Overview of Federal and State Healthcare Fraud and Abuse Initiatives

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Given the size and scope of healthcare expenditures in the United States, the healthcare industry has been a major target of fraud and abuse. In response, both Federal and State governments have developed myriad initiatives to target such activities. The government has made great strides in the past decade in establishing several key programs and partnerships that focus on coordination and cooperation between various agencies to combat healthcare fraud and abuse. The government has also utilized, to great success, advances in information technology to collect and analyze large amounts of data to predict, uncover, and prevent healthcare fraud and abuse. Below is an overview of several key initiatives.

FEDERAL HEALTH CARE FRAUD AND ABUSE CONTROL (HCFAC) PROGRAMS BUDGET

Mandatory Resources

| Office of Inspector General | $187,097,926 |
| Health and Human Services Wedge | $34,819,122 |
| Medicare Integrity Program | $851,509,634 |
| MIP/Medicare (non-add) | $797,581,005 |
| Medi-Medi (non-add) | $53,928,629 |
| Department of Justice Wedge | $58,164,042 |
| Federal Bureau of Investigation | $128,149,615 |
| **Subtotal, Mandatory HCFAC** | **$1,259,740,339** |

Discretionary Resources

| Office of Inspector General | $28,121,691 |
| CMS Program Integrity | $237,343,109 |
| Medicare Program Integrity (Non-Add) | $207,984,175 |
| Medicaid Program Integrity (Non-Add) | $29,358,934 |
| Department of Justice | $28,121,691 |
| **Subtotal, Discretionary HCFAC** | **$293,586,491** |
| **Grand Total, HCFAC** | **$1,553,326,830** |

- The Inspector General for the U.S. Department of Health and Human Services recently reported that for every dollar the Departments of Justice (DOJ) and Health and Human Services (HHS) have spent fighting health care fraud, they have returned an average of nearly eight dollars to the U.S. Treasury, the Medicare Trust Fund, and others.
- Sequestration hit the DOJ and HHS hard. A total of $30.6 million was sequestered from the HCFAC program for fiscal year 2013.

THE HEALTH CARE FRAUD PREVENTION AND ENFORCEMENT ACTION TEAM (HEAT)

The Health Care Fraud Prevention & Enforcement Action Team (HEAT) was established in May 2009 as a cabinet-level commitment to both prevent health care fraud and enforce current anti-fraud laws prevent and prosecute health care fraud around the country.

- **HEAT is jointly led** by the Deputy Attorney General and HHS Deputy Secretary.
- **HEAT is comprised of** top level law enforcement agents, prosecutors, attorneys, auditors, evaluators, and other staff from DOJ and HHS and their operating divisions.
The Medicare Fraud Strike Force program, explained below, is a key component of HEAT.

THE HEALTHCARE FRAUD PREVENTION PARTNERSHIP (HFPP)

The Healthcare Fraud Prevention Partnership (HFPP) is the groundbreaking public/private partnership between the government and private sector insurance payers. The purpose of the partnership is to exchange data and information between the partners to help improve capabilities to fight fraud, waste and abuse in the health care industry.

- **Current partners** include federal (HHS-OIG, DOJ, FBI, CMS), states, private plans, and associations.
- **HFFO’s first information sharing study** included exchanging codes and code combinations frequently associated with fraud, waste, or abuse, as well as fraud schemes and descriptions.

THE DOJ-HHS MEDICARE “STRIKE FORCE”

The joint DOJ-HHS Medicare Fraud Strike Force is a multi-agency team of federal, state, and local investigators designed to fight Medicare fraud.

- The Strike Force uses Medicare data analysis techniques and an increased focus on community policing to combat fraud.
- The Strike Force teams use advanced data analysis techniques to identify high-billing levels in health care fraud hot spots so that interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers.
- The Center For Medicare and Medicaid Services (CMS) has designated program integrity field offices located in or near Miami, Los Angeles, and Brooklyn with CMS Strike Force Liaisons, who:
  - Coordinate with law enforcement
  - Facilitate data analysis
  - Expedite suspension requests
  - Work with CMS and Zone Program Integrity Contractors to conduct data analysis to proactively identify targets and to coordinate efforts among various contractors and agencies to identify local issues and vulnerabilities with national or regional impact
- **The Strike Force is currently operating in nine cities:**
  - Baton Rouge, Louisiana
  - Brooklyn, New York
  - Chicago, Illinois
  - Dallas, Texas
  - Detroit, Michigan
  - Houston, Texas
  - Los Angeles, California
  - Miami, Florida
  - Tampa, Florida
- **HHS reports the following progress since the Strike Force started seven years ago:**
  - Strike Force prosecutors filed more than 788 cases charging more than 1,727 defendants who collectively billed the Medicare program more than $5.5 billion
  - 1,137 defendants pleaded guilty and 148 others were convicted in jury trials
1,087 defendants were sentenced to imprisonment for an average term of approximately 47 months

- HHS reports the following Strike Force accomplishments in 2013:
  - 137 indictments, informations [formal criminal charge pleading], and complaints involving charges filed against 345 defendants who allegedly collectively billed the Medicare program more than $1.1 billion
  - 234 guilty pleas negotiated and 34 jury trials litigated, with guilty verdicts against 48 defendants
  - Imprisonment for 229 defendants sentenced during the fiscal year, averaging more than 52 months of incarceration

**Example of Strike Force activity:**

In May 2013, a nationwide takedown by Medicare Fraud Strike Force operations in eight cities resulted in charges against 89 individuals, including doctors, nurses and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $223 million in false billings. The defendants charged were accused of various health care fraud-related crimes, including conspiracy to commit health care fraud, violations of the anti-kickback statutes and money laundering. The charges were based on a variety of alleged fraud schemes involving various medical treatments and services, primarily home health care, but also mental health services, psychotherapy, physical and occupational therapy, durable medical equipment (DME) and ambulance services. This coordinated takedown was the sixth national Medicare fraud takedown in Strike Force history.

**HHS AUDITS**

HHS also uses targeted audits to uncover misuse of Medicare and Medicaid dollars.

In 2013 HHS targeted audits at the following:

- Preventing and Detecting Medicaid Fraud
- Medicaid Payments to Excluded Providers
- Medicaid Data for Program Integrity
- Medicaid Disproportionate Share Hospital Payments
- Medicaid Inpatient Psychiatric Services
- Medicaid Payments for Personal Care Services
- Medicaid Home Health Services
- Medicaid Family-Based Treatment Rehabilitation Services
- Medicaid Family Planning Services
- Medicaid School-Based Services
- Medicaid Overpayments
- Detecting Fraud in Medicare
- Theft of Medicare Identities
- Part C and Part D Program Integrity Activities
- Payments for Individuals Ineligible for Medicare
HCFAC PROGRAM OVERSIGHT

- HHS’s Office of the Inspector General (OIG) continues to use data mining, predictive analytics, trend evaluation, and modeling approaches to better analyze and target the oversight of HHS programs.
- Analysis teams use near-time data to examine Medicare claims for known fraud patterns, identify suspected fraud trends, and to calculate ratios of allowed services as compared with national averages, as well as other assessments.

OIG’S PROVIDER SELF-DISCLOSURE PROTOCOL (SDP)

In 1998, OIG published the Provider Self-Disclosure Protocol to establish a process for health care providers to voluntarily identify, disclose, and resolve instances of potential fraud involving the Federal health care programs. Voluntary disclosure does not guarantee any sort of settlement. However, OIG would prefer to resolve an issue through settlement rather than trial, and health care providers can mitigate the risk of civil monetary penalties, criminal prosecution, and program exclusion by voluntarily disclosing potential instances of fraud through the SDP.

- Since 1998, OIG has resolved over 800 disclosures, resulting in recoveries of more than $280 million to the Federal health care programs.
- Over 200 matters have been disclosed under the new Stark self-disclosure protocol.
- Self-disclosure of potential fraud can limit civil penalties. OIG reports that its general practice in Civil Monetary Penalty settlements of SDP matters is to require a minimum multiplier of 1.5 times the single damages, which is far lower than the potential criminal and civil penalties available if the case were to be prosecuted.
- Self-disclosure of potential fraud can also limit program exclusion. Since 2008, OIG has resolved 235 SDP cases through settlements. In all but one of these cases, OIG released the disclosing parties from permissive exclusion without requiring any integrity measures.

VIRGINIA’S MEDICAID FRAUD CONTROL UNIT (MFCU)

The Virginia Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General was certified October 1, 1982, by the United States Department of Health and Human Services. The Unit is one of 50 units throughout the United States with the same mission. In deciding to establish a MFCU in Virginia, the General Assembly stated:

> The General Assembly finds and declares it to be in the public interest and for the protection of the health and welfare of the residents of the Commonwealth that a proper regulatory and inspection program be instituted in connection with the providing of medical, dental and other health services to recipients of medical assistance. In order to effectively accomplish such purpose and to assure that the recipient receives such services as are paid for by the Commonwealth, the acceptance by the recipient of such services and the acceptance by practitioners of reimbursement for performing such services shall authorize the Attorney General or his authorized representative to inspect and audit all records in connection with the providing of such services.

Virginia Code § 32.1-310.
• The MFCU employs a professional staff of criminal investigators, auditors, attorneys and support staff who work together to develop investigations and prosecute cases.

• The Virginia MFCU works regularly with federal, state and local law enforcement agencies to combat fraud, protect our most vulnerable citizens and to save taxpayer dollars.

• Since 1982, the MFCU has recovered more than $800 million in criminal and civil recoveries including affirmative civil enforcement cases (ordered and collected reimbursements, fines and restitutions).

• In 2008, the Virginia MFCU was named the number one MFCU in the country by the United States Department of Health and Human Services, Office of Inspector General.

• The MFCU is proud to serve among the nation’s leaders in combating fraud in the Medicaid program.

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**SOURCES:**


• http://www.stopmedicarefraud.gov/aboutfraud/heattaskforce/


• http://www.oag.state.va.us/Programs%20and%20Resources/Medicaid_Fraud/MFCU_2012/MFCU_About.html