Medicaid Report: New Hampshire

Exploring Measures to Prevent and Detect Fraud

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EXECUTIVE SUMMARY

At present, more than 20 percent of total state spending nationally is dedicated to Medicaid, making it the second largest item in most state budgets after education.[1] As funds become limited and health care needs expand, states must search for ways to cut costs while still providing quality services. With funding avenues exhausted, states seek to rein in costs by restructuring their Medicaid programs to produce greater efficiency, which includes initiating preventative measures against Medicaid fraud. Reducing the amount of Medicaid funds that go to fraudulent claims will increase the amount of money available in state budgets for health care funding and other needs. This report examines measures to prevent and detect Medicaid fraud, such as the implementation of more stringent enrollment controls and increased use of Information Technology (IT) for data analysis, and identifies sources for the expansion of fraud prevention programs in New Hampshire.

1. THE NATURE AND IMPACT OF MEDICAID FRAUD

Fraud is a growing problem for state governments. To date, the impact of fraud has only been quantified in funds returned after successful fraud investigations; there is no information available that estimates the total amount of fraud. Furthermore, the Centers for Medicare and Medicaid Services' (CMS) efforts through the pilot Payment Accuracy Measurement (PAM) program have not yet produced assessments of the accuracy rates of each state's Medicaid claims and payments.[2] Nevertheless, the Government Accountability Office (GAO) estimated that Medicaid inaccuracy rates as modest as three percent in the fiscal year 2004 would have resulted in an approximate loss of $5 billion in federal funds.[3]

Medicaid fraud includes, but is not limited to, the following practices by providers:[4]

- *Billing for services not performed* – A provider bills Medicaid for a treatment, procedure, or service that was not actually performed.

- *Double billing* – A provider bills Medicaid and a private insurance company or patient for the same treatment.

- *Substitution of generic drugs* – A pharmacy bills Medicaid for the cost of a name brand prescription when a less costly generic substitute is actually provided.

- *Unnecessary services* – A provider misrepresents a diagnosis in order to receive payment for extraneous procedures or lab tests.

- *Kickbacks* – Providers conspire to give money, gifts, or products when they receive referrals from other providers.

- *Upcoding* – A provider exaggerates the level of service provided to increase the amount billed to Medicaid.

- *Unbundling* – A provider divides one medical event into many parts; for example, billing for a procedure and then a routine follow-up, when the follow-up should be included in bundle of services provided with the primary procedure.

- *Supplemental Charges* – A provider charges a Medicaid recipient for a service covered by Medicaid, or charges a recipient the difference between what Medicaid pays and the provider's usual fee.

- *Inflating Charges* – A provider charges Medicaid more than it would a private insurance company or the general public for the same service.

Although Medicaid fraud is also committed by recipients, the vast majority of existing research and preventative efforts to date focus on providers. Therefore, this study explores the prevention and detection of provider fraud.

2. MEDICAID FRAUD CONTROL UNITS

Currently, New Hampshire has a Medicaid Fraud Control Unit (MFCU) under the jurisdiction of the state Attorney General's office. All MFCUs nationally receive federal grants from the U.S. Department of Health and Human Services that account for 75 percent of their budgets. This incentive funding is matched by 25 percent state funding and requires MFCUs to employ full-time attorneys, investigators, and auditors with specialized expertise. Units are recertified annually and must be autonomous – they may not receive funds from the state's Medicaid agency.[5] Below is a table comparing New Hampshire's MFCU to those of states with similar legislative and regional characteristics:

Table 1. Comparative MFCU Statistics

	MFCU Staff[6]	MFCU Budget 2006 [7]	Total Medicaid Enrollment FY 2003 [8]	Total Medicaid Spending FY 2005 (in millions) [9]
New Hampshire	2 Attorneys, 3 Auditors, 1 Investigator, 1 Other	$750,000	129,700	$1,258
Maine	2 Attorneys, 1 Auditor, 4 Investigators, 1 Other	$722,098	378,200	$2,249
Rhode Island	2 Attorneys, 3 Auditors, 5 Investigators, 1 Other	$947,000	210,900	$1,691
Vermont	2 Attorneys, 1 Auditor, 2 Investigators, 1 Other	$676,000	159,700	$868

In comparison to neighbor states, New Hampshire is dedicating a comparable amount of resources MFCU activities, but there is room for expansion in the state's fraud prevention measures. Notably, New Hampshire lacks a state statute that specifically targets Medicaid fraud. Therefore, the MFCU must prosecute Medicaid fraud under more generic statutes such as mail fraud, racketeering, or conspiracy.[10] Creating and implementing a statute specifically to prosecute Medicaid fraud, such as the Model Managed Care Criminal and Civil Fraud Statutes

created by the National Association of MFCUs and CMS, has the potential to streamline the prosecution of Medicaid fraud.

3. IMPLEMENTING MEASURES TO PREVENT AND DETECT FRAUD

In response to federal standards as well as through their own initiative, states have implemented a range of programs and statutes to decrease the occurrence of fraud. The following is a list of potential program types that have shown success in reducing instances of fraud as well as detecting fraud in order to recover state funds:[11]

- *Onsite Inspections* – Targeting high-risk providers – those with unusual billing trends or who are not subject to state licensure, for example – through onsite inspection to validate a provider's existence and garner information about its service capacity. Illinois officials reported to have avoided an estimated $1 million of potential improper payments between 2001 and 2002 by conducting onsite inspections that revealed 49 potential providers to be inadequate in their service standards.

- *Criminal Background Checks and Surety Bonds* – Applicants' self-disclosures may not be completely reliable. Therefore, some states run checks with federal agencies to compare the disclosures with information that is available on the provider. Furthermore, surety bonds protect states against financial loss if the terms of a provider's contract are not fulfilled.

- *Probationary and Reenrollment Policies* – When providers periodically reapply for enrollment, provider information can be verified and reevaluated. Also, placing new high-risk providers on probationary status ensures continued compliance with standards for enrollment and allows states to monitor billing patterns and conduct onsite inspections as necessary.

- *Using Advanced Technology* – States can invest in IT to preauthorize the provision of Medicaid services and augment their data processing capabilities. Contracting with companies that specialize in claims utilization review can identify aberrant billing patterns. Also, databases can be compiled and updated in order to avoid paying bills claimed under inactive or unauthorized provider numbers.

- *Creating Incentives for Reporting Fraud* – The practices of the federal False Claims Act (FCA) can be adapted by states in order to provide for penalties for anyone who knowingly involves or submits to fraudulent funds claims. Furthermore, the FCA allows whistleblowers to file a case on behalf of the government and share in money that governments recover from successful fraud claims. Between 1987 and 2005, the federal government recovered over $15 billion in successful fraud prosecutions, which is testament to the success of the FCA incentives.[12]

- *Prescription Drug Controls* – Prescription records can be audited for patterns that may indicate fraudulent behavior. In both Texas and New York, authorities use computer software to map out doctors and pharmacies that attract Medicaid patients from unusually

long distances, a potential signifier of drug fraud. New York also examines pharmacies that fill the most prescriptions locally. At present, New York utilizes a phone ordering system for physicians to obtain payment authorization numbers for the prescriptions they give their Medicaid patients. Officials estimate that the system saved the state $15.4 million over a six-month period in 2003.[13]

- *Contracting Out* – Contracting with a private technology company may aid in the identification of overpayments. In fiscal year 2005, Alabama contracted with Health Watch Technologies to review provider claims payments. The company identified $9 million in Medicaid overpayments, of which the state recouped $4 million.[14] Kentucky also contracted with a private firm to use computer systems to investigate claims payments. From January 1995-1998 the contractor discovered $137 million in overpayments, which netted a recovery of more than $4 million dollars for the state, compared to past annual recovery averages of $75,000.[15]

A 2004 GAO survey released information on participating states' efforts to uphold Medicaid program integrity. According to the report, when dealing with high-risk providers, New Hampshire currently conducts onsite inspections and has intensified its auditing and provider education practices. The state suspends payments to inactive billing numbers and utilizes a data clearinghouse that stores information on claims, beneficiaries, and providers as an integrated database with search and analysis capability. New Hampshire also takes part in a CMS-run Technical Assistance Group, which provides a forum for state MFCUs to discuss preventative strategies and share information on emerging trends in Medicaid fraud and abuse.[16]

New Hampshire might benefit from expanding its fraud prevention practices by implementing probationary and reenrollment policies, which, along with increased scrutiny of provider applications, saved California an estimated $200 million in expenditures in 2003. That constitutes just a small portion of California's $38 billion Medicaid budget, but is nevertheless a significant savings.[17] The same level of success for New Hampshire could save approximately $6 million of the state's Medicaid budget. In New York, the use of IT to study prescribing patterns and monitor over-utilization through payment authorization programs saved an estimated $15.4 million in a six-month period in 2003, and such expansion of New Hampshire's IT capabilities could be beneficial in detecting instances of fraud.

4. FUNDING SOURCES

4.1 Deficit Reduction Act

Through the Deficit Reduction Act of 2005 (DRA), the federal government sought to provide incentive to those states enacting anti-fraud legislation modeled after the FCA. DRA incentives entitle any state with fraudulent claims laws meeting federal standards to retain ten additional percentage points of the federal share of payments recovered through their state FCA. New Hampshire's Federal Medical Assistance Percentage (FMAP) for fiscal year 2007 is 50, which is the lowest rate possible.[18] By implementing the FCA standards outlined in Appendix A, New Hampshire could benefit from enhanced federal matching funds.[19]

The DRA also established the Medicaid Integrity Program within the Department of Health and Human Services, which provides funding to the CMS to combat fraud. By fiscal year 2009, the CMS will receive $75 million annually in Congressional appropriations to implement a comprehensive plan to prevent and detect Medicaid fraud.[20] Thus far, CMS plans include the expansion of the Medicare-Medicaid Data Match Program (Medi-Medi). Medi-Medi analyzes identifies abnormal billing and utilization patterns in order to reduce the occurrence of fraud that crosses program boundaries. At the current time, only seven states have fully operational Medi-Medi programs. The program reported a total of $133 million in returns, while restoring $2 million in overpayments to the states and identifying another $59.7 million vulnerable to fraud.[21] In 2001, a pilot program saved California an estimated $58 million, with a return ratio of 21:1 on their expenditures.[22] Since the program's inception, Medi-Medi projects have yielded 335 investigations and identified an estimated $182 million in at-risk Medicaid funds.[23]

CMS will also make the Payment Accuracy Measurement pilot project permanent by establishing the Payment Error Rate Management (PERM) program, which will use its results (expected in 2008) to identify states requiring special assistance in payment accuracy. CMS will continue its Technical Assistance Group as well, and all states, including New Hampshire, stand to benefit greatly from CMS's expanded resources and increased scrutiny into states' fraud prevention programs.[24]

4.2 Information Technology Enhancements

There is a cost inherent in the implementation of any new fraud prevention or detection program, but there is also revenue generated by effective measures. States have implemented preventative measures ranging from large scale IT investments to simple data crosschecks:

- Florida recently invested $308 million in a new computer system contracted by Electronic Data Systems (EDS). Florida's Agency for Health Care Administration anticipates savings of more than $20 million per year, with federal funding covering approximately 90 percent of development costs and 75 percent of operations costs. In comparison, similar savings for New Hampshire would total approximately $2 million per year.[25]

- Michigan cross-checks death records with Medicaid enrollment lists. Doing so has saved the state approximately $5 million per year, which more than covers its $4.8 million MCFU budget.[26] Comparatively, New Hampshire's savings would be approximately $800,000 if the state's success with cross-checks was on the same scale as Michigan's.

Preventative measures both large and small can have a significant impact on fraud and inefficiency in the implementation of Medicaid. Increased accuracy in Medicaid payments saves states money and with more detection measures in place, states can recover revenue through successful fraud claims. In this way, programs that make Medicaid services more effective and reduce fraud are investments that can provide great revenue returns long after the provision of funds for their implementation.

5. CONCLUSION

As Medicaid expenditures take up increasing proportions of state budgets, it is becoming more important to implement programs efficiently and cost-effectively. Taking preventative measures against Medicaid fraud is one way for states to reduce their spending and provide greater quality care to Medicaid recipients. Fraud prevention measures such as probationary and reenrollment policies, utilization of advanced technologies, and incentivized fraud reports can help state governments reduce fraudulent claims paid and save valuable resources for other budgetary needs. Furthermore, augmenting fraud policies to meet FCA standards can enhance federal contributions to state fraud prevention. Addressing Medicaid fraud proactively and preventatively with more stringent provider enrollment standards has saved states millions of dollars and could be similarly beneficial to New Hampshire. Increased utilization of New Hampshire's existing data warehouses can help to detect fraud and recover funds already paid.

Further research should include a more detailed cost-benefit analysis of fraud prevention program implementation for New Hampshire. Also, a comparative analysis of the success of fraud prevention in those states that have augmented their mandates to meet FCA standards versus those that have yet to do so would provide more information as to the potential benefits of such changes in New Hampshire.

Appendix A - Model State FCA[27]

According to the Taxpayers Against Fraud Education Fund, a state FCA including the following provisions would qualify New Hampshire for an enhanced FMAP:

1) A provision providing *qui tam* whistleblowers (formally known as "relators") standing to bring FCA actions on behalf of the state government, under the seven types of conduct currently prohibited in 31 U.S.C. 3729(a), including the following:
   - Presenting, or causing to presented, a false claim;
   - Making, or causing to be made, a false statement or record in support of a false claim;
   - Conspiring to violate the FCA;
   - Making, using, or causing to be made or used a "false record or statement to conceal, avoid or decrease an obligation to pay to transmit money or property to the Government."
2) A provision statutorily setting treble damages (with double damages in instances of sufficient cooperation) and civil penalties at amounts of $5,000 to $10,000 per false claim.
3) A provision permitting successful relators to collect at least the same percentage of the recovery as allowable under 31 U.S.C. 3730(d), namely that the relator is guaranteed 15 to 25 percent of judgment when the State government intervenes, and 25 to 30 percent if the State government does not intervene.
4) A provision awarding reasonable attorneys fees and costs to a successful relator.
5) A provision defining the Act's *mens rea* requirement of "knowing" or "knowingly" to include: "(1) actual knowledge of the information, (2) deliberate ignorance of the truth or falsity of the information, or (3) reckless disregard of the truth or falsity of the information," and further specifying that "no proof of specific intent to defraud is required."
6) A provision setting the statute of limitations for all violations under the FCA, including actions under the Act's retaliation provision, to be ten years after the date on which the violation occurred. The federal FCA provision, 31 U.S.C. § 3730(b)(1), has a confusing formula that calls for a 10-year, 6-year, and 3-year limitation, based on various situations. TAF Education Fund recommends that the States simply the statute of limitations provision by adopting a single statutory term of ten years, which would comply with Social Security Act section 1909(b)'s requirement that the state FCA be "as effective in rewarding and facilitating *qui tam* actions" as the federal False Claims Act.
7) A provision establishing the burden of proof as a "preponderance of the evidence" standard.
8) A provision providing a cause of action for relators who suffer retribution from employers for whistleblower activities related to the FCA.
9) A provision that allows relators to go forward with a *qui tam* action, even if government officials are aware of the fraud at issue, unless the elements of the actionable false claims alleged in the *qui tam* complaint had been publicly disclosed specifically in the news media or in a publicly disseminated governmental report at the time the complaint was filed and the relator did not have independent knowledge of the fraud.
10) A provision providing that the first to file a *qui tam* claim is the only relator who qualifies to pursue such a claim.
11) A provision providing that the *qui tam* complaint is filed under seal and not served on the defendant or made public in any way, and that the entire action is stayed while the State (acting through its Attorney General) is notified of the lawsuit by service of a copy of the complaint and "written disclosure of substantially all material evidence and information the person possesses."
12) A provision providing that the State's Attorney General assumes "primary responsibility" for the lawsuit, but also that the relator continues also as plaintiff.
13) A provision preserving certain rights of the relator when the State government intervenes, including the right to object and be heard on a motion to limit the relator's role, or to dismiss or settle the case.
14) A provision providing that if the Government elects not to intervene, the *qui tam* relator may proceed with the action.
15) A provision providing that during litigation, a relator's role may be restricted by the court "[u]pon a showing by the government that the unrestricted participation during the course of the litigation by the person initiating the action would interfere with or unduly delay the government's prosecution of the case, or would be repetitious, irrelevant, or for purposes of harassment," or "[u]pon a showing by the defendant that unrestricted participation during the course of the litigation by the person initiating the action would be for purposes of harassment or would cause the defendant undue burden or unnecessary expense."
16) A provision providing that upon a showing of "good cause," the court may permit the government to intervene "at a later date," even if the government originally declined to intervene.

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