The Challenge of Health Care Fraud

• An opportunistic crime.

• Continuously changing, morphing and migrating, taking countless forms, limited only by the creativity of the perpetrator.

• The U.S. health care system is complex, therefore, health care fraud is inevitably a complex crime. Fraudsters exploit the complexity of the system—there are so many entry points and variables at play.

• Detection of health care fraud often requires the application and knowledge of medical and clinical best practices and terminology and arcane coding systems - ICD-9, CPT and CDT codes, DRGs, etc.
The ability to spread false claims among many insurers and payers (including Federal and state governments) simultaneously, increasing proceeds from fraud while lessening the chances of detection.

Health care fraud isn’t just a financial crime. Patients can be put at risk for, or be a victim of, physical harm through unnecessary or dangerous procedures.

The sheer volume of health care claims makes fraud detection a challenge. Those committing fraud have the full range of medical conditions, treatments and patients on which to base false claims.
The Challenge of Health Care Fraud

• Health care fraud often entails patient access to health care and involves the health care profession, which is well-respected and trusted. These factors make it a particularly challenging crime to address.

• The challenges of HIPAA Privacy regulations.

• The importance of health plan provider networks.

• Prompt pay laws.

• The Medical Loss Ratio (MLR) rule, which excludes “fraud prevention activities” from activities that improve health care quality (note that adjustments to incurred claims must include “the amount of claims payments recovered through fraud reduction efforts not to exceed the amount of fraud reduction expenses”—so a limited acknowledgement).
How Big is the Problem?

- Estimates of the amount of fraud in the U.S. health care system vary widely with most estimates ranging from 3% to 10% of NHE.

- No one has a definitive answer because:
  - It is a crime that, by its very nature, depends on going undetected.
  - The U.S. health care system is very large, complex and diffuse with multiple payers and programs, involving hundreds of thousands of providers.
  - The blurring of the lines of what is fraud, compared to waste and abuse.
How Big is the Problem?

- NHCAA estimates that the financial losses due to health care fraud are in the tens of billions of dollars each year.

- Other estimates:
  - Institute of Medicine of the National Academies estimates health care fraud at $75 billion a year (2013)
  - The FBI estimates the loss between $78 billion and $260 billion (2012)
  - The Journal of the American Medical Association (JAMA) estimates fraud and abuse to be between $82 billion and $272 billion (2011)
Information Sharing, Cooperation & Partnership
Cooperation and information exchange between public and private payers of health care is critical to the success of anti-fraud efforts and should be encouraged and enabled.

Health care fraud does not discriminate between types of medical coverage. The same schemes used to defraud Medicare and Medicaid migrate to private insurance, and schemes perpetrated against private insurers make their way into government programs.

Many private insurers are Medicare Parts C and D contractors or provide Medicaid coverage in the states, making clear the intrinsic connection between private and public interests on this issue.
When analyzing a provider’s claims for potential fraud or abuse, each payer is limited to the claims it receives and adjudicates and is not privy to claims information collected by other payers.

Those who perpetrate health care fraud bank on the assumption that payers are not working together to collectively connect the dots and uncover the true breadth of a scheme.

The sharing of preventive and investigative information among payers is crucial for successfully identifying and stopping health care fraud.
Payers, whether private or public, who limit the scope of their anti-fraud information to data from their own organization or agency are taking an uncoordinated and piecemeal approach to the problem.

Many U.S. Attorney Offices sponsor health care fraud task forces that hold routine information-sharing meetings, and when invited to do so, private insurers often participate in these meetings to gather and offer investigative insight.

The Dept of Justice has guidelines for the operation of the Health Care Fraud & Abuse Control Program (HCFAC) established by HIPAA which provide a strong basis for information sharing: “Statement of Principles for the Sharing of Health Care Fraud Information between the Department of Justice and Private Health Plans”
NHCAA’s Role

• As a national association with private- as well as public-sector members, NHCAA provides a trusted venue for facilitating information sharing, cooperation and partnership.

• We were founded in 1985 as a private-public partnership against health care fraud and that theme has remained central to what we do.

• Provide a forum for information sharing and anti-fraud education.
Our Mission

- To protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud and abuse.
NHCAA Member Organizations

1199SEIU Benefit & Pension Fund · AdvanceMed Corporation · Aetna · American Specialty Health, Inc. · AMERIGROUP Corporation · APWU Health Plan · Arkansas Blue Cross Blue Shield · Blue Cross Blue Shield Association · Blue Cross Blue Shield of Alabama · Blue Cross Blue Shield of Kansas · Blue Cross Blue Shield of Louisiana · Blue Cross Blue Shield of Massachusetts · Blue Cross Blue Shield of Nebraska · Blue Cross Blue Shield of Rhode Island · Blue Shield of California · BlueCross BlueShield of Minnesota · BlueCross BlueShield of Mississippi · BlueCross BlueShield of North Carolina · BlueCross BlueShield of South Carolina · BlueCross BlueShield of Tennessee · Capital BlueCross · Capital District Physicians Health Plan, Inc. · CareFirst BlueCross BlueShield · CareSource Management Group · Catamaran · Centene Corporation · Central States Funds · CIGNA · Community Health Network of Connecticut, Inc. · Coventry Health Care, Inc. · Crossroads Healthcare Management LLC · Delta Dental Plans Association · EmblemHealth · Excellus Blue Cross Blue Shield · Florida Blue · Government Employees Health Association, Inc. · Guardian Life Insurance Co. · Harvard Pilgrim Health Care, Inc. · Hawaii Medical Services Association · Health Care Service Corporation · Health Integrity, LLC · Health Net Federal Services Tricare · HealthFirst · HealthMarkets · HealthNow New York, Inc. · HealthSpring, Inc. · Highmark · Horizon Blue Cross Blue Shield of New Jersey · Humana · IHC Health Solutions · Independence Blue Cross · Independent Health · Kaiser Permanente · Magellan Health Services, Inc. · Medical Excess LLC · Medical Mutual of Ohio · Meridian Health Plan of Michigan · Mutual of Omaha · MVP Health Care · National Elevator Industry Benefit Plans · Nationwide Specialty Health · Network Health Plan · New Directions Behavioral Health, LLC · Organización de Servicios Directos Empresarios (OSED) · Premera Blue Cross · Prime Therapeutics LLC · Principal Financial Group · SCAN Health Plan · State Farm Insurance Companies · The Regence Group · TMG Health, Inc. · Travelers Insurance · TriWest Healthcare Alliance · Trustmark Insurance Company · Truven Health Analytics · Tufts Health Plan · UnitedHealthcare Employer & Individual · UnitedHealthcare/OptumInsight · UnitedHealthcare/Public & Senior Market Group · Universal American · Universal Health Care · UPMC Health Plan · Virginia Premier Health Plan · Vision Service Plan · WEA Trust · WellCare · WellPoint, Inc. · Western-Southern Life Insurance Company · Wisconsin Physicians Service · XLHealth
Alameda County District Attorney’s Office, Consumer & Environmental Protection Division · Amtrak, Office of Inspector General · Arizona Health Care Cost Containment System, Office of Program Integrity · Arkansas Department of Insurance, Criminal Investigation Division · California Department of Insurance, Fraud Division · California Dept. of Health Services, Audits & Investigations · California Dept. of Managed Health Care, Office of Enforcement · Cape May County Prosecutors Office · Connecticut Department of Insurance · Connecticut Department of Social Services · Cumberland County District Attorney's Office · DC Dept of Insurance Securities & Banking · Florida AHCA, Bureau of Medicaid Program Integrity · Florida Department of Financial Services, Division of Insurance Fraud · Idaho Dept. of Health & Welfare · Iowa Insurance Fraud Bureau · Kansas Insurance Department · LAPD, Worker's Compensation Fraud Coordination Unit · Los Angeles County Metropolitan Transit Authority · Louisiana State Police · Maryland Dept. of Health & Mental Hygiene, Board of Chiropractic Examiners · Maryland Dept. of Health & Mental Hygiene, OIG · Maryland Insurance Administration, Insurance Fraud Division · Massachusetts OAG, Insurance and Unemployment Fraud Division · Massachusetts Office of Inspector General · Medicaid Fraud Control Unit of Iowa, DIA · Medicaid Fraud Control Unit of Kentucky, OAG · Medicaid Fraud Control Unit of Louisiana, OAG · Medicaid Fraud Control Unit of Massachusetts, OAG · Medicaid Fraud Control Unit of Missouri, OAG · Medicaid Fraud Control Unit of Montana, DCI · Medicaid Fraud Control Unit of Nebraska, OAG · Medicaid Fraud Control Unit of Ohio · Medicaid Fraud Control Unit of Pennsylvania, Office of the Attorney General · Medicaid Fraud Control Unit of South Dakota, Office of the Attorney General · Medicaid Fraud Control Unit of Texas, OAG · Medicaid Fraud Control Unit of Vermont, Office of the Attorney General · Medicaid Fraud Control Unit of West Virginia, OIG · Michigan Office of Health Services Inspector General · Minnesota Dept of Commerce, Insurance Fraud Division · National Association of Attorneys General · National Association of Insurance Commissioners, Anti-Fraud Task Force · National Association of Medicaid Fraud Control Units · Nebraska Department of Insurance · Nevada Attorney General's Office, Insurance Fraud Unit · New Jersey Dept. of Banking & Insurance, Bureau of Fraud Deterrence · New Jersey Office of the Insurance Fraud Prosecutor · New Jersey Office of the State Comptroller, Medicaid Fraud Division · New York City Human Resource Administration · New York City Police Dept., Health Care Fraud Task Force · New York State Insurance Department · New York State Office of the Comptroller · New York State Office of the Medicaid Inspector General · New York State Workers' Compensation Board · North Carolina Dept of Insurance, CID · North Dakota Insurance Department · Ohio Auditor of State · Ohio Bureau of Workers Compensation · Ohio Department of Insurance · Ohio State Chiropractic Board · Oklahoma Insurance Department, Anti-Fraud Unit · Ontario Provincial Police · Orange County District Attorney’s Office · Pennsylvania Insurance Department · Pennsylvania Insurance Fraud & Auto Theft Prevention Authorities · San Diego County District Attorney’s Office · Somerset County Prosecutor's Office · South Carolina Department of Health & Human Services · State of Alabama, Dept. of Public Health · State of California, Office of the Inspector General · State of Georgia, Dept of Law, Georgia Medicaid Fraud Control Unit · State of Utah, Insurance Fraud Division · Texas Department of Insurance, Fraud Unit · Texas Health & Human Services Commission, OIG · U.S. Dept. of Defense, OIG-DCIS · U.S. Dept. of Defense, TRICARE Management Activity · U.S. Dept. of Health & Human Services, CMS · U.S. Dept. of Health & Human Services, OIG-OI · U.S. Dept. of Homeland Security, TSA · U.S. Dept. of Justice, Criminal Division, Fraud Section · U.S. Dept. of Justice, Drug Enforcement Administration · U.S. Dept. of Justice, Federal Bureau of Investigation · U.S. Dept. of Labor, Employee Benefits Security Administration · U.S. Dept. of Labor, OIG · U.S. Dept. of Treasury, Internal Revenue Service, CI · U.S. Dept. of Veterans Affairs, OIG · U.S. Dept. of Veterans Affairs, Purchased Care, Directorate of Program Oversight & Informatics · U.S. Gov’t Accountability Office, Office of Special Investigations · U.S. Nuclear Regulatory Commission, Office of Investigations · U.S. Office of Personnel Management, OIG · U.S. Postal Service, Postal Inspection Service · United States Attorney’s Office, District of Montana · United States Attorney’s Office, District of Nebraska · United States Attorney’s Office, Western District of Missouri · United States Railroad Retirement Board · Washington State Dept. of Social & Health Services
NHCAA’s Education Initiatives

- Annual Training Conference
- In-person/web-based training programs
- Investigator’s Boot Camp
- AHFI Designation
Case Information Discussion Roundtable Meetings
SIRIS (Special Investigation Resource & Intelligence System)
Requests for Investigation Assistance (RIAs)
*Inside SIRIS*, monthly intelligence report
*The Compass*, quarterly newsletter with investigative case information and intelligence from SIRIS, law enforcement and insurer SIUs
Fraud Alerts
Peer Experience Resource Center (PERC)
NHCAA Information Sharing

Case Discussion Roundtable Meetings

• Quarterly in-person meetings (held in conjunction with NHCAA training events).

• Format is flexible and may include: emerging scheme or case overviews; break-out discussions based on geographic regions, products and programs; reporting out of break-outs with overall group discussion.

• Case Discussion Roundtables are open to Member Organizations that have signed information sharing agreements on file with NHCAA as well as NHCAA Law Enforcement Liaisons.

• Interface of our members to discuss and share information is invaluable.
NHCAA Information Sharing

Special Investigation Resource & Intelligence System (SIRIS)

- Online, searchable database of fraud schemes and allegations accessible by Member Organizations and Law Enforcement Liaisons.
- Supported by LexisNexis on a secure platform. Data belongs to NHCAA.
- SIRIS & NAIC OFRS Integration: NHCAA members able to enter a record in SIRIS which transmits to the 42 referral accepting states.
Requests for Investigative Assistance (RIA)

- These are case-specific requests from law enforcement.
- Allows prosecutors and law enforcement agencies who partner with NCHAA to submit inquiries about specific fraud cases to take into account or gauge exposure among private insurers.
- NHCAA receives RIA requests and disseminates them to Members encouraging direct contact between private investigative staff and law enforcement.
- Facilitates information sharing and collaboration-building.
Global Health Care Anti-Fraud Network

- NHCAA
- CHCAA (Canada)
- EHFCN (Continental Europe)
- HICFG (UK)
- HFMU (South Africa)
Memorandums of Understanding
- EHCFN, CHCAA, HICFG, HFMU

International Fraud Prevention Summits

Global Cooperation

Fraud Awareness

www.ghcan.org
National Summit on Health Care Fraud

- January 28, 2010 in Washington, D.C.
- Signaled a new era leading to greater private-public cooperation against HCF

Purpose:
- To bring together leaders from the public and private sectors to identify and discuss innovative ways to eliminate fraud, waste and abuse in the U.S. health care system.
- Part of the Obama Administration’s coordinated effort to fight health care fraud under the Health Care Fraud Prevention & Enforcement Action Team (HEAT) initiative.
Healthcare Fraud Prevention Partnership (HFPP)

• More than two years in development

• A series of informational discussions and meetings among several interested parties to develop the idea

• A joint HHS-DOJ project together with associations, insurers, and other private, government and law enforcement groups

• Primary goal in developing the project was better information sharing as a means to fight health care fraud
Formally announced July 26, 2012 by the White House.

The HFPP Charter offers the purpose and framework:

“The Partnership's purpose will be to exchange facts and information between the public and private sectors in order to reduce the prevalence of health care fraud. The Partnership will also enable members to individually share successful anti-fraud practices and effective methodologies and strategies for detecting and preventing health care fraud.”
Healthcare Fraud Prevention Partnership

Framework

- Executive Board
- Data Analysis and Review Committee (DARC)
- Information Sharing Committee (ISC)
- Trusted Third Party (TTP)
- Administrative Office (AO)
- Participating Entities—organizations that have medical claims payment or other data that they wish to share with the Partnership in order to combat health care fraud.
Healthcare Fraud Prevention Partnership

Participants

- CMS (Administrator)
- DOJ (AG’s Office)
- HHS (Secretary’s Office)
- HHS-OIG
- FBI
- National Association of Insurance Commissioners (NAIC)
- Healthcare and/or fraud related associations: NHCAA, NAMFCU, AHIP, BCBSA, CAIF, NICB
- Private-sector insurers and/or health plans

Participants are required to sign the Memorandum of Understanding.
A Study Driven Approach

• Studies follow a defined life cycle and any partner can propose a new study.
• A technical subgroup is formed to design each study.
• The Trusted Third Party collects data and provides results back to the participating partners.
To realize greater information sharing, cooperation and partnership among private and public payers and law enforcement the HFPP will demand consistent, high-level support.
Other Data Pooling Ventures

- Property/Casualty Industry
- Claims Warehouse Vendors
- Anti-fraud Technology Vendors
Anti-Fraud Provisions and the ACA

- H.R. 3590 – The Patient Protection & Affordable Care Act

- Section 6401 – Provider screening and other enrollment requirements under Medicare, Medicaid, and CHIP.

- Opportunity for additional and enhanced screening of providers who participate in Medicare and Medicaid.

- Directs the HHS Secretary to determine by regulation the “level of Screening” for provider enrollment “according to the risk of fraud, waste, and abuse,…with respect to the category of provider of medical or other items or services or supplier.

- Authorizes the Secretary to impose additional burdens where there are more significant fraud concerns.

- Creates additional requirements related to ongoing licensing and oversight of newly enrolled providers, for both Medicare and Medicaid.
Anti-Fraud Provisions and the ACA

- H.R. 3590 – The Patient Protection & Affordable Care Act
  - Section 6401 – Provider screening and other enrollment requirements under Medicare, Medicaid, and CHIP.

- Authorizes the Secretary to impose a temporary moratorium on the enrollment of new providers of services and suppliers under Medicare, Medicaid and CHIP when necessary to prevent or combat fraud, waste or abuse.

- Mandates providers and suppliers to establish compliance programs as a condition for enrollment in the Medicare, Medicaid and CHIP programs and directs the HHS Secretary to develop the “core elements” for such a compliance program.
Anti-Fraud Provisions in the ACA

• Provider Screening Rules

- Establishes the procedures under which screening is conducted for providers of medical or other services and suppliers in the Medicare program, providers in the Medicaid program, and providers in CHIP.

- Effective Date: March 25, 2011
Anti-Fraud Provisions in the ACA

- **Provider Screening Rules**
  - Designated categories of providers or suppliers that are subject to screening procedures based on assessment of the level of screening based on the risk presented by the category of provider.
  - Three levels of screening and associated risk:
    - Limited
    - Moderate
    - High
  - Each provider/supplier category is assigned to one of these three screening levels
## Anti-Fraud Provisions in the ACA

<table>
<thead>
<tr>
<th>Final Level of Required Screening for Medicare Physicians, Non-Physician Practitioners, Providers, and Suppliers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of screening required:</strong></td>
</tr>
<tr>
<td>Verification of any provider/supplier-specific requirements established by Medicare</td>
</tr>
<tr>
<td>Conduct license verifications (may include licensure checks across States)</td>
</tr>
<tr>
<td>Database Checks (SSN, NPI, NPDB licensure, an OIG exclusion; Tax ID, tax delinquency; death)</td>
</tr>
<tr>
<td>Unscheduled or Unannounced Site Visits</td>
</tr>
<tr>
<td>Fingerprint-Based Criminal History Record Check of law enforcement repositories*</td>
</tr>
</tbody>
</table>

*This category merges “fingerprinting” and “criminal background checks,” which were listed as separate categories under the proposed rules.*
Anti-Fraud Provisions and the ACA

• Temporary Moratorium on Provider Enrollment, Rule

- HHS may impose a temporary moratorium (6 months) on provider enrollment in situations where:
  
  • CMS identifies a trend that appears to be associated with a high risk of fraud, waste or abuse;
  
  • A state has imposed a moratorium on enrollment in a particular geographic area or on a particular provider of supplier type or both; or
  
  • CMS identifies a particular provider or supplier type and/or a particular geographic area as having a significant potential for fraud, waste or abuse.
Anti-Fraud Provisions and the ACA

- H.R. 3590 – The Patient Protection & Affordable Care Act

  - Section 6402(a) – Expanded Data Matching

    Mandates an expanded “Integrated Data Repository” at CMS that will incorporate data from all federal health care programs:
    - Medicare (Parts A, B, C & D)
    - Medicaid
    - CHIP
    - Health-related programs administered by the Secretary of Veterans Affairs.
    - Health-related programs administered by the Secretary of Defense.
    - Federal old-age, survivors, & disability insurance benefits established under Title II.
    - The Indian Health Service and the Contract Health Service program.
Anti-Fraud Provisions and the ACA

- H.R. 3590 – The Patient Protection & Affordable Care Act
  - Section 6402(a) – Expanded Data Matching

  - Inclusion of Medicare data into the Integrated Data Repository “shall be a priority.”

  - Data from the other Federal programs shall be included “as appropriate.”

  - Appears to be an “all claims” database that is limited to government programs.

  - Purpose: conducting law enforcement and oversight activities to the extent consistent with applicable information, privacy, security, and disclosure laws.
Anti-Fraud Provisions and the ACA

• H.R. 3590 – The Patient Protection & Affordable Care Act

  ▪ Section 6402(a) – Return of Overpayments
    • Providers and insurers participating in Federal health care programs have a legal obligation to report and return overpayments received from Medicare and Medicaid.
    • This is consistent with the new False Claims Act amendments, where a failure to return an overpayment in light of a legal obligation constitutes a “false claim.”
    • “Overpayment” is defined broadly as Medicare or Medicaid funds received or retained by a person who is not entitled (after applicable reconciliation) under Medicare or Medicaid laws.
    • An overpayment must be reported and returned the later of:
      ○ 60 days after the date on which the overpayment was identified; or
      ○ The date any corresponding cost report is due (if applicable).
    • Written notification of the reason for the overpayment is required.
Anti-Fraud Provisions and the ACA

- H.R. 3590 – The Patient Protection & Affordable Care Act
  - Section 6402(f) – Expansion of the Anti-Kickback Statute’s (AKS) Intent Standard
    - Adds a new provision to the Anti-Kickback Statute that states: “With respect to violations of [the AKS], a person need not have actual knowledge of [the AKS] or specific intent to commit a violation of [the AKS].”
    - This amendment to the AKS nullifies a significant amount of case law that had required specific knowledge of and intent to violate that Anti-Kickback Statute.
    - With this change it is now less difficult for the government to pursue and prove AKS violations.
    - Clarifies that a claim involving an illegal kickback can be pursued under the False Claims Act.
Anti-Fraud Provisions and the ACA

- Section 6402(d) of HR 3590 - Civil Monetary Penalties

- Makes various modifications to existing exclusion and civil monetary penalties to incorporate specific types of fraud activities subject to civil monetary penalties.
- A false statement prohibition in “any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program” (including Medicare Advantage organizations and Part D sponsors).
- Penalty of up to $50K for each false statement, omission or misrepresentation.
- A $15K per-day penalty for failing to provide timely access to the HHS-OIG for audits, investigations, evaluations or other statutory functions.
Antifraud Provisions and the ACA

- Section 6408 of HR 3590 provides for enhanced penalties for various acts.
- There are new provisions relevant to Medicare Advantage and Part D Plans, particularly around marketing whereby penalties and sanctions would be applied:
  - Enrolling individuals in a plan without prior consent
  - Transferring beneficiaries to a different plan without prior consent or solely to earn a commission
  - Failing to comply with marketing restrictions
  - Employing or contracting with individuals or entities who engage in conduct that qualifies for “intermediate sanctions” (as described in 42 U.S.C. § 1395w-27(g)(1)).
- Adds language stating that the Secretary may apply any of the remedies available if the Secretary determines that “any employee or agent of such organizations, or any provider or supplier who contacts with such organization” has committed a violation.
Anti-Fraud Provisions and the ACA

• H.R. 3590 – The Patient Protection & Affordable Care Act

  ▪ Section 10606 - Health Care Fraud Enforcement
    ▪ Lowers the level of intent required to prove a federal health care fraud offense under the Crimes and Criminal Procedure Title (U.S. Code, title 18, §1347).
    ▪ Adds provision: “With respect to violations of [§1347], a person need not have actual knowledge of [§1347] or specific intent to commit a violation of [§1347].”
    ▪ This amendment makes it less difficult for the government to pursue and prove federal health care fraud violations.
    ▪ Expands the type of conduct that constitutes “federal health care fraud offenses” to now include violations of:
      • The Anti-Kickback Statute; and
      • The Federal Food, Drug and Cosmetic Act and §501 of ERISA when the offense is related to a “health care benefit program”
Anti-Fraud Provisions and the ACA

• Medical Loss Ratio (MLR) Requirement Rule

  – Based on Section 2718 of the Patient Protection & Affordable Care Act: “Bringing Down the Cost of Health Care Coverage” which requires large group market insurers to expend at least 85% of annual premium revenue on a combination of reimbursement for medical services and for activities that improve health care quality (for the individual and small group market the percentage is 80%).


  – On December 30, 2010, HHS issued a three-page “technical correction” to the interim final rule; this notice included changes that affected the fraud provisions.

  – December 7, 2011, The Final MLR rule was published in the Federal Register; Effective January 3, 2012. No changes made to the sections relating to anti-fraud efforts.
Anti-Fraud Provisions and the ACA

• Medical Loss Ratio (MLR) Requirement Rule

  - The MLR final rule excludes anti-fraud efforts in the definition developed for “Improving Health Care Quality Expenses.”
  - It only allows a very limited recognition that the lesser of recoveries or recovery expenses shall be counted against fraud claims expenses.
  - The rule is careful not to categorize this recognition as a quality-improving activity (any perceived link between fraud recoveries and quality improvement was stripped by to Dec. 30, 2010 “technical corrections” document).
  - Otherwise, all other anti-fraud expenses are reported as cost containment.
Anti-Fraud Provisions and the ACA

- CMS has made it very clear that its overarching goal in developing anti-fraud rules is to facilitate its transition from a “pay and chase” mode of operation to one focused on “fraud prevention.”

- Excerpt from the rule conclusion: “This final rule with comment period contains provisions that are of critical importance in the transition of CMS’ antifraud activities from ‘pay and chase’ to fraud prevention.”
Credible Allegation of Fraud

• Medicare:

• A credible allegation of fraud is an allegation from any source, including but not limited to the following:
  • (1) Fraud hotline complaints.
  • (2) Claims data mining.
  • (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

• Allegations are considered to be credible when they have indicia of reliability.
Credible Allegation of Fraud

• Medicaid:

  • A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following:

  • (1) Fraud hotline complaints.
  • (2) Claims data mining.
  • (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

  • Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.
Suspension of Payments - Rules

**Medicare:**

- In cases of suspected fraud, payments may be suspended “in whole or in part” by CMS or a Medicare contractor if they have consulted with HHS-OIG (and the DOJ as appropriate) and determined that a “credible allegation of fraud” exists.

- Explains what a “good cause exception” would be, whereby the Secretary would not suspend payments.

- Every 180 days after the initiation of a suspension of payments, CMS will evaluate whether there is good cause to continue the suspension and request certification from the investigating agency that a continued suspension is warranted.
Exchanges - New Opportunities

State Health Insurance Marketplace Decisions, 2014

* In Utah, the federal government will run the marketplace for individuals while the state will run the small business, or SHOP, marketplace.

Requirements for Individuals

Must reside in state in order to participate in that state’s exchange

Cannot be incarcerated

Must be a citizen or lawful alien anticipated to be in the country for the enrollment period.
State Residency Requirements

• Typically 6 months
• Actual street address
• Expect these to tighten up
  ▪ Delaware - using Medicaid eligibility requirement
  ▪ Most states have additional requirements for establishing residency for in-state tuition
Discussion Scenario

Insurer offering a QHP in the MD Exchange. Application for family of 4 approved, coverage issued 4/1/14

Family members:
- Husband, age 56
- Wife, age 52
- Adult Son, age 24
- Son, age 16

Residence, MD
All Non-smokers

Six months later wife has a bone marrow transplant due to advanced leukemia

Medical record review reveals:
- Wife is a smoker
- Wife and younger son live in NY since 2012
- Husband and wife are divorced
- Husband lives in MD
Residency Fraud

- Internet based shopping, very transparent
- Creative residency interpretations
- New market for “residency” for rehab centers, snfs, mental health facilities
Sober Homes

Seeking help but finding a scam in sober homes

*Scandal afflicts some ‘sober homes,’ where recovering addicts must agree to drug testing by labs closely tied to landlords*

By Patricia Wen
| GLOBE STAFF APRIL 01, 2012
How the Scam Works
ACA changes regarding enrollment fraud

Must analyze the financial incentives:

• Wherever there is a material difference in price or premiums or terms of coverage, there will be an incentive to misrepresent to take advantage of the lower price or greater coverage

• If there are large variations between the cost of plans between states, applicants have the incentive to lie about residency
Who else is Incentived?

• **Employers**
  - If small group coverage is cheaper than individual, creative individuals may form a phony employer arrangement for a better rate
  - Solos practitioners offering coverage to employees then billing for unnecessary services to cover the cost of insurance
  - Larger employers splintering into small groups to take advantage of exchange prices
Factor VIII Example

- Misrepresentation
- ID theft
- Billing for services not rendered
- Drug diversion
Who else?

Brokers’ incentives remain the same but types of misrepresentation will change:

- Health condition is no longer relevant
- Collude with insured to understate insured’s income
- Collude with employer to manipulate the number of employees
- Prey upon fears and uncertainty to churn or upsell to insureds
Navigators

• James O’Keefe video (TX)
• NAIC advocates that they be licensed like brokers
• FL passed law requiring registration, evidence of completion of required training
Navigators

- ID resale
- Divert individuals to phony insurance
- Collude with criminal enterprises
ID Theft is Rarely Just ID Theft

• Plethora of ID theft schemes
• Street value of a medical ID more than a SSN
• IDs resold and used to bill private and public programs
• Individuals enrolled in insurance plans without their knowledge
Medical Insurance Tourism

- Physician shortages, US citizens seek care outside the US
- Coverage open to lawful aliens, overseas alien could obtain tourist visa, qualify for individual coverage through an exchange, seek major surgery and follow up care, and return home.
- Alien must be lawfully present during the entire enrollment period, so an enrollment period of more than 6 months would allow the insurer to assess if the member can lawfully remain in the country.
Massachusetts Example

• Facility assists alien enrollment through the Massachusetts Connector
  - Alien family living with relatives in Boston
  - Seeking liver transplant and follow up care
  - Health Plan SIU sees new enrollee receives liver transplant 30 days after enrollment with no prior claims for transplant work up
Massachusetts Example

• Health plan uncovers:
  ▪ Unable to verify transplantee’s SSN
  ▪ Dependents’ SSN belong to others
  ▪ Does not meet eligibility under individual contract rules
  ▪ Evidence that the hospital colluded with the transplantee to get coverage for the transplant
  ▪ Ongoing case - health plan seeking reimbursement from the hospital.
Presumptive Eligibility: Medicaid
Enrollment by Hospitals

- Hospitals able to temporarily enroll individuals in Medicaid
- Ensures compensation for hospital-based services
- States charged with developing policies and procedures
- States charged with training PE providers, tracking provider performance and overseeing program quality.
Presumptive Eligibility:
Qualified Provider Requirements

- Hospital must participate in Medicaid
- PE determinations can only be made by hospital employees
- Required to assist with the completion of the application
- Can extend to family members
- May allow candidate to self-attest to citizenship
Presumptive Eligibility:

- No formal training program required
- States required to provide information to qualified hospitals
- Varied state requirements on performance and tracking
- 33 states currently participating
Fraud prevention

- Several states have adopted safeguards - disqualifying a provider if more than 10% - 15% of the application submitted contain errors, or if less than 85-90% of those enrolled do not submit a Medicaid application.
Essential Health Benefits

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- mental health and substance use disorder services, including behavioral health treatment
- prescription drugs
- rehabilitative and habilitative services and devices;
- laboratory services
- preventive and wellness services and chronic disease management
- pediatric services, including oral and vision care.
Prescription Drugs

- Compounding
- B-12, Testosterone, Wellness “drugs”
- HIV - Jcodes
mental health and substance use disorder services, including behavioral health treatment

- Rehab vacation centers
- Community mental health centers
- Vulnerable population
- Expected increase in volume of claims
rehabilitative and habilitative services and devices

- Not always covered in commercial plans
- States have broad and varied definitions
- Time to test and define the definitions, as well as to develop claims history and rules.
Multi-layered Scheme

In-Patient Facility

Ambulance Service

Habilitation Center
Laboratory Services

- Urine drug screens
- Micronutrient testing
- Genetic testing - personalized medicine
Preventive and Wellness Services

• Big uptick in autism testing claims
• E/M - level 5
Pediatric Dental

• Variation in state interpretation
• Medically necessary orthodontia
Interesting New Models

• Sec. 2706: Non-discrimination in health care

(a) Providers - A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health provider who is acting within the scope of that provider’s license or certification under applicable State law.
Emerging Scheme

Look for advertisements encouraging chiropractors to “integrate” their practices

- peripheral neuropathy
- endocrine disorder management
- weight loss
- allergy testing
- wellness services
Insurers Participating in the Exchanges

- ACA makes it clear that payments made by, through or in conjunction with an Exchange are subject to the False Claims Act and conditions for eligibility are a material condition for payment.

- If an insurer certifies that it has complied with all the requirements of participation in the exchange and it is determined that the certification was false, the insurer could be subject to false claims liability.
Follow the Incentives

- Varied plan costs across states
- Varied state definitions
- Expanded benefits
- New enrollees
Thank you!

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