest possible fraud and abuse. Each MAC will interact with one PSC to handle fraud and abuse issues within their jurisdiction.
- **Quality Improvement Organizations (QIOs)** review complaints about the quality of healthcare services given to Medicare beneficiaries and certain appeals determinations of services. Such reviews would include cases from acute care hospitals to ensure that care was medically necessary, provided in an appropriate setting, and coded correctly.
- **Qualified Independent Contractors (QICs)** are responsible for conducting the second level of appeals, after the first level of appeal by the MAC. A QIC task order in September 2006 established three jurisdictions (north, south, and durable medical equipment [DME]) to review appeals.
- **Recovery Audit Contractors (RACs)** are responsible for identifying overpayments and underpayments made to health care providers that were not identified through the claims payment efforts. RACs will be paid on a percentage basis of the identified overpayments. Four RAC jurisdictions will cover the country. RACs will begin operations in March 2008.

Medicaid. The OIG and CMS initiatives for Medicaid audits and enforcement efforts to curtail fraud and abuse are on the rise. The future of Medicaid enforcement will be greatly impacted by various factors. The following includes a number of factors that will lead to heightened Medicaid integrity scrutiny:

- **OIG Federal Investigators, Auditors, and Contractors:** Under the Deficit Reduction Act of 2005, OIG was allotted an additional $25 million annually from FY 2006 to FY 2010 to expand its Medicaid enforcement and fraud activities.[1]
- **CMS:**
  - **Medicaid Integrity Program (MIP)** was created by the DRA to promote the integrity of the Medicaid Program. A five-year plan for the program was issued in 2006, and a revision was issued in 2007 that detailed the steps CMS has taken in the planning and implementation of the program.[2]
  - **Medicaid Integrity Group (MIG)** currently in its planning stage,

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is a part of the MIP. It will have two functions: Medicaid Integrity Contracting performed by the Medicaid Integrity Contractors (MICs); and State Program Integrity Operations, described as "effective support and assistance to states to improve overall Medicaid integrity activities and provide oversight of state Medicaid integrity programs."[3] CMS has currently hired 28 staff members for the MIG, with a proposed total of 79 full time staff members.

- **Medicaid Integrity Contractors (MICs)** will be involved in auditing Medicaid claims and identifying overpayments.[4] A Sources Sought/Request for Information for the Medicaid Integrity Contractors was published on November 22, 2006, and a Request for Proposals was published in July 2007. The auditing protocols and the selection process for the MICs is currently under development. The MICs are scheduled to start their audits in the spring of 2008.

- **Payment Error Rate Measurement (PERM) auditors** measure improper payment in Medicaid and the State Children's Health Insurance Program (SCHIP) in three areas. The PERM initiative was created to measure improper payments in Medicaid to fulfill requirements of the Improper Payments Information Act of 2002. The three contractors are Livanta, the documentation/database contractor; HealthData Insights, the review contractor; and Lewin Group, the statistical contractor. Working in tandem, these three contractors determine error rates on both state and national levels.[5] They do not collect overpayments, but they will report the overpayments they identify to the state, which is required to collect overpayments from the provider.[6] "Under PERM, states will be expected to ultimately reduce their payment error rates over time by better targeting program integrity activities in their Medicaid and SCHIP."[7]

- **State Efforts**
  - **Single State Agency: Program Integrity Unit** is focused on promoting the integrity of Medicaid through preventive measures, as well as data reviews and evaluations. They can also be a point of contact for the Medicaid Fraud Control Unit. Such Program Integrity Units will continue their efforts.
  - **State Auditor, Comptroller, or Inspector General** may review, investigate, and recover funds from the operation of the state Medicaid program. Some states have recently developed dedicated Medicaid enforcement efforts. For example, New York has recently created the New York State Office of the Medicaid Inspector General lead by James G. Sheehan, former U.S. Attorney. Other states such as Texas and Georgia have also developed specific Medicaid Inspectors General, in addition to pre-existing MFCUs.
  - **Attorney General Medicaid Fraud Control Units (MFCUs)** investigate and prosecute cases of Medicaid fraud. The MFCUs are funded by the OIG, but are administered by the state. In the majority of states, the MFCU is located within the Attorney General's office.[8] MFCUs have varying degrees of sophistication, activity, and available resources.
  - **False Claims Acts** Section 6031 of the DRA and Section 1909 of the Social Security Act provide financial incentives for states to enact False Claims Acts (FCA) that establish liability to the state for submitting false or fraudulent claims to a state's Medicaid program. If a state FCA is determined to meet certain requirements, the state is entitled to a 10% increase in its share of any amounts recovered under a state action brought under such law. For states to qualify for the incentive, the state must have in effect a law that meets four applicable requirements.[9] The OIG is required to determine, in consultation with the Attorney General of the United States, whether a state has in effect a law that meets applicable requirements relating to false or fraudulent claims submitted to a state Medicaid program. The OIG published guidelines for reviewing state FCAs that invited states to determine if their laws meet the requirements of section 1909(b) of the Social Security Act.[10] At this time, the OIG has reviewed 13 state False Claims Acts. The FCAs of New York, Nevada, Texas, Hawaii, Virginia, Illinois, Massachusetts, and Tennessee have been approved by the OIG.

However, California, Michigan, Louisiana, Indiana, and Florida failed to meet OIG expectations for FCAs and will remain ineligible for additional monies unless their laws are amended.

Impact on providers

Three fairly obvious results of this surge of activity surround Medicare and Medicaid integrity issues:

1. **Increased number of audits:** The chances of being audited by either a state or federal oversight entity will be much greater in the months and years to come. While the state and federal enforcers are supposed to be coordinating site visits, providers could be faced with both federal and state contractor reviews and audits.
2. **State and federal auditors will have better data:** The information and data files available to state and federal auditors will be qualitatively better and timelier. An increased effort has been made to exchange Medicare and Medicaid data, and the new systems at the MACs will produce more useful provider and patient-specific information than the current FI and Carrier data.
3. **Providers need to prepare:** The fact that state and federal regulators will have more useful information – and will visit more providers – suggests a greater need and urgency for providers to review and update, or possibly upgrade, their compliance program efforts to monitor and audit regulatory compliance. The various state and federal healthcare laws, passed in the previous five years, will demand increased risk-assessment oversight efforts on the part of boards, executives, and compliance officers at various healthcare providers. The planned government contracting changes will soon be fully implemented and will be using provider's historical claims data for overpayments and fraud and abuse analysis. It is imperative that providers take action today to strengthen their compliance with these government rules and regulations and monitor internal controls to safeguard provider revenue cycle exposure. ■

1 Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program, June 2006, Page 7.
2 The Comprehensive Medicaid Integrity Plans for June 2006 and August 2007 can be accessed at http://www.cms.hhs.gov/DeficitReductionAct/02_CMIP.asp.
3 Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program, August 2007, page 4.
4 Ibid. .
5 http://www.cms.hhs.gov/PERM/03_permprocess.asp#TopOfPage
6 PERM Second Interim Final Rule, FR/Vol 71, No.166/Monday (August 28, 2006).
7 Testimony Before the Subcommittee on Federal Financial Management, Government Information, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate United States Government Accountability Office, Medicaid Integrity Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud, Waste, and Abuse. Statement of Leslie G. Aronovitz, Director, Health Care. (March 28, 2006).
8 OIG State Medicaid Fraud Control Units Annual Report, Fiscal Year 2006.
9 See http://www.oig.hhs.gov/fraud/falseclaimsact.html for a brief summary on state False Claims Act requirements for OIG approval.
10 On August 21, 2006, OIG published a notice in the Federal Register (71 FR 48552 PDF) that sets forth OIG's guidelines for reviewing state False Claims Acts.

Be Sure to Get Your CHC CEUs

Inserted in this issue of **Compliance Today** is a quiz related to this article: "Mandatory rules for reporting medical errors, adverse events, near misses, and device failures" by Michael A. Morse beginning on page 4.

To obtain your CEUs, take the quiz and print your name at the top of the form. Fax it to Liz Hergert at 952/988-0146, or mail it to Liz's attention at HCCA, 6500 Barrie Road, Suite 250, Minneapolis, MN 55435. Questions? Please call Liz Hergert at 888/580-8373.

Compliance Today readers taking the CEU quiz have ONE YEAR from the published date of the CEU article to submit their completed quiz.

CMS Posts Advisory Opinion on Physician Self Referral

On October 3, 2007, CMS posted advisory opinion CMS-AO-2007-01. It concerns whether a recruitment arrangement would meet the requirements of the exception set forth in section 1877(e)(5) of the Social Security Act and 42 C.F.R. § 411.357(e) if the income guarantee loan agreement portion of the arrangement was modified after the inception of the arrangement to eliminate an excess receipts provision. The advisory opinion may be found at: *http://www.cms.hhs.gov/PhysicianSelfReferral/07_advisory_opinions.asp*

OIG Issues Advisory Opinion No. 07-12

This Advisory Opinion oncerns two proposals to accept low or no-cost bids for the provision of therapy services at state-operated veterans' homes. More: *http://oig.hhs.gov/fraud/docs/advisoryopinions/2007/AdvOpn07-12G.pdf*

CMS Project Finds Bed Sores Can Be Prevented

On October 22, 2007, the Centers for Medicare & Medicaid Services announced that a diligent and sustained focus on preventing serious bed sores in nursing home residents was remarkably effective according to the results of a project the agency sponsored. For more: *http://www.cms.hhs.gov/apps/media/press_releases.asp*

NY Nurses Charged with Medicaid Fraud

On October 17, 2007, *WSTM* reported that three home care nurses are charged with bilking the Medicaid system for nearly $200,000 in fraudulent claims.

The three defendants allegedly billed Medicaid for the care of their patient during times when they were out of the country on vacation, when the patient was receiving care from her parents, and when the patient was in the care of another nurse. For more: *http://www.wstm.com/Global/story.asp?S=7226737*

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