

Issues in Missouri Health Care 2009

Compliance: Myths and Facts
About Medicaid Fraud and Abuse

Acknowledgement

This is one in a series of issue papers on critical health care issues facing Missouri and the nation prepared by Health Management Associates, Inc., a national health care policy research and consulting firm and made possible by funding from the Missouri Foundation for Health and the Healthcare Foundation of Greater Kansas City. The papers are intended to provide nonpartisan expert analysis in an accessible format that will contribute to the public dialogue on the state of health care in Missouri. Questions should be directed to Thomas McAuliffe, Policy Analyst, Missouri Foundation for Health, 314.345.5574, tmcauliffe@mffh.org.

Issue Statement

Why is Medicaid Fraud Important? The Medicaid program is the largest of the federal-state partnerships for low-income Americans and provides a critical safety net for health care services. Medicaid serves children, low-income adults, the disabled, and the elderly. It is also a part of the federal government's effort to transition adults from welfare to work. Many entry level jobs offer no health benefits and Medicaid fills that gap. In Missouri the Medicaid program covers more than 800,000 people; this translates to almost 1 out of every 7 Missourians, 34 percent of Missouri's children, and 1 out of every 10 seniors over age 65.¹ Enacted through Title XIX of the federal Social Security Act, Medicaid provides health coverage for certain low-income Americans. The federal government offers matching funds to states to support the financing of Medicaid. For Missouri, as with most states, Medicaid represents a significant portion (about 25 percent) of the overall state budget.² Increases in program costs can have a serious impact on the overall fiscal condition of the state. Between 1995 and 2005, Missouri's program nearly doubled in size.³ For state fiscal year (SFY) 2008, Missouri's Medicaid budget was \$5.4 billion with about \$1.2 billion coming from state general revenue, \$3 billion from federal funds and the remainder coming from other funds.⁴ As Medicaid budgets across the country have grown, neither the federal government nor the states accompanied this huge increase with additional resources for fraud detection. In 2005, in an effort to control costs, Missouri made significant Medicaid eligibility changes that scaled back coverage for low-income parents on Medicaid. These changes transitioned the state from one with eligibility for low-income parents at 75 percent of poverty, to one dramatically lower at about 20 percent of poverty.⁵

In recent years there has been increased federal and state awareness of the importance of tackling Medicaid fraud. In 2006, Congress created the Medicaid Integrity Program, a federal effort within the Centers for Medicare and Medicaid Services (CMS) to ensure program integrity in the Medicaid program. The MO HealthNet Division participates in the CMS Payment Error Rate Measurement (PERM) project. The purpose of this project is for CMS to measure the accuracy of payments for Medicaid services at the state and

¹ Missouri Medicaid Basics, Winter 2008. Missouri Foundation for Health (MFH) <http://www.mffh.org/medicaidbasics07.pdf>.

² Missouri Medicaid Basics, Winter 2007. Missouri Foundation for Health (MFH) (<http://www.mffh.org/medicaidbasics07.pdf>) Budget numbers are for 2006.

³ Debating Medicaid and Morality in Missouri, Frank Morris, National Public Radio (<http://www.npr.org/templates/story/story.php?storyId=4647327>).

⁴ Missouri Medicaid Basics, Winter 2008

⁵ Medicaid Kaiser Commission, Issue Paper, April 2008 Few Options for States to Control Medicaid Spending in a Declining Economy (<http://www.floridakidcare.org/council/mm-5-16-08/20-Kaiser-FewOptions.pdf>).

national levels. The PERM project is designed to comply with the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300).⁶

In Missouri, as in many states, the Medicaid Fraud Control Unit (MFCU) is charged with identifying and prosecuting Medicaid fraud. Located in the state Attorney General's Office, the MFCU conducts fraud and abuse investigations on health care providers receiving payments from the Medicaid program. Section 191.907 of the Missouri Revised Statutes allows any person who reports MOHealthNet fraud to receive 10 percent of the amount recovered by the state through the use of that person's information. One estimate cites savings due to the work of MFCU at over \$80 million since its inception in 1994.⁷

The only estimate of the cost of provider fraud is the often quoted, but dated, 1994 Office of the Inspector General (OIG) testimony to the US Congress where it was estimated that fraud and abuse were 10 percent of all Medicaid payments. However, others believe it is much higher. Based on Missouri's spending of \$5.4 billion, this would result in \$540 million lost to Medicaid fraud. Fraud affects all Missouri taxpayers who fund the program, Medicaid enrollees who are victims of fraud, and Missourians who are adversely affected, financially and medically, by the consequences of the poor health of fellow Missourians.

What is Medicaid Fraud?

The fraud control game is dynamic, not static. Fraud control is played against opponents: opponents who think creatively and adapt continuously and who relish devising complex strategies; this means that 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. – Malcolm K. Sparrow⁸

Fraud in healthcare has been defined variously by a number of legal authorities and experts; however, these definitions share a common element - a false representation of fact or a failure to disclose a fact that is material to a healthcare transaction, along with some damage to another party that reasonably relies on the misrepresentation or failure to

⁶ Division of Medical Services Provider Bulletin, Missouri Dept of Social Services, August 10, 2007 (http://www.dss.mo.gov/mhd/archive/bulletins/pdf/bulletin30-04_2007aug10.pdf).

⁷ Margaret Donnelly for Attorney General web page (<http://www.donnellyforattorneygeneral.com/>) Accessed September 11, 2008.

⁸ *License to Steal: How Fraud Bleeds America's Health Care System – Updated Edition*, Malcolm K. Sparrow. Westview Press, Boulder, CO, 2000, p. 126.

disclose.⁹ Types of fraud are only limited by the creativity of entrepreneurial criminals; however, a few examples are examined in the following sections.

Billing for Services Not Performed

This is one of the largest areas of Medicaid provider fraud. A provider tries to bill Medicaid for a treatment, procedure, or service that was not actually performed. 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, and billing for home health care hours when they were not provided. In Missouri, the owners of a nursing home management company and three nursing facilities agreed to pay \$1.25 million in civil damages to resolve allegations of false and fraudulent billing to Medicare and Medicaid that stemmed from complaints of poor quality of care. It was alleged that numerous residents at their facilities suffered from dehydration and malnutrition and went for extended periods of time without being properly bathed. Additional allegations were made that some residents had contracted preventable pressure sores.¹⁰

Substitution of Generic Drugs or other Pharmacy Fraud

Pharmacy and pharmaceutical fraud is manifested in many ways. One example is a pharmacy that tries to bill an insurance carrier or the patient for the cost of a name brand prescription when in fact a generic substitute was supplied at a substantially lower cost. Another example occurred in the summer of 2008 when Walgreens agreed to pay \$35 million in a settlement with 42 states, including Missouri, and the federal government to resolve allegations that the national drug store chain improperly billed Medicaid. The settlement was the result of a joint federal-state investigation that arose from a whistleblower complaint in a federal lawsuit filed in 2003 alleging that Walgreens filled prescriptions for numerous Medicaid recipients by switching the dosage forms on three widely used medications.¹¹ A 2008 case involved a settlement with the pharmaceutical company Bristol-Myers Squibb (BMS) that was accused of engaging in several practices that resulted in Medicaid programs paying too much for prescription drugs and in other cases Medicaid being underpaid for rebates by BMS. Missouri will receive more than \$11 million from this \$403 million nationwide Medicaid fraud settlement.¹²

There are many other examples of fraud that take place not only in Missouri but in many states across the nation. These include, but are not limited to:

⁹ "Fraud Control: New Tools, New Potential", Susan P. Hanson and Bonnie S. Cassidy, *Journal of AHIMA* 77, no.3 (March 2006): 24-30.

¹⁰ Dept of Health Services, Office of the Attorney General, State Medicaid Fraud Control Units Annual Report Fiscal Year 2006.

¹¹ Missouri Attorney General News Release, June 4 2008.

¹² Attorney General News Release, July 15 2008.

- Upcoding for services more expensive than those provided, as when a patient sees a doctor for ten minutes on a simple matter such as a cold and the doctor then submits a bill for an hour-long complex visit.
- Fabricated claims from nonexistent clinics, nonexistent patients, or deceased patients.
- Claims for durable medical equipment that was never received.
- Providers who pay enrollees with no health problems to make unnecessary visits.
- Claims for unnecessary surgical procedures.
- Payment for services for claims with medical necessity certificates signed by a provider for a referral kickback.
- Nonprofessionals posing as healthcare professionals and providing services without proper licenses.
- Multiple prescriptions for controlled substances obtained by patients who doctor-shop or bounce from one doctor to another.

There are a variety of schemes that fit within the categories above, which just begin to capture the most common types of fraud.

Policy Options

Identification, prosecution, and recovery of Medicaid fraud is crucial. However, it is important to also recognize that prevention of Medicaid fraud is significantly more cost effective than combating it through law enforcement and criminal prosecution. In reality, a two handed approach is necessary since not all fraud can be prevented.

The specifics of deterring various types of fraud vary, however, there are key strategies that have demonstrated success and have huge potential to reduce Medicaid fraud and abuse. Some of these are outlined in the following sections.

Enact the 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. FCAs contain *qui tam*, or whistleblower provisions that allow citizens with evidence of fraud against government contracts and programs to sue on behalf of the government in order to recover the stolen funds (a portion of which may be awarded to the whistleblower). Under provisions found in the Deficit Reduction Act

(DRA) of 2005, states with FCAs that meet federal standards are granted a portion of any federal Medicaid funds recovered through Medicaid-related actions brought under FCAs.¹³ Missouri has considered but not passed legislation for a state FCA. State legislation was supported by the MO HealthNet Division, but opposed by many medical groups because it would cause physicians to stop seeing Medicaid patients due to the fear that a minor mistake could result in a felony prosecution. Appropriately conceived, the FCA can be one weapon in an arsenal against Medicaid fraud but only with reasonable reforms to discourage abuses, including limiting the size of whistle-blower awards and requiring that whistle-blowers try to end fraud at their place of employment before filing suits. While the FCA gets the most press, CMS does offer a website that provides information on state Medicaid statutes that address Medicaid fraud in order for states to learn from one another (<http://www.cms.hhs.gov>).

Enhance an electronic fraud and abuse detection system. The Medicaid claims data provide a warehouse of information to uncover fraud schemes through electronic data mining and visualization tools. Various vendors have recently developed software for capturing three phases of fraud (i.e., prepayment prevention, prepayment investigation, and retrospective recovery). Claims can be analyzed using three 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, claims are scored based on their deviance from norms established by provider peer groups, individual provider behavior over time, and patient behavior over time. Technology can play a critical role in detecting fraud and abuse and it can help enhance fraud management programs. While technology cannot eliminate the fraud problem, it can significantly minimize fraud and abuse and ultimately reduce healthcare fraud losses.

Expand provider education. Currently, Missouri provider education occurs through the Department of Social Services (DSS) on-line web site. Through development of a specific web site component, providers and participants can receive educational materials related to waste, fraud, and abuse. Additionally, the site could include materials that have been developed by federal agencies focusing on how fraud is manifested differently within the managed care setting and how programs to address it should be structured.

¹³ The False Claims Act Legal Center, Taxpayers Against Fraud Education Fund, available at <http://www.taf.org/statefca.htm>, accessed April 11, 2007.

Advertise fraud hotlines. Increased awareness by the general public of the impact of fraud and the importance of exposing fraud is another weapon in the antifraud arsenal. A marketing plan that includes development of web site capabilities and taglines could be utilized to promote the use of hotlines for reporting fraud.

Improve coordination between federal and state efforts. Since Medicaid is funded through both state and federal funds, both state and federal officials have incentives to reduce fraud. Improved coordination and collaboration with and between CMS and other states would go a long way to building on other's efforts (e.g., awareness of a new fraud scheme identified in California could allow officials to take steps to ensure it was not implemented in Missouri).

There are many other fraud reduction strategies, as well as expanded details of the ones discussed above that cannot be adequately discussed in the scope of this paper. The key is to develop an integrated strategic plan that incorporates coordination of multiple strategies to address not only existing fraud but also the creative schemes that criminals are preparing to implement in the future.

Implications

Fraud harms everyone in healthcare. If Medicaid fraud is left unmonitored or addressed ineffectively it will become more pervasive and audacious, consume more scarce federal and state resources, and potentially have a critical impact on public health.

Fraud means fewer dollars going to legitimate providers and providing fewer necessary services to Medicaid enrollees. Developing a strategic plan that combats fraud by integrating electronic fraud and abuse detection systems, provider education, legal measures, public education on how Medicaid fraud directly impacts each citizen, and coordination between federal and state agencies is critical to ensuring that Medicaid can provide the lifeline necessary to hundreds of thousands of Missourians directly and all Missourians indirectly.