FIGHTING FRAUD MEDICAID

States are sniffing out Medicaid swindlers and saving a lot of money.

BY MEGAN COMLOSSY

Combating Medicaid fraud and abuse is no easy task. And while some states do it better than others, all face enormous challenges. Limited resources, mountains of transactions and sophisticated scams make for a very tough, but extremely important, job. Just ask Texas.

Dr. Michael David Goodwin, an orthodontist, devised a scheme to defraud the Lone Star State's Medicaid program out of more than $2.6 million. From 2008 to 2011, he billed for services that weren't medically necessary and during times when he wasn't even in town. His bonanza ended when he was caught by state and federal anti-fraud agencies.

Goodwin was by no means a lone ranger. Texas has been hit hard by similar attempts to defraud Medicaid in the past few years. After dental and orthodontic reimbursement rates increased for children's Medicaid in 2007, spending on those services in Texas shot through the roof, much more than in other states. It's not that children in Texas were in greater need of orthodontic services or receiving more expensive care than kids in other states. Rather, it was a handful of orthodontists putting braces on children who didn't need them that was behind the spike in reimbursable care. Some dental clinics were even going so far as to entice Medicaid patients with gift cards and other incentives.

These cases of crooked orthodontists, physicians, home health care providers, pharmacists or other providers are not unique to Texas. Nor are fraud, waste and abuse new to Medicaid programs across the country.

The sheer size and complexity of the joint state-federal Medicaid program—60 million Americans covered at a cost of more

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than $450 billion annually—put it at considerable risk for violations. Exactly how much is unknown, although estimates by the Centers for Medicare and Medicaid Services suggest tens of billions of dollars each year.

Senator Kemp Hannon (R) New York

"There are too many instances of providers engaging in waste, fraud and abuse," says New York Senator Kemp Hannon (R). And many agree with him. Although this is not a new issue, states and the federal government have renewed their efforts to protect the integrity of the Medicaid program as one way to contain rising costs.

Fraud Fighters

Even in an age of bitterly divided politics and polarization, legislators—from both sides of the aisle and at the state and federal levels—agree that detecting, deterring and combating Medicaid fraud is a way to hold down costs. So what can lawmakers do?

Senate President Wayne Niederhauser (R) Utah

"Our role is to create an environment where auditors, investigators and other fraud-fighters have the statutory authority and budgetary resources to do their jobs," says Utah Senate President Wayne Niederhauser (R).

How states do that looks somewhat different from one state to another. Federal funding, support, technical assistance and, in some cases, collaboration from federal agencies, aid states' efforts to combat fraud. But day-to-day responsibility for fighting fraud rests with state entities. Depending on the state, these may include Medicaid agencies, Medicaid fraud control units, Medicaid inspectors general, attorneys general, auditors or others.

To address the reports of costly dental and orthodontic fraud in Texas, for example, the state formed a task force with officials from the Health and Human Services Commission, that agency's Office of Inspector General, the Office of Attorney General and the OAG Medicaid Fraud Control Unit. These fraud-fighting agencies are common in many states.

The Texas Office of Inspector General, a division of the state's Health and Human Services Commission, is charged with preventing, detecting and pursuing fraud, waste and abuse in all the state's health and human services programs—including Medicaid. Independent of the state Medicaid agency, the office conducts audits and investigations to ensure fraudulent beneficiaries and providers—such as Goodwin—are held accountable. Depending on the situation, the inspector general may try to recover taxpayer money from fraudsters, or refer cases of suspected fraud to the Medicaid Fraud Control Unit for prosecution.

At least eight states have established independent offices of Medicaid inspector general, similar to the one in Texas. Utah is the most recent state to set up an independent Medicaid watchdog. A 2009 report by the Utah Legislative Auditor General estimated the state could save millions of dollars by curbing fraud and abuse in the Medicaid program. Senator

The Defining Differences

Abuse: Conducting unnecessary medical services, procedures or treatments or engaging in questionable and costly business, fiscal or medical practices.

Fraud: Deceiving Medicaid intentionally for unauthorized financial gain. This includes getting kickbacks for promoting certain tests, treatments or medications; billing for services not provided; and billing more complex and costly procedures than were actually performed.

Waste: Misusing resources or billing incorrectly, usually unintentionally, and overusing services, either by beneficiaries or providers.

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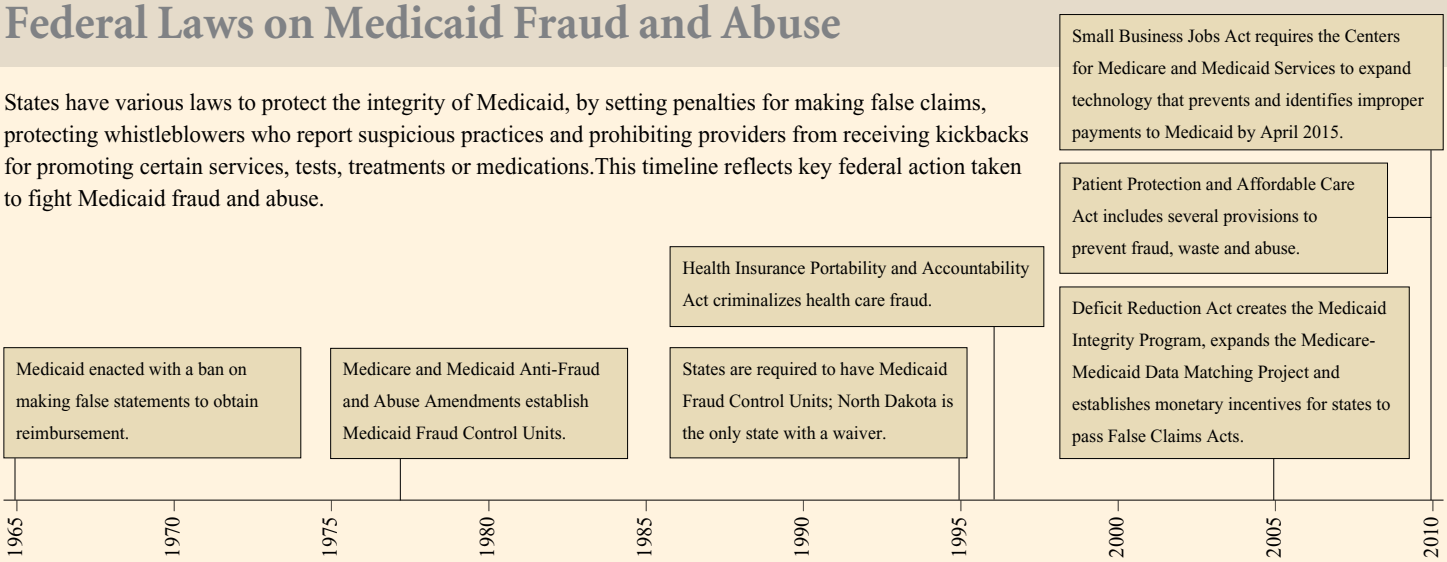
Federal Laws on Medicaid Fraud and Abuse

States have various laws to protect the integrity of Medicaid, by setting penalties for making false claims, protecting whistleblowers who report suspicious practices and prohibiting providers from receiving kickbacks for promoting certain services, tests, treatments or medications.This timeline reflects key federal action taken to fight Medicaid fraud and abuse.



Fighting Fraud

The Patient Protection and Affordable Care Act contains several provisions to help states fight fraud. A few follow.

1. Information Sharing

The federal law requires states to share information about providers whose billing privileges have been revoked, so they aren't allowed into other state Medicaid or Medicare programs. Previously, a shady Medicaid provider could simply hop state lines to continue swindling taxpayers.

2. Heightened Scrutiny

The law also creates new screening and enrollment requirements for some Medicaid providers—such as home health care attendants and durable medical equipment providers—who historically have higher levels of fraud and abuse. These high-risk providers will be subject to a higher level of scrutiny, including licensure checks, fingerprinting, criminal background checks, and medical site visits to confirm legitimacy and location.

3. Payment Freezes

States now can freeze payments to Medicaid providers if there is a "credible allegation of fraud." The potential savings to Medicaid are obvious: fewer improper payments and less time lost trying to recover funds. Many providers, however, are concerned that Medicaid reimbursements may be halted without just cause, potentially restricting resources for legitimate services.

Niederhauser says the report prompted lawmakers to establish a more "accountable system," with an Office of Inspector General of Medicaid Services.

It's been worth the investment, he says. "We're spending pennies but saving dollars. Having an independent office of inspector general has been money well spent and good policy for Utah so far."

While inspectors general and Medicaid officials are responsible for preventing and investigating fraud and abuse, they also refer certain cases to the state Medicaid Fraud Control Unit. Typically located within the Office of Attorney General, Medicaid Fraud Control Units are responsible for conducting criminal investigations and prosecuting providers suspected of fraud, fraud in the administration of the Medicaid program, and physical abuse in Medicaid-funded facilities. With the exception of North Dakota, every state has one.

Coordination is Key

Despite the fact that these state entities share the common goal of detecting and prosecuting Medicaid fraud, they have not always—and, in some states, still do not—work together. So lawmakers in a few states have mandated interagency collaboration through legislative action. A recent law in Oklahoma, for example, requires the attorney general and the Health Care Authority to share data and allows the attorney general to pursue cases without a referral from the Health Care Authority.

Interagency collaboration has resulted in successful investigations of fraudulent providers, which can send a powerful message that Medicaid fraud won't be tolerated. For example, in Florida, the Medicaid Fraud Control Unit opened an investigation on Nasim Hashmi, based on information provided by the Agency for Health Care Administration. The investigators discovered Hashmi, the owner of L'Image Physical Therapy and Rehabilitation in Miami-Dade County, had billed Medicaid for therapy provided by unlicensed therapists and overbilled for work done by assistant therapists. Hashmi was sentenced to five years' probation and ordered to repay nearly $500,000.

And in New York, the attorney general, armed with information from the Office of the Medicaid Inspector General, caught Brooklyn pharmacist Rao Veeramachaneni buying prescription medications on the black market, dispensing them to unknowing patients, and then submitting claims to Medicaid. Between 2006 and 2008, Veeramachaneni bilked the state out of $1.2 million, the amount he was charged to repay. He was also banned from ever working in the pharmaceutical or health care industry again.

Looking for Savings

"Preventing fraud and abuse is always a priority," says Washington Representative Eileen Cody (D), "but when facing tough economic times, as we have over the last few years, we are looking for coins in the couch cushions."

Representative Eileen Cody (D) Washington

For many state lawmakers, those coins are the savings that come from the difficult re-examination of how limited resources are currently used.

When Douglas Wilson took the reins as Texas inspector general, for example, most investigations were aimed at Medicaid beneficiaries. Based on historical trends, however, Wilson knew that efforts to recover fraud, waste and abuse from Medicaid providers—rather than beneficiaries—reaped a much higher rate of return for the state. So he switched gears and focused the majority of efforts instead on catching fraudulent providers. Although it's hard to prove that a single policy reduced fraud by a specific amount, officials believe that this change, and others designed to improve efficiency and increase monetary returns, are yielding positive results.

North Carolina beefed up its fraud prevention resources—doubling the Medicaid Fraud Control Unit's Medicaid Investigation Division—believing the money it saves will more than pay for their added costs.

Wisconsin appropriated an additional $2 million and 19 positions to the Department of Health Services' Office of Inspector General to support fraud prevention and program integrity efforts, beginning in FY 2013.

With the nation's most expensive Medicaid program, New York has taken various steps to combat fraud in the past few

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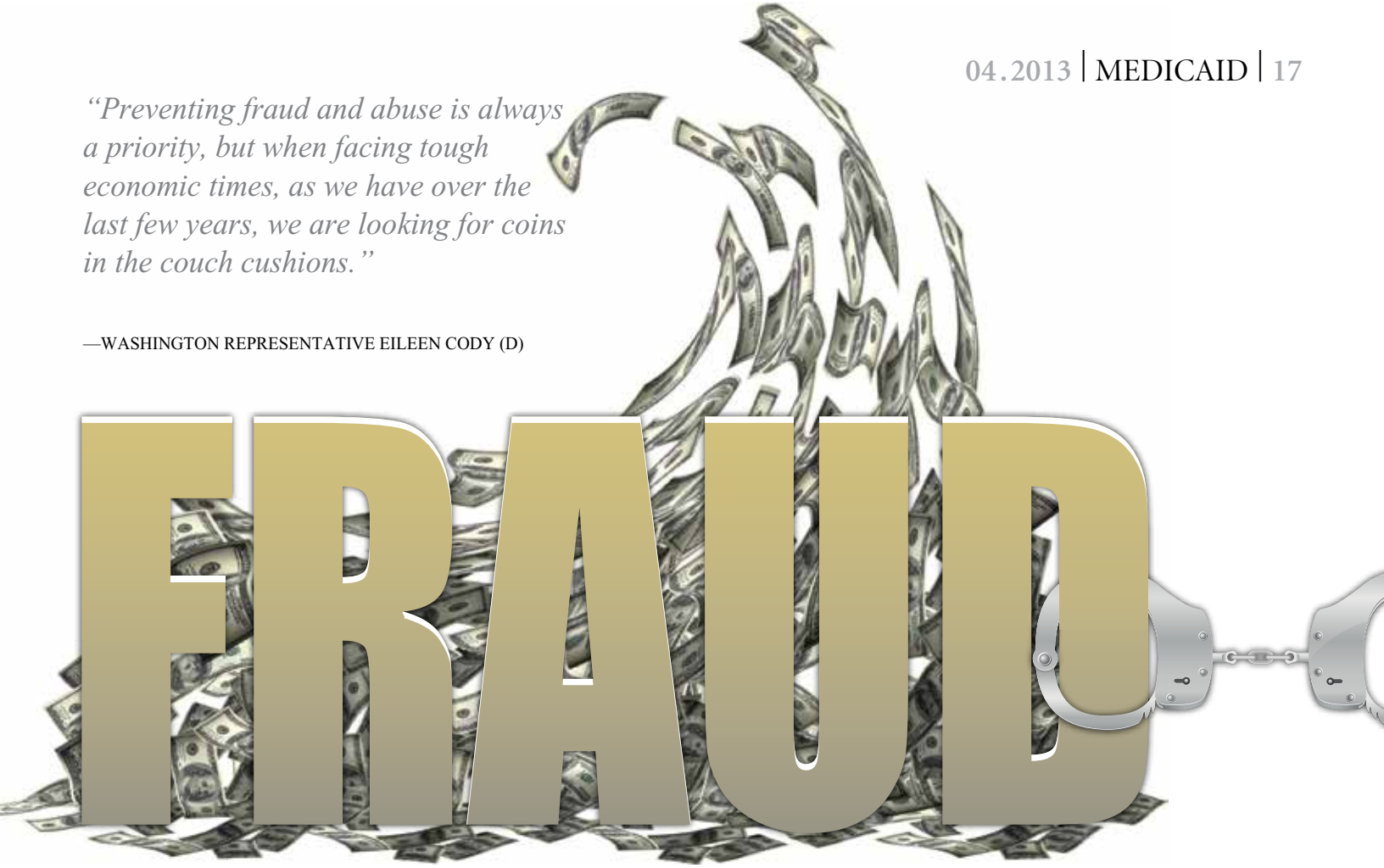

years. In 2006, legislation increased fraud penalties; 2010 saw the creation of a Republican Task Force on Medicaid Fraud; and, in 2011, the governor formed a statewide team to develop recommendations to reform the Medicaid system and reduce costs.

Nevertheless, the state has come under increased scrutiny, after a recent report from the U.S. House Committee on Oversight and Government Reform identified waste, fraud and mismanagement in New York Medicaid. In response, Senate Republicans called for an immediate independent audit of the program and announced a joint roundtable meeting of the Senate Health and Investigations Committees to investigate allegations of inaction by the Office of the Medicaid Inspector General.

"Medicaid is New York state's largest spending program, and we must conduct a thorough and sweeping audit of the entire system to make certain that it is operating as efficiently as possible," says Senator Hannon. "We need to constantly monitor and review Medicaid because taxpayers have a right to expect that their tax dollars are being spent wisely to care for people who truly need health care."

Moving Away From "Pay and Chase"

Fraud fighters are getting assistance from new technology that helps catch fraud before it occurs, rather than chasing after it later on. The technology aims to detect illicit behavior and suspicious billing practices before reimbursement checks are written. It uses real-time data and advanced analytics to identify suspect patterns, flag dubious claims and, potentially, deny payments.

Texas, for example, secured matching federal funds to develop "pattern recognition analysis" technology, a system that will provide near real-time analysis, capable of sifting through immense amounts of data to identify suspicious activity. Illinois' Office of Inspector General developed its own highly advanced predictive analytics technology using a 2007 federal Medicaid Transformation Grant that does similar analyses.

Other technical innovations also offer hope in thwarting Medicaid abuse and fraud. New York, for example, enacted legislation that requires certain groups of providers with a history of Medicaid fraud—such as large home health agencies, long-term home health care programs and personal care providers—to electronically verify services performed. The technology quickly verifies that the services billed to Medicaid are what beneficiaries actually receive.

"History has shown that there are always individuals who try to take advantage of the program—either by outright fraud or not carrying out program requirements properly," says New York's Senator Hannon. "What we need to do is keep a careful eye on providers—and on government—to ensure that entitlements are allotted, apportioned, paid and accounted for in a very fair way."

As Medicaid continues to evolve and expand, those intent on cheating the system will invariably develop new, sophisticated schemes. The challenge for states is to develop equally intelligent, timely strategies to keep one step ahead of the fraudsters.