Federal Fraud and Abuse Enforcement Efforts Get Kicked Up a Notch, but Will It Be a Wash?

Frank W. Dawkins, J. D., LL.M. candidate

The federal government’s seriousness in rooting out fraud and abuse in the federal health care programs, especially Medicare and Medicaid, cannot be doubted, even though the numbers clearly demonstrate that fraud and abuse are but a tiny fraction of the total outlay of federal health care dollars annually.

The U. S. Department of Health and Human Services and Department of Justice Health Care Fraud and Abuse Control Program (HCFAC) Annual Report for Fiscal Year 2005, rendered in August 2006, reports that for FY 2005 (October 1, 2004 through September 30, 2005), the Medicare Trust Fund received transfers of nearly $1.55 billion during this period as a result of fraud and abuse enforcement efforts, plus $63.6 million in federal Medicaid funds transferred to the Centers for Medicare and Medicaid Services (CMS). The HCFAC has returned over $8.85 billion to the Medicare Trust Fund since its inception from FY 1997 – FY 2005, a nine year period, or a little less than $1 billion per year.¹

Contrast these numbers with the following: in 2005, Medicare alone spent $336.4 billion in beneficiary claims, total outlays for Medicaid (federal and state) were $317.7 billion and for SCHIP $7.3 billion, for a total of $661.4 billion.² The total enforcement recovery for FY 2005 compared to the federal health care dollars spent in FY 2005 amounted to .24%. Even if one assumes that only one fourth of all fraud and abuse actually committed was recovered through civil and criminal enforcement efforts, and quadrupled the amount actually recovered, that sum would constitute approximately $6 billion or roughly 1% of the total federal health care dollars expended over the same time period. Despite this compelling evidence that fraud and abuse are not major factors in causing federal health care costs to rise, the federal government has committed to increasing its efforts to combat fraud and abuse in the federal Medicare and Medicaid programs.

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) authorized the establishment of the HCFAC Program under the joint direction of the Attorney General and the Office of Inspector General (OIG) of DHHS.³ At the same time, HIPAA authorized the establishment of the Medicare Integrity Program within HCFAC under CMS.⁴ The Medicare Integrity Program goal was to reduce payment errors and protect and strengthen the Medicare Trust Fund, including anti-fraud efforts to improve payment

³ 42 U. S. C. Section 1320a-7c.
⁴ 42 U. S. C. Section 1395ddd.
The larger goal of HCFAC jointly directed by DOJ and OIG was to coordinate federal, state and local law enforcement efforts in combating fraud and abuse. Additionally, in 1998, the Medicare Incentive Reward Program (IRP) was created under the authority of HIPAA to encourage others to report information on individuals and entities that were engaged in or had engaged in illegal acts that constituted grounds for imposition of sanctions under Sections 2238A or B, or otherwise engaged in sanctionable fraud and abuse against the Medicare program under Title XI of the Social Security Act.

While these programs were implemented at the same time under the authority of HIPAA to aggressively pursue fraud and abuse in the Medicare program, none of them mandated major provider participation in educating employees, contractors and agents to spot and report fraud and abuse as a condition for continued participation in Medicare. Rather, these programs emphasized government’s efforts by such means as effective enrollment of providers, voluntary education of physicians, providers, suppliers and beneficiaries, early detection through Medical Review and data analysis, coordination with “partners” including contractors and law enforcement agencies, fair and firm enforcement policies, and voluntary reporting of fraud and abuse.

The Deficit Reduction Act of 2005 (DRA) mandated a significant shift in the government’s fraud and abuse enforcement efforts. Section 6031 of the Act created a major incentive for states to enact state civil false claims acts similar to the Federal False Claims Act, 31 U. S. C. 3729-3732, in the form of permitting states to keep an additional 10% of any recovery made as a result of fraud and abuse claims arising under a state Medicaid program.

The DRA, however, takes the government’s fraud and abuse enforcement efforts, in its own words, “to a new level.” Section 6032 mandates, in pertinent part, that

“any entity that receives or makes annual payments under the State [Medicaid] plan of at least $5,000,000, as a condition of receiving such payments, shall—
(A) establish written policies for all employees of the entity (including management) and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under Sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and
statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f));

(B) include as part of such written policies, detailed provisions regarding the entity’s 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 subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse.”

As a practical matter, this mandatory obligation will impact not only large institutional providers such as major hospitals, large nursing home corporations that house Medicaid residents, major pharmaceutical corporations and major durable medical equipment suppliers, but also smaller providers such as rural hospitals, especially ones designated by Medicare as “critical access hospitals,” some with as few as 25 beds. According to Mr. Gordon Rountree, Jr., general counsel and chief compliance officer for Lafayette General Medical Center in Lafayette, Louisiana, a 296-bed, tertiary full service non-profit community hospital, many of these smaller rural hospitals likely receive more than $5 million annually from State Medicaid plans and will have to comply with the DRA’s education requirement.

It is also not clear from the statute whether a provider that receives more than $5 million annually from various State Medicaid plans but not more than $5 million from any one State’s plan would be required to comply with this section of the DRA. However, this $5 million threshold will most likely exempt individual physicians and most physician group practices from complying with this provision of the DRA.

Hospitals and other qualifying entities are required to instruct their staffs, physician and health care contractors, hospital suppliers, and their own management about the federal False Claims Act, that particular State’s False Claims Act, administrative remedies for false claims under federal law, federal or state criminal penalties for false claims, and “whistleblower” protection afforded under these laws, including the purpose of such laws in preventing and detecting fraud, waste and abuse in federal health care programs. Covered entities must also set forth their own written policies for detecting fraud, waste and abuse. Finally, covered entities that have employee handbooks must include specific discussion of fraud and abuse laws, the rights of employees to protection as a whistleblower and the covered entity’s procedures for detecting fraud, waste and abuse.

11 Id.
12 Interview with Gordon Rountree, Jr., General Counsel and Chief Compliance Officer, Lafayette General Medical Center, in Lafayette, LA (Mar. 13, 2007).
Section 6034 of the DRA establishes the Medicaid Integrity Program and commits 100 full time federal employees to this effort to assist the States in preventing and detecting Medicaid fraud. Beginning in FYs 2007 and 2008, the law appropriates $50 million each year to implement the Medicaid Integrity Program, and thereafter $75 million for each succeeding fiscal year through 2010. Additionally, the DRA provides an additional $25 million annually to OIG to assist its Medicaid fraud and abuse enforcement efforts. Given that only $63.6 million in civil and criminal enforcement recovery funds was transferred to CMS in FY 2005, one has to wonder whether this intensified effort will result in greater amounts of recovery to justify these significantly increased enforcement costs.

On the Medicare enforcement side, as noted by the Kaiser Commission on Medicaid and the Uninsured, “even when funding grows to $75 million in fiscal year 2011, the annual new federal investment in the Medicaid Integrity Program will be roughly one-tenth of what the federal government currently invests annually in the Medicare Integrity Program.” Indeed, according to DHHS, “(p)roposed FY 2007 total HCFAC [Health Care Fraud and Abuse Control] funding is $1.2 billion.” Contrast that with the reported recovery of $1.55 billion in FY 2005 transferred to the Medicare Trust Fund from fraud and abuse enforcement efforts, and it is readily apparent that the cost of enforcement is just paying for itself on the Medicare side.

What is it going to cost qualifying providers to comply with the newly mandated education requirement that went into effect on January 1, 2007? The government is not reimbursing these providers for their compliance efforts in order to be eligible for continued participation in the Medicaid program, which historically has among the lowest reimbursement rates of any federal health care program. Since this mandated obligation just took effect barely two months ago, cost estimates for the industry are not currently available. While larger providers who have established, comprehensive compliance programs will incorporate these mandated requirements at little additional cost, smaller providers such as the rural “critical access hospitals” that have only basic or no real compliance plans in place may incur significantly higher costs to ramp up their mandated DRA compliance.

Will this huge enforcement apparatus assembled by the government to police fraud and abuse in the Medicare and Medicaid programs, a veritable army of acronyms, proceed with the usual bureaucratic inefficiency and glacial pace to merely justify its existence by barely recovering what it costs to operate, or will it truly step up its efficiency and have its Comprehensive Medicaid Integrity Plan “degenerate into hard work” and yield in recovery efforts, perhaps, double what it currently costs to operate? That would be

17 Interview with Gordon Rountree, Jr., supra note 12.
18 DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES, COMPREHENSIVE MEDICAID INTEGRITY PLAN OF THE MEDICAID INTEGRITY PROGRAM – FY 2006-2010, 20
progress and might justify the added costs incurred by effected health care industry providers to comply with this new legal mandate, but I for one wouldn’t hold my breath.

March 2007

(July 2006), http://www.cms.hhs.gov/DeficitReductionAct/Downloads/CMIP%20Initial%20July%202006.pdf (quoting the late Peter Drucker: “Plans are only good intentions unless they immediately degenerate into hard work”); id. at 36, (providing a list of acronyms, including CMIP (Comprehensive Medicaid Integrity Plan), CMSO (Center for Medicaid and State Operations), DFO (Division of Field Operations), DFRD (Division of Fraud Research & Detection), DMIC (Division of Medicaid Integrity Contracting), MAPS (Medicaid Alliance for Program Safeguards), MFCU (Medicaid Fraud Control Unit), MIC (Medicaid Integrity Contractors), MIG (Medicaid Integrity Group), MIP (Medicaid Integrity Program), PERM (Payment Error Rate Measurement project), SPIA (State Program Integrity Assessment), and TAG (Technical Advisory Group)).