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The New Imperative for Texas Medicaid: Zero Tolerance

• **HOUSTON**

THIS ARTICLE FOLLOWS MY (DACSO) ATTENDANCE AT A PRESENTATION GIVEN BY THE NEW HEAD OF OFFICE OF INSPECTOR GENERAL (OIG) FOR TEXAS MEDICAID GIVEN AT THE JOINT HEALTH Care Compliance Association (HCCA)/American Health Lawyers Association (AHLA) conference on "Healthcare Compliance" held in Baltimore, Maryland. I was struck by the openness and honesty of our State's newest agency head and thought this month's article should focus on the State's new policy for Medicaid integrity, and its affect on physicians who care for patients covered by this program. Texas has been at the forefront in its efforts to establish a program in response to the federal Deficit Reduction Act of 2005 (DRA) imperatives for states as a condition of funding and avoiding penalties. This has developed, in part, because of the reduction in federal funding to the states by eight percent.

As a result of the DRA, the Centers for Medicare & Medicaid Services (CMS) has set forth a Comprehensive Medicaid Integrity Plan for the Medicaid Integrity Program (MIP). The MIP is CMS' first national initiative to combat fraud, waste, and abuse in Medicaid's forty-one-year history. As a result of this initiative, states funding from CMS is now tied to establishing systems to support federal-state data matching programs that will allow the federal agencies to link with the states agencies to coordinate efforts in enforcement. With these new funds comes enhanced staff whose sole focus is the investigation and enforcement of potential violations of Medicaid and Medicare law on both the federal and state level.

States now find themselves under increasing pressure to meet the demanding caseloads with less funding. Implementing new whistleblower laws, investigation and litigation with the expectation of recovering monies for funding needs makes the state's focus on enforcement a financial imperative. For example, Texas increased its fraud and abuse recoveries by $130 million dollars in two years after centralizing the Office of Inspector General. Given the current Texas OIG budget of $38 million dollars, the return on investment to the state of Texas is ten to one. These recoveries help pay for Medicaid services affected by the reductions in federal funding. Because of the potential for federal penalties and funding reductions to states that fail to implement and enforce compliance, the states have no choice but to pursue providers to recover improper Medicaid payments.

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IMPORTANT ISSUES AFFECTING PHYSICIANS

All entities that make or receive at least $5 million in annual Medicaid payments are required to establish specific written policies and procedures to

inform employees and others about certain federal and state false claims and whistleblower laws beginning January 1, 2007. The result of these changes is that compliance is no longer voluntary, even for providers that do less than the statutory level. The burden on health care providers will be substantial since their activities will now be subject to three different auditors at both the federal and state levels. The history of many small physician practices is that they are not aware of the consequences of non-response to any of these agencies. Unfortunately, response to one auditor does not satisfy the requirement to respond to the others. Failure to respond within the will trigger an automatic recoupment of funds without the ability to informally appeal.

WHAT SHOULD PHYSICIANS DO?

The most important thing for a physician to do is not ignore a request for information from the federal or state OIG. Other compliance requirements include:

1. **Develop Written Policies and Procedures**. The DRA requires written policies and procedures. Training is not specifically required, but the provisions contemplate that entities dealing with state Medicaid programs will inform their employees of their policies.

2. **Who to Inform**. The policies and procedures must inform all employees, including management, and anyone who could be considered a contractor or agent of the entity.

3. **Content of the Policies and Procedures**. The policies and procedures must provide information on the following laws, including the role of such laws in preventing and detecting fraud, waste, and abuse in federal healthcare programs:

- The federal False Claims Act;
- Federal administrative remedies for false claims and statements;
- State laws pertaining to civil or criminal penalties for false claims and statements; and
- Whistleblower provisions under the federal and state laws.

4. **Employee Handbook**. The entity must include in its employee handbook: (a) the specific discussion of applicable fraud and abuse laws, (b) the rights of employees who are whistleblowers to be protected from retaliation, and (c) the entity's policies and procedures for detecting and preventing fraud, waste, and abuse. • DT

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