

Deficit Reduction Act Heightens Corporate Compliance Requirements for Medicaid Providers

by Andrew E. Blustein and Stacey L. Gulick

The federal Deficit Reduction Act of 2005 (DRA),¹ which was signed into law on Feb. 8, 2006, includes a mandatory provision that all entities receiving annual Medicaid payments of at least \$5 million (Medicaid providers) must have in place various policies and procedures that address prevention of fraud, waste and abuse. As the largest health benefit program in the United States, Medicaid, which is jointly funded by federal and state programs, has seen a tremendous growth in payments over the last few years, but still lacks federal oversight of the individual state program safeguards.

In order to address this concern, the federal government, under DRA, is requiring states to ensure their Medicaid providers adopt compliance programs to prevent and combat Medicaid fraud and abuse. In addition, the DRA offers financial incentives to states that enact laws relating to false or fraudulent claims that, among other things, contain provisions for rewarding and facilitating *qui tam*² actions in a manner that is at least as effective as the same provisions under federal law.³

Although the U.S. Department of Health and Human Services, Office of Inspector General (OIG), has for several years recommended voluntary compliance programs for hospitals (as well as other types of healthcare providers), the DRA is the first federal law to explicitly require Medicaid providers to implement a compliance program as a “condition of payment.” In particular, the DRA requires Medicaid providers to have, among other things, written policies for all employees, providing a detailed discussion of both federal and applicable state false claims acts and whistleblower protections.

The purpose of this article is to provide a summary of the basic elements of a corporate compliance program for a New Jersey Medicaid provider, taking into account the recommendations of the OIG, as well as the requirements of the DRA.⁴

Model Compliance Programs

No discussion of healthcare compliance programs would be complete without a review of the model compliance programs published by the OIG. Although the DRA has its own requirements, the OIG’s model programs have traditionally provided the framework for compliance programs. These model compliance programs are based upon the federal sentencing guidelines providing seven minimal requirements that have become the hallmarks of an effective compliance program.

Simply stated, a compliance program should include a discussion of the seven essential elements that demonstrate due diligence to prevent and detect criminal conduct and promote an organizational culture that encourages commitment to compliance with the law. These seven elements include:

1. standards and procedures to prevent and detect criminal conduct;
2. governing authority oversight of the implementation and effectiveness of the compliance program;
3. appropriate delegation of authority;
4. effective communication of standards through training and education, including training of the upper levels of the organization;

5. monitoring, auditing and reporting systems, including mechanisms that allow for anonymity or confidentiality;
6. enforcement and discipline, including incentives for cooperation with compliance programs; and
7. appropriate and consistent response upon detection of an offense (e.g., corrective action plan, program modifications).

DRA—General Requirements

The requirements for a compliance program under the DRA are consistent with the OIG's model program in that the DRA requirements focus on policies describing prevention of fraud, waste and abuse; training; and protection of employees who make good faith reports of compliance violations to an entity's compliance officer or government officials (e.g., compliance hotline reports or whistleblowers). The DRA, however, also requires a detailed discussion of false claims laws and whistleblower protections. Specifically, the DRA requires state Medicaid plans, as of Jan. 1, 2007, to compel Medicaid providers to have the following in place:

- written policies and procedures for all employees (including management), contractors and agents that provide detailed information on the federal False Claims Act; federal administrative remedies for false claims and statements; any state laws pertaining to civil or criminal penalties for false claims and statements; whistleblower protections under such laws; and the role of these laws in preventing and detecting fraud, waste and abuse in federal healthcare programs;
- written policies and procedures for all employees detailing the entity's methods for detecting and preventing fraud, waste and abuse; and
- a section in any employee handbook for the Medicaid provider that: a) provides a specific discussion of the

laws described above, b) highlights the right of employees to be protected as whistleblowers, and c) summarizes the entity's policies and procedures for detecting and preventing fraud, waste and abuse.

While not expressly stated in the DRA, it is implied that any Medicaid provider that does not comply with these requirements will not be entitled to submit Medicaid claims, and if a Medicaid provider does submit claims without having complied, it could potentially be liable for submitting false claims under the federal (and state, if applicable) False Claims Act.

For New Jersey Medicaid providers who receive Medicaid revenues of \$5 million or more, this means that they must have a compliance program with written policies and procedures for detecting and preventing fraud, waste and abuse (e.g., a compliance program that addresses the seven elements from the federal sentencing guidelines, discussed above), as well as a summary of federal and state laws regarding false claims. Furthermore, the policies and procedures regarding the federal and state false claims laws must be made available to agents and vendors, in addition to all employees.

Following is a description of some of the false claims laws and whistleblower protections applicable to covered New Jersey Medicaid providers.

Federal Laws

Federal False Claims Act

The federal False Claims Act⁵ prohibits a person or entity from "knowingly" presenting or causing to be presented a false or fraudulent claim for payment or approval to the federal government, and from knowingly making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the federal government. These prohibitions extend to

claims submitted to federal healthcare programs, such as Medicare or Medicaid.

The federal False Claims Act broadly defines the term "knowingly." Specifically, knowledge will have been proven for purposes of the federal False Claims Act if the person or entity: 1) has actual knowledge of the information; 2) acts in deliberate ignorance of the truth or falsity of the information; or 3) acts in reckless disregard of the truth or falsity of the information. The act specifically provides that a specific intent to defraud is not required in order to prove the act has been violated.

A person or entity found guilty of violating this act is obligated to repay all of the reimbursement obtained for such claims. Further, a violator may be liable for a civil penalty of up to \$11,000, plus three times the amount of actual damages sustained by the government as a result of the prohibited conduct, for each violation of the act. In addition to being liable for damages and civil penalties, violating the federal False Claims Act can subject a person or entity to exclusion from participation in federal healthcare programs, such as Medicare and Medicaid.

Federal Whistleblower Protections

Private persons are permitted to bring civil actions for violations of the federal False Claims Act on behalf of the United States (also known as *qui tam* actions), and are entitled to receive percentages of monies obtained through collected settlements, penalties and/or fines.⁶ Individuals bringing these claims (also known as relators or whistleblowers) are granted protection under the law. Specifically, any whistleblower who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against by his or her employer because of reporting violations of the federal False Claims Act will be entitled to reinstatement with seniority, double back pay, interest, special damages sus-

tained as a result of discriminatory treatment, and attorneys' fees and costs.

Federal Program Fraud Civil Remedies Act

The Program Fraud Civil Remedies Act (PFCRA)⁷ makes it illegal for a person or entity to make, present or submit a request, demand or submission (each a claim) for property, services, or money to the executive department of the federal government, (e.g., the U.S. Department of Health and Human Services, which oversees Medicare and Medicaid programs) when the person or entity knows, or has reason to know, that the claim:

1. is false, fictitious or fraudulent; or
2. includes or is supported by any written statement that asserts a material fact which is false, fictitious or fraudulent; or
3. includes or is supported by any written statement that omits a material fact, is false, fictitious or fraudulent because of the omission and is a statement in which the person or entity has a duty to include such material fact; or
4. is for the provision of items or services the person or entity has not provided as claimed. The law specifically provides that a specific intent to defraud is not required in order to prove that the law has been violated.

The PFCRA provides for civil penalties of up to \$5,000 for each false claim paid by the government, and, in certain circumstances, an assessment of twice the amount of each claim. In addition, if a written statement omits a material fact and is false, fictitious or fraudulent because of the omission, and is a statement in which the person or entity has a duty to include such material fact and the statement contains or is accompanied by an express certification or affirmation of the truthfulness and accuracy of the contents of the statement, the law

provides for a penalty of up to \$5,000 to be imposed for each such statement.

New Jersey State Laws

False Claims Under New Jersey State Law

Although in New Jersey there is no comprehensive false claims act that addresses all of the issues discussed in the federal False Claims Act, there are a number of laws that address false or fraudulent claims. Under the DRA, each of these would need to be included in the covered Medicaid providers compliance policies and procedures.

For example, compliance policies would need to include a description of the Insurance Fraud Prevention Act,⁸ which makes it unlawful to, among other things, knowingly submit false claims under an insurance policy for healthcare benefits or to conceal the occurrence of an event that affects any person's initial or continued right or entitlement to any insurance benefit or payment. A violation of this law can subject a person or entity to civil penalties equal to three times the amount of damages; penalties of \$5,000 for the first offense, \$10,000 for the second offense and \$15,000 for each subsequent offense; and a surcharge paid to the state of \$1,000 or five percent of an out-of-court settlement. In addition, the attorney general is authorized to pursue criminal penalties under this act.

Another law to incorporate into compliance policies and procedures is the Medical Assistance and Health Services Act,⁹ which allows for the imposition of criminal fines (up to \$10,000) and imprisonment (up to three years) for various violations involving the submission of claims for payment under the Medical Assistance Program. Also to be included would be summaries of the criminal laws and penalties associated with healthcare claims fraud¹⁰ and false claims for payment of government contracts,¹¹ both of which make it a crime to knowingly submit false, fictitious or fraudulent claims.

Whistleblower Protections

In addition to a discussion of the various laws that provide prohibitions on submission of false claims, under the DRA compliance policies must include the state whistleblower protections, if any. Under the New Jersey Conscientious Employee Protection Act,⁹ employers are prevented from taking any retaliatory actions against an employee who discloses (or threatens to disclose) to a supervisor or a public body any activity, policy, or practice of the employer that the employee reasonably believes is fraudulent or criminal, and that may defraud a patient or governmental entity, among others. In addition, this act protects employees who object to or refuse to participate in such activity, policy or practice. Specific protection also is given to licensed or certified healthcare professionals who object to or refuse to participate in an activity, policy or practice the employee reasonably believes constitutes improper quality of care.

Conclusion

Although it is clear that Medicaid providers are required to include in their policies and employee manuals a discussion of federal and state false claims laws and statutes, as well as whistleblower protections, there is still ongoing debate regarding the extent to which employees must be educated and trained regarding these topics, particularly in regard to the whistleblower protections. It is anticipated that the promised regulations will provide clarification regarding this issue.

In the interim, Medicaid providers need to ensure they have compliance programs that are consistent with the OIG's model compliance programs, and address related laws. Finally, providers need to keep abreast of laws that the state of New Jersey may pass to address the various provisions of the DRA, including any additional false claims legislation that incorporate *qui tam* pro-

visions, similar to that already included in federal law. ☞

Endnotes

1. DRA, Pub. L. No. 109-1711, Ch.3, Section 6032.
2. A *qui tam* action is a lawsuit under a statute, which gives to the plaintiff bringing the action part of the penalty recovered, with the balance going to the state. The plaintiff describes him or herself as suing for the state as well as for him or herself.
3. DRA, Pub. L. No. 109-1711, Ch. 3, Section 6031.
4. The discussion contained in this article is general in nature and does not address the unique needs of every type of healthcare provider. Legal counsel should be sought to develop individual compliance programs.
5. 31 U.S.C. 3729 *et. seq.*
6. 31 U.S.C. 3730(h).
7. 31 U.S.C. 3801, 3802.
8. N.J.S.A. 17:33A-1 *et seq.*
9. N.J.S.A. 30:4D-1 *et seq.*
10. N.J.S.A. 2C:21-4.3.
11. N.J.S.A. 2C:21-34.
12. N.J.S.A. 34:19 *et seq.*
13. N.J.S.A. 34:19-3.

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