Issues in Missouri Health Care 2011

Addressing Medicaid Fraud and Abuse: Facts and Policy Options

Acknowledgement

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Issue Statement

Health care fraud is a national problem, prevalent in federal and state as well as private insurance programs… [F]raud is on the rise and the criminals who perpetrate it have become more organized and sophisticated.

Deputy Secretary William Corr, U.S. Department of Health and Human Services, 2010 [1]

The National Health Care Anti-Fraud Association estimates conservatively that at least 3 percent of spending for health services—more than $60 billion each year—is lost to health care fraud in the private and public sectors,[2] including Medicaid. The Missouri Medicaid program, known as MO HealthNet, covers about one in every seven Missourians, or 895,000 beneficiaries.[3] The MO HealthNet budget for fiscal year 2008 was appropriated at $5.8 billion, with about $1.2 billion coming from state general revenue, $3 billion from federal funds,[4] and the remainder from other funds. This funding represented about 26 percent of the total state general revenues.[5] Thus, the state has a large stake in preventing fraud in the Medicaid program. If the proportion of state-funded Medicaid spending that is lost to fraud is the same as the amount estimated for the nation as a whole, the cost to the state is $36 million per year (3% of $1.2 billion). Given continued budget constraints, initiatives to deter, detect, and prosecute Medicaid health care provider fraud are increasingly critical avenues of savings.

This issue brief discusses what health care fraud is, summarizes some of the attempts at the federal and state levels to address fraud, and then discusses further policy options that Missouri might wish to consider to cope with this problem.

What Is Health Care Fraud?

Fraud in health care has been defined differently by different legal authorities and experts, but they generally agree that fraud involves a false representation of fact or a failure to disclose a

1 William Corr, Deputy Director, U.S. Department of Health and Human Services, before the Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, U.S. House of Representatives, March 4, 2010, available at http://www.hhs.gov/asl/testify/2010/03/t20100304a.html.

2 Daniel R. Levinson, Inspector General, Office of the Inspector General, before the Senate Special Committee on Aging, U.S. Senate, May 6, 2009, available at http://www.hhs.gov/asl/testify/2009/05/t20090506d.html.

3 *Missouri Medicaid Basics, Spring 2010*, Missouri Foundation for Health (MFH), available at http://www.mffh.org/mm/files/MedicaidBasics2010.pdf.

4 Missouri received a Federal Medical Assistance Percentage (FMAP) of 75.16 percent in September 2010 under American Recovery and Reinvestment Act. Without the ARRA adjustment, its FMAP would be 64.51 percent. Source: MO Health Net Medicaid Pharmacy Report, November 16, 2009.

5 *Missouri Medicaid Basics, Winter 2009* and *Missouri Medicaid Basics, Winter 2007*, MFH, available at http://www.mffh.org/content/408/archived-publications.aspx.

fact that is material to a health care transaction, along with some damage to another party that reasonably relies on the misrepresentation or failure to disclose.[6]

Medicaid regulations differentiate between fraud and abuse, as follows:

> "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.
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> "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.[7]

While the types of health care fraud are unlimited, the next sections highlight common examples.

Billing for More Expensive Services Than Were Actually Rendered (Upcoding)
Upcoding occurs when a health care provider bills for a more complex service than was actually performed. For example, a Missouri psychiatrist recently settled a case of alleged fraud for $440,000 that involved billing Medicaid for 20-minute counseling sessions when he actually spent only five minutes with patients.[8]

Billing Dispensed Generics as Brand Name Drugs and Other Types of Manufacturer Fraud
Prescription drug fraud is manifested in many ways. One example is a pharmacy that bills for a higher-cost brand name drug when a substantially lower-cost generic or brand name drug was dispensed. As an example, in 2008, a national drug store chain agreed to pay $35 million in a settlement with the federal government and 42 states, including Missouri, to resolve allegations that the chain improperly billed Medicaid. The settlement was the result of joint federal-state investigations that arose from a whistleblower complaint alleging that the chain switched its billings from dispensed tablets to capsules on three widely used medications, which resulted in higher reimbursement.[9] In another case, in 2010, a pharmaceutical company was found to have engaged in off-label marketing to promote its antipsychotic drug Seroquel. Missouri will recover $8.9 million from this $520 million nationwide Medicaid fraud settlement.[10]

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6 Hanson and Cassidy, *Fraud Control: New Tools, New Potential,* Journal of AHIMA 77, no.3 (March 2006): 24-30.

7 42 C.F.R. §455.2.

8 Attorney General Koster settles with St. Louis physician in Medicaid fraud case—state to receive more than $400,000, Attorney General's News Release, October 12, 2010, available at http://ago.mo.gov/newsreleases/2010/Attorney_General_Koster_settles_with_St_Louis_physician_in_Medicaid_fraud_case_state_to_receive_more_than_440_000_/.

9 Missouri Attorney General News Release, June 4, 2008, available at http://ago.mo.gov/newsreleases/2008/National_drug_store_chain_improperly_billed_Medicaid/.

10 Missouri Attorney General News Release, June 15, 2010, available at http://ago.mo.gov/newsreleases/2010.

Other Examples

Other types of health care provider fraud include:

- Billing for services actually not performed, known as phantom billings. Examples include billing for blood tests when no samples were drawn, billing for X-rays when none were taken, billing for a dental filling when one was not done, or billing for home health care hours when they were not provided.
- Billing several services that should be combined into one billing, known as unbundling, to obtain additional reimbursement.
- Billing more than once for the same medical service or prescription.
- Fabricating claims from nonexistent clinics, nonexistent patients, or deceased patients.
- Giving or accepting something in addition to normal reimbursement from a patient, other health care provider, or insurer, in return for medical services. This is known as a kickback.
- Paying beneficiaries with no health problems to make unnecessary visits.
- Bribery.
- False cost reports.
- Embezzlement of recipient funds.

Initiatives to Prevent and Deter Fraud

As evidenced by the following activities, there is increased awareness about the importance of tackling health care fraud and abuse.

- *Medicaid Integrity Program:* In 2006, Congress created the Medicaid Integrity Program, a federal effort within the Centers for Medicare and Medicaid Services (CMS) of the United States Department of Health and Human Services (HHS) to prevent and reduce provider fraud, waste, and abuse in the Medicaid program. CMS responsibilities under this program include (1) hiring contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers on program integrity issues; and (2) providing support to assist states in their activities to address fraud and abuse.[11]
- *List of Excluded Individuals/Entities:* Under the authority of Sections 1128 and 1156 of the Social Security Act, the Office of Inspector General (OIG) within HHS maintains a list of excluded individuals/entities with convictions for program fraud and patient abuse, licensing board actions, or defaults on Health Education Assistance loans. When listed, individuals/entities are prohibited from receiving payment directly or indirectly from any federal health care program, including Medicare and Medicaid, for any items or services that they furnish, order, or prescribe. The prohibition also applies to health care providers,

11 Medicaid Integrity Program – General Information, available at http://www.cms.gov/MedicaidIntegrityProgram.

(e.g., hospitals, pharmacies, long-term care facilities, laboratories) that employ or contract with an identified individual/entity on the OIG's list.[12] State Medicaid agencies are required to block payments to the OIG's excluded health care providers.

- *Deficit Reduction Act and Fraud and Abuse Compliance Plans:* The Deficit Reduction Act (DRA) of 2005 requires that Medicaid health care providers and other contractors that receive or pay out at least $5 million annually in Medicaid funds must report any actual or suspected instance of fraud, waste, or abuse. Also, these entities must adopt "compliance plans" that provide training for their staff and subcontractors related to the identification of fraud, waste, or abuse within the provider's or entity's organization.
- *Payment Error Rate Measurement (PERM) Program:* Under this program, CMS hires contractors to review Medicaid eligibility determinations and state payments under fee-for-service and capitated managed care programs, and to identify processing errors. Each state is reviewed once every three years. Sample errors that are flagged during PERM reviews include payments for unnecessary medical services and claims with insufficient documentation for ineligible individuals or from ineligible health care providers. [13]
- *Health Care Fraud Prevention and Enforcement Action Team (HEAT):* This project is administered by HHS and the United States Department of Justice (DOJ). Its goals are (1) to identify systemic vulnerabilities and geographic areas with potential for Medicare and Medicaid fraud; (2) to provide resources and other legal tools to aid civil enforcement efforts under the federal False Claims Act[14] and increase recoveries; (3) to improve data sharing to detect patterns of fraud; and (4) to disseminate best practices to address fraud and build partnerships between the public and private health care sectors.[15]
- *HEAT Medicare Fraud "Strike Force" Teams:* A Strike Force team is a multi-agency unit of investigators, prosecutors, and health care analysts that is established to collectively address Medicare fraud. Included are the OIG, the Federal Bureau of Investigation (FBI), DOJ, CMS, and other local/state law agencies. Strike Force teams have been operational in Houston, Texas; Brooklyn, New York; Baton Rouge, Louisiana; Tampa and Miami, Florida; Los Angeles, California; and Detroit, Michigan.[16]
- *Center for Program Integrity:* In March 2010, CMS formed a new Center for Program Integrity within its organization. This center is designed to oversee all CMS activities relating to national and statewide Medicare, Medicaid, and Children's Health Insurance Program (CHIP) fraud and abuse issues. Its tasks include promoting program integrity through

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12 Exclusions Program, available at http://oig.hhs.gov/fraud/exclusions.asp.

13 Payment Error Rate Measurement (PERM), available at http://www.cms.gov/PERM.

14 31 U.S.C. §§ 3729 - 3733 available at http://www.law.cornell.edu/uscode/31/3729.html.

15 William Corr, before Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, United States House of Representatives, March 4, 2010.

16 Ibid. and The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2009, May 2010, available at http://www.justice.gov/dag/pubdoc/hcfacreport2009.pdf.

provider and contractor audits; identifying and monitoring program vulnerabilities; working with other CMS organizations to develop legislation to deter and reduce fraud, waste, and abuse; and providing support and assistance to states.[17]

- *Affordable Care Act and Health Care Fraud Prevention:* The Patient Protection and Affordable Care Act (ACA) of 2010, which enacted federal health care reform, also included significant provisions aimed at preventing health care fraud and abuse (Table 1). CMS believes that the changes "will not only help us crack down on criminals who are seeking to scam the system, but will also help us to save millions of taxpayer dollars in Medicare, Medicaid and CHIP – three vital programs that more than 100 million Americans count on for their health care… Using these new fraud prevention measures, CMS will be able to move from a 'pay and chase' approach to one that makes it harder to commit fraud in the first place."[18]
- *State Medicaid Fraud Control Units:* The OIG provides administrative oversight over state Medicaid Fraud Control Units (MFCU). Forty-nine states and the District of Columbia operate Medicaid Fraud Control Units—most within the office of a state's Attorney General.[19] Each is separate and distinct from the Medicaid agency, but the Medicaid agency must have a "Memorandum of Understanding" with the state's MFCU that outlines each agency's responsibilities to the other. MFCUs may have statewide criminal prosecution authority or formal procedures for referring cases to local authorities related to detection, investigation, and prosecution of suspected provider fraudulent activities. Federal regulations prohibit the units from pursuing most cases of beneficiary fraud unless there is a conspiracy with a provider. Financing for a MFCU is 75 percent from the federal government with 25 percent matching funds from the state. The National Association of Medicaid Fraud Control Units provides technical assistance and training for the state MFCU staff and a national forum to improve the quality of Medicaid prosecutions.[20]
- *MO HealthNet Investigations Unit:* This unit investigates fraud and abuse committed by beneficiaries against MO HealthNet providers, and conducts provider compliance investigations. Its activities include, but are not limited to, review of beneficiary service utilization and provider claims payment profiles to detect aberrant patterns; internal audits of claims pricing, quantity, and duration screening; provider and beneficiary eligibility; and review of established coverage parameters for health care services.[21]

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17 Statement of Organization, Functions, and Delegations of Authority, Centers for Medicare & Medicaid Services, Department of Health and Human Service, Federal Register/Vol. 75, No. 56, Wednesday, March 24, 2010, available at http://edocket.access.gpo.gov/2010/pdf/2010-6429.pdf.

18 HHS announces new tools and resources from the Affordable Care Act…, HHS News Release, September 20, 2010, available at http://www.hhs.gov/news/press/2010pres/09/20100920e.html.

19 Only North Dakota does not have a unit.

20 Medicaid Fraud Control Units, available at http://www.namfcu.net.

21 MO HealthNet Manual, Section 2 – Provider Conditions of Participation, available at http://manuals.momed.com/collections/collection_aid/General_Section02.pdf.

Table 1. Key Fraud and Abuse Provisions from the Affordable Care Act

- $350 million additional funding to detect and fight fraud and abuse over 10 years from October 1, 2010, through September 30, 2020
- Enhanced screening requirements for providers that desire to enroll in Medicare, Medicaid, and CHIP, including licensure checks, criminal background checks, fingerprinting, and unscheduled and unannounced site visits
- Requirements that providers must develop and implement compliance plans focused on preventing fraud, as condition of continued enrollment in Medicare, Medicaid, or CHIP
- Expanding federal recovery audit contractor (RAC) efforts to Medicaid, Medicare Advantage, and Medicare Part D's prescription drug program
- HHS authority to impose stronger civil and monetary penalties for fraudulent activities and to enforce temporary payment moratoria to prevent or combat fraud in Medicare, Medicaid, and CHIP

Source: *Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions, and Compliance Plans for Providers and Suppliers*, a Proposed Rule by CMS, September 23, 2010[22] and

The Affordable Care Act: New Tools to Fight Fraud, Strengthen Medicare and Protect Taxpayer Dollars, available at http://www.healthreform.gov/affordablecareact_summary.html.

Missouri Medicaid Fraud Control Unit

> *In these times of dwindling state budgets, recovering Medicaid funds back for the state is like a windfall of money… Missouri's Medicaid Fraud Control Unit prides itself for being efficient, creative, aggressive, and extremely hard-working, keys to our state's success…*
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> Missouri Attorney General Chris Koster, June 2010

The Missouri Medicaid Fraud Control Unit (MFCU), located in the state Attorney General's Office, is charged with identifying, investigating, and prosecuting Medicaid fraud and abuse by health care providers. Section 191.907 of the Missouri Revised Statutes allows any person who reports MO HealthNet fraud to receive 10 percent of the amount recovered by the state through the use of that person's information. During federal fiscal year 2008, the Missouri MFCU received a federal grant of $1.6 million from HHS and used this funding to recover nearly $30 million.[23] The Missouri MFCU also ranked within the top five

22 Available at http://www.federalregister.gov/articles/2010/09/23/2010-23579/medicare-medicaid-and-childrens-health-insurance-programs-additional-screening-requirements.

23 U.S. Department of Health and Human Services ranks Missouri Medicaid Fraud Unit number one in nation for 2008, Attorney General's News Release, January 12, 2010, available at http://ago.mo.gov/newsreleases/current.htm.

in the nation for select recovery activities[24] and set an all-time Missouri record for Medicaid fraud recovery by obtaining $81.6 million in 2009.[25]

Policy Options

> *Fraud control is a dynamic game (like chess), not a static one. Fraud control is played against opponents who think creatively, adapt continuously, and relish devising complex strategies. So a set of fraud controls that is perfectly satisfactory today may be of no use at all tomorrow, once the game has progressed a little. Maintaining effective fraud controls demands continuous assessment of emerging fraud trends and constant, rapid revisions of controls.*
>
> Malcolm K. Sparrow [26]

While identification, prosecution, and recovery of fraudulent payments are crucial, ongoing preventive options are equally important to combating fraud. A multi-pronged approach is best, not only to address existing fraud but also to deter schemes that criminals might have otherwise perpetrated in the future. Following are several key strategies that have been used to address Medicaid fraud.

- *Enact a state False Claims Act and other legislation:* State False Claim Acts (FCAs) are state-level extensions of the Federal False Claims Act, 31 U.S.C. 3729-3733, which stipulates that those who knowingly submit, or cause another person or entity to submit false claims for payment of government funds can be held liable for the government's damages plus civil penalties. The federal FCA also contains *qui tam*, or whistleblower, provisions that allow citizens with evidence of fraud against government contracts and programs to sue on behalf of the government to recover the stolen funds, a portion of which may be awarded to the whistleblower. Under provisions found in the Deficit Reduction Act of 2005, a state with FCAs that meet federal standards is entitled to an additional 10 percentage points in the state's medical assistance percentage for any Medicaid funds recovered through actions brought under its FCAs.[27] The OIG, in consultation with the DOJ, determined 14 state FCAs (California, Georgia, Hawaii, Illinois, Indiana, Massachusetts, Michigan, Nevada, New York, Rhode Island, Tennessee, Texas, Virginia, and Wisconsin) met the federal standards. The *Missouri Health Care Payment Fraud and Abuse Act* does not include a *qui tam* provision—i.e., whistleblowers cannot prosecute an

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24 Missouri again gains national attention in Medicaid fraud recovery – state ranks among top five in five important categories, Attorney General's News Release, June 29, 2010, available at http://ago.mo.gov/newsreleases/current.htm.

25 Attorney General Koster announces record Medicaid collections for 2009, December 30,2009, available at http://ago.mo.gov/newsreleases/archives.htm.

26 Sparrow, Malcolm, *Fraud Control in the Health Care Industry: Assessing the State of the Art*, National Institute of Justice, research in Brief, December 1998, available at http://www.ncjrs.gov/pdffiles1/172841.pdf.

27 *State False Claims Act Reviews*, Office of Inspector General, available at http://oig.hhs.gov/fraud.asp.

action on the state's behalf—and thus it does not qualify for this funding incentive. Missouri has considered but not passed legislation for a state FCA.

- *Maintain and enhance electronic systems to identify and deter fraud:* Medicaid claims data provide a wealth of information to uncover fraudulent schemes through electronic data mining and visualization tools. Various vendors have recently developed software for capturing three phases of fraud— prepayment prevention, prepayment investigation, and retrospective recovery. Claims can be analyzed using various approaches: (1) a provider-centric detection methodology to identify providers who consistently submit questionable claims; (2) A claim-centric methodology to identify patterns within individual claims without reference to the provider, and stop suspicious claims for further investigation; and (3) the predictive model to identify new and previously undetected suspect behavior. In the predictive model, a claim is scored based on its deviance from norms established by provider peer groups, individual provider behavior over time, and patient behavior over time.

  Another tool is electronic health records. The MO HealthNet version *CyberAccess* is a web-based tool that allows physicians to view a beneficiary's diagnosis data, laboratory data, medical history, and drug profiles; to electronically prescribe; and to request drug and medical prior authorizations.[28] These capabilities also allow MO HealthNet providers to monitor a beneficiary's services ordered or rendered by other providers, and address aberrant utilization patterns at point-of-care. Technology can play a critical role in detecting fraud and enhancing fraud management programs. While technology cannot totally eliminate the fraud problem, it can significantly minimize fraud and reduce health care fraud losses.

- *Advertise fraud hotlines and educate the public:* Increased awareness by the general public of the impact of fraud and the importance of exposing fraud is another weapon in the anti-fraud arsenal. A marketing plan that includes development of website capabilities and taglines could be used to promote the use of hotlines for reporting fraud.

- *Improve coordination between federal and state efforts:* The OIG provides a website[29] addressing fraud prevention and detection that includes advisory opinions, alerts, bulletins, and other guidance. The National Association of Medicaid Fraud Control Units[30] also provides updates on state fraud and abuse activities. This information sharing and other ongoing collaboration between the federal government and states are vital. For example, awareness of a new fraudulent scheme identified in California or in Medicare could allow officials to take steps to ensure it was deterred in Missouri.

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28 *CyberAccess, Electronic Health Record Program for MO HealthNet*, available at http://www.dss.mo.gov/mhd/cs/medprecert/pages/cyberaccess.htm.

29 http://oig.hss.gov/fraud.asp.

30 http://www.namfcu.net.

Implications

Fraud means fewer dollars are going to legitimate providers for necessary services to Medicaid beneficiaries. If Medicaid fraud is ineffectively addressed, it will become more pervasive and consume scarce federal and state financial resources. Developing a strategic plan that combats fraud by integration of electronic detection systems; provider and public education on how Medicaid fraud directly impacts each citizen; and coordination between federal and state agencies are critical to ensuring that Medicaid can provide a needed lifeline to a state's most vulnerable citizens.