

Section 3

Medicaid

Medicaid Reform and the Deficit Reduction Act of 2005

A Medicaid Commission was formed in July 2005 to advise CMS on ways to modernize the Medicaid program to provide high-quality health care to beneficiaries in a financially sustainable way. The Commission was charged to submit two reports for consideration by the Secretary of CMS and submission to Congress. The first report due September 1, 2005, provided recommendations and options on achieving a \$10 billion savings in the program over the next five years. The second report is due December 31, 2006 and is to include long term recommendations on the future of the Medicaid program.

The Commission has met four times in 2006 (January, March, May and July) in preparation for the December report. Further information and minutes can be viewed at the [HHS website](#). Staff attended the meeting held in Washington, DC on July 11-12, 2006, which included a presentation by Dr. Alan Dobson, Assistant Secretary for Health Policy and Medical Assistance, North Carolina Department of Health and Human Services. Dr. Dobson, a long time member of the AAFP, presented on the success of the North Carolina Community of Care Network. The AAFP conducted a case study of this program for the use of constituent chapters in their reform efforts.

AAFP Policy on Medicaid:

[Medicaid Core Principles](#)

[Medicaid Services](#)

Medicaid Integrity Plan – Fraud and Abuse

As part of the myriad provisions of the Deficit Reduction Act (DRA), the Centers for Medicare and Medicaid Services (CMS) received new authority and support to oppose Medicaid fraud and abuse more stringently than efforts to date. The new DRA-enabled fraud and abuse efforts primarily will come through three means: encouraging states to adopt state-level False Claims Acts, adding 100 more auditors to the CMS payroll and hiring two contractors to pursue fraud, waste and abuse in Medicaid—the latter two falling under the rubric of the new Medicaid Integrity Program (MIP).

The Letter of the Law

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Among the DRA's fraud and abuse provisions was one encouraging states to adopt state-level False Claims Acts.



President Abraham Lincoln signed the Federal False Claims Act into law during the Civil War to combat the spread of war profiteering. Over the years the Act has expanded as the government expanded, now covering most business dealings with the Feds. The Act allows for prosecution and punishment for false, fraudulent, wasteful and/or abusive billing of the government for products and services through government contracts, as well as providing cover for the government to recover ill-got gains from violators.

States now are encouraged to use the Federal law as a general model for their own legislation. The DRA includes (in Section 6031) the provision that states implementing false claims acts and working with the US Department of Justice in prosecuting such claims shall receive an enhanced share of recoveries from those cases.

CO H 1359	SPONSOR: McFadyen [D] TITLE: False Claims Act DISPOSITION: Failed - Adjourned SUMMARY: Concerns creation of a false claims act; authorizes civil actions by the state, a political subdivision, or a private person against a person who submits a false claim to the state or a political subdivision; specifies penalties for submitting false claims; specifies requirements for each plaintiff and percentages of recoveries that may be awarded as attorney fees; prohibits an employer from preventing an employee from disclosing information related to a claim.
CT H 5205	INTRODUCER: Joint Cmte on Government Administration TITLE: Recovery Of Misappropriated State Funds DISPOSITION: Failed - Adjourned SUMMARY: Concerns recovery of misappropriated state funds; provides the state with a means to recover misappropriated state funds.
HI S 1799	AUTHOR: Menor [D] TITLE: Insurance Fraud Investigations Branch DISPOSITION: Failed - Adjourned SUMMARY: Establishes insurance fraud investigations branch. Establishes penalties. Authorizes whistleblower lawsuits.
HI S 2254	AUTHOR: Bunda [D] TITLE: Department of the Attorney General DISPOSITION: Failed - Adjourned SUMMARY: (Governor's Package Bill) Relates to the Department of the Attorney General.
KS H 2729	AUTHOR: Appropriations Cmt TITLE: False Claims Act DISPOSITION: Failed - Adjourned SUMMARY:



Provides for civil action against the submission of false claims to the State or to local Governments; provides for qui tam awards; enacts the Kansas false claims act.

- MN H 2254 COMPANION: MN S 1428
AUTHOR: Slawik [DFL]
TITLE: Operation of State Government
DISPOSITION: Failed - Adjourned
SUMMARY:
Relates to operation of state government; establishes the Minnesota False Claims Act; assesses penalties.
- MN S 1428 COMPANION: MN H 2254
AUTHOR: Wiger [DFL]
TITLE: Operation of State Government
DISPOSITION: Failed - Adjourned
SUMMARY:
Relates to operation of state government, and establishes the Minnesota False Claims Act. Assesses penalties.
- MO S 1210 SPONSOR: Koster [R]
TITLE: Medicaid Fraud
DISPOSITION: Failed - Adjourned
SUMMARY:
Authorizes individuals to sue for Medicaid fraud; modifies various provisions relating to the reporting and investigation of such fraud.
- MS H 170 AUTHOR: Moak [D]
TITLE: Health Care False Claims Act
DISPOSITION: Failed
SUMMARY:
Creates the Health Care False Claims Act; provides for subpoenas, limitations of actions and burden of proof.
- MS H 249 AUTHOR: Moak [D]
TITLE: Medicaid False Claims Act
DISPOSITION: Failed
SUMMARY:
Medicaid False Claims Act; create.
- NC S 2033 AUTHOR: Rand [D]
TITLE: Medicaid Fraud Private Civil Actions
DISPOSITION: Failed - Adjourned
SUMMARY:
Relates to Medicaid fraud; authorizes civil actions by private persons for violations of the provider false claims act; and to appropriate funds to the Department of Justice to implement this act.
- NJ A 2186 SPONSOR: Gusciora [D]
TITLE: New Jersey False Claims Act
DISPOSITION: Pending
SUMMARY:
Establishes the New Jersey False Claims Act.



NJ A 3025 SPONSOR: Conaway [D]
 TITLE: New Jersey Medicaid False Claims Act
 DISPOSITION: Pending
 SUMMARY:
 Establishes New Jersey Medicaid False Claims Act.

NJ A 3428 SPONSOR: Conaway [D]
 TITLE: False Claims Act
 DISPOSITION: Pending
 SUMMARY:
 Establishes the New Jersey False Claims Act.

NJ S 360 SPONSOR: Adler [D]
 TITLE: False Claims Act
 DISPOSITION: Pending
 SUMMARY:
 Establishes the New Jersey False Claims Act.

NJ S 1829 SPONSOR: Vitale [D]
 TITLE: Medicaid False Claims Act
 DISPOSITION: Pending
 SUMMARY:
 Establishes New Jersey Medicaid False Claims Act.

NY A 8107 SAME AS: NY S 3895
 SPONSOR: Weinstein [D]
 TITLE: Definition of False or Fraudulent Claim
 DISPOSITION: Pending
 SUMMARY:
 Defines false and/or fraudulent claim against the state; authorizes individual with knowledge of such claim to sue on behalf of the state and share in the recovery; provides that the state may join in a claim and move to dismiss original plaintiff; provides that the state is not liable for action of such plaintiff; provides reward for report of certain fraudulent acts.

NY A 10257 SPONSOR: Rules Cmt
 TITLE: Health and Mental Hygiene Budget
 DISPOSITION: Pending
 SUMMARY:
 Implements the health and mental hygiene budget for the 2006-07 fiscal year; relates to MEDICAID; relates to fraudulent claims; relates to EPIC coverage; relates to prescription drug retail price list; relates to payments to certain hospitals; relates to health care initiatives pool distribution; relates to anti-tobacco program; relates to indigent care; relates to excess medical malpractice; relates to nursing homes; relates to reproductive cloning; creates stem cell research.

NY A 11498 SPONSOR: Gottfried [D]
 TITLE: Office of The Medicaid Inspector General
 DISPOSITION: Pending
 SUMMARY:
 Establishes the office of the Medicaid inspector general, and providing for its powers and duties; designates such office as a qualified agency for the purposes of



criminal information; relates to the development and testing of new methods of Medicaid claims and utilization review to improve Medicaid fraud control and expenditure accountability and to create a provider compliance program.



NY S 3895	<p>SAME AS: NY A 5496, NY A 8107</p> <p>SPONSOR: Farley [R]</p> <p>TITLE: Definition of False or Fraudulent Claim</p> <p>DISPOSITION: Pending</p> <p>SUMMARY: Defines false and/or fraudulent claim against the state; authorizes individual with knowledge of such claim to sue on behalf of the state and share in the recovery; provides that the state may join in a claim and move to dismiss original plaintiff; provides that the state is not liable for action of such plaintiff; provides reward for report of certain fraudulent acts.</p>
NY S 5945	<p>SPONSOR: DeFrancisco [R]</p> <p>TITLE: New York State False Claims Act</p> <p>DISPOSITION: Pending</p> <p>SUMMARY: Creates the New York State False Claims Act; provides definitions; provides for liability for certain acts of defrauding the state; provides for qui tam civil actions; provides for compensation for report of insurance fraud to law enforcement authorities.</p>
SC S 1176	<p>AUTHOR: Malloy [D]</p> <p>TITLE: Fraudulent Claims</p> <p>DISPOSITION: Failed - Adjourned</p> <p>SUMMARY: Provides liability for false or fraudulent claims under certain circumstances, procedures for civil actions for false claims, the procedure and contents of civil investigative demands, and creating the state false claims act investigation and prosecution fund.</p>

The Auditor Centuria

The DRA allows CMS to hire 100 new employees to help the Centers detect and pursue fraud and abuse. CMS plans to pepper the new employees throughout the Federal Medicaid bureaucracy, with some reporting to regional CMS offices, some based in the CMS headquarters, some placed in the Office of the Inspector General and a few will go to an existing Medicare fraud and abuse program.

The Hired Guns

In addition to the 100 new auditors, CMS will hire two contractors to help it with audit program development (APD) and state program integrity assessment (SPIA). According to CMS, the APD contractor, "will be expected to design and develop a Medicaid payment integrity audit program and develop audit protocols, methodologies, and standards for MIP." Meanwhile the SPIA contractor's efforts, "will include surveying the [state Medicaid] landscape, identifying State program integrity baselines, and recommending performance metrics and standards against which States' performance may be measured in the future," as well as building a database to serve as a repository for all information gathered.



The Target

All, except for perhaps those guilty of such practices, agree that fraud and abuse in Medicaid is a bad thing. The MIP—funded at \$75 million annually—aims at four initial focus areas:

- nursing and personal care such as fraud related to long term care facilities and home health agencies;
- the provision of prescription drugs to beneficiaries and the underlying costs of those drugs as reported to the States;
- durable medical equipment and other medical suppliers; and
- improper claims for payment from hospitals and individual practitioners.

Based on the Medicaid reform debate leading up to the passage of the DRA, combined with a consideration of the language in the MIP initial report (particularly discussions of “oversight” of the states) and the first aforementioned focus of long-term care, intergovernmental transfers may also be an *a priori* target.

The MIP hints at an attempt to go after the “low-hanging fruit” in fraud and abuse recovery. However, how CMS pursues it is worth continued attention. A portion of the MIP is based upon the Medi-Medi program. Since Medi-Medi’s inception in California in 2001, some 335 investigations resulted in 42 referrals to law enforcement.

CMS stated in its initial MIP report that “quality of care” will be a consideration in the combat of fraud and abuse. Family physicians should continue to work with CMS to inform that agency of the need for personal care plans developed by patient and physician with the medical home. Though it is unlikely that individual physicians will have auditors banging down their doors looking to review all records with a fine-tooth comb, family physicians should continue to strengthen their billing practices and heed forthcoming CMS advisories.

Medicare Part D and Clawback

A joint lawsuit filed by the states of Kentucky, Main, Missouri, New Jersey in March 2006 asked the Supreme Court to issue an injunction against the Medicare Modernization Act. The lawsuit challenged a provision of the law creating the prescription drug benefit – better known as the claw back – in which states would be required to pay the federal government most of the money they are expected to save because they no longer must pay for drugs for people in state Medicaid programs who are also enrolled in Medicare. In June 2006, the justices declined without comment to temporarily halt the drug benefit from Medicare stating the dispute belongs in a lower court, not the Supreme Court.

