Detecting and Preventing Fraud, Waste and Abuse

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Disclaimer

The views and opinions expressed in this presentation are those of the presenter and do not represent the views of the Health Care Compliance Association, nor of the presenter's employer, past or present.

Objectives

- Gain a high-level understanding of some of the statutory and regulatory requirements for detecting and preventing fraud, waste and abuse in Medicaid managed care
- Examine what constitutes fraud, waste and abuse (look at some case studies)
- Provide strategies to detect and prevent fraud, waste and abuse

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Recent Economic Impact of Medicaid Managed Care

Centers for Medicare and Medicaid Services (CMS) reports that by FY2017 over 68 percent of all Medicaid beneficiaries were enrolled in comprehensive plans offered by Medicaid managed care organizations (MCOs).

Medicaid expenditures on managed care account for nearly 50 percent of total Medicaid spending ($553 billion in FY 2016 with 63 percent paid by the federal government and 37 percent by states), and MCOs represent 95 percent of this total.

Managed care has become a population health mechanism for furnishing primary and preventive care for low income working age adults, and the means by which the country's most at-risk populations are provided long term health care services and supports.

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Oversight

Both the federal and state governments extensively regulate managed care. The modern federal framework began under President George W. Bush's administration and continued its evolution under President Obama.

As is the case with Medicaid generally, states maintain their own regulatory frameworks, the core of which being the large purchasing agreements between states and managed care contractors.

These contracts provide the terms and details for coverage, health care delivery, quality improvement, plans' administrative responsibilities, and payment terms. As part of its Medicaid oversight function, the federal government oversees and regulates these contracts.

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Program Integrity Safeguards Against Fraud, Waste and Abuse

CMS is committed to combating Medicaid provider fraud, waste, and abuse which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid enrollees.

CMS has broad responsibilities under the Medicaid Integrity Program to:

•Hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues

•Provide effective support and assistance to states in their efforts to combat Medicaid provider fraud and abuse

•Eliminate and recover improper payments in accordance with the Improper Payments Information Act of 2002, Executive Order 13520 and the Improper Payments Elimination and Recovery Act of 2010

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State Medicaid program administrators and CMS share responsibility for the integrity of the Medicaid program and for program safeguards necessary to ensure proper use of both federal and state dollars.

As a federal-state partnership, the Medicaid program presents program integrity challenges and opportunities that are unique from Medicare.

States are the first line of defense against fraud, waste, and abuse in their Medicaid programs as they enroll providers, establish payment policies, contract with managed care entities, process claims, and pay for services furnished to Medicaid beneficiaries.

CMS provides states with guidance on federal Medicaid policies, education and technical assistance, program assessment and feedback, and federal resources for strengthening their program integrity capacities.

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Section 1936(d) of the Social Security Act requires the Secretary of Health and Human Services (HHS) to establish, on a recurring 5-fiscal year basis, a comprehensive plan for ensuring the integrity of the Medicaid program by combating fraud, waste, and abuse.

The following elements of the Comprehensive Medicaid Integrity Plan sets forth the CMS strategy for safeguarding the integrity of the Medicaid program during federal fiscal years (FFY) 2014-2018.

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The Plan is informed by the evaluation of past and current program integrity efforts by CMS and its state partners.

It is also informed by recommendations made by the HHS Office of Inspector General, the Government Accountability Office, the Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission, the National Association of Medicaid Directors, and ongoing feedback and engagement of the Medicaid Fraud and Abuse Technical Advisory Group.

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To increase the ability of state Medicaid agencies and CMS to leverage program data to protect Medicaid from fraud, waste, and abuse, CMS will:

- Improve the quality and consistency of Medicaid data reported to CMS
- Increase state Medicaid agency access to Medicare program integrity data
- Improve the analysis of Medicaid program data to identify potential fraud, waste, and abuse

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To build the capacity of state Medicaid agencies to prevent and detect fraud, waste, and abuse against the Medicaid program, CMS will:

- Streamline CMS assessment of state Medicaid program integrity activities;
- Support state oversight of program integrity in Medicaid managed care;
- Provide technical assistance to state Medicaid agencies with respect to data analysis
- Expand training of state staff through the Medicaid Integrity Institute

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To expand the capacity of CMS to protect Medicaid program integrity and to manage risk in the administration of federal grants to states, CMS will:

- Eliminate duplication of efforts by integrating Medicare and Medicaid audits and investigations
- Improve financial accountability for Medicaid managed care organizations
- Improve safeguards for Medicaid fee-for-service claims
- Expand reporting and controls for provider rate setting
- Enhance beneficiary eligibility safeguards
- Improve the accuracy of state claiming and grant management
- Execute safeguard strategies for new forms of payment and new delivery systems
- Revise measurement of error rates to align with program changes

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At state option and largely at federal expense, Medicaid coverage of low-income adults will increase significantly. This enrollment growth, in turn, will create demand for additional providers to meet the health and long-term care needs of Medicaid beneficiaries.

Medicaid long-term care services and supports will increasingly be provided in the community rather than in nursing facilities. States will continue to expand their reliance on managed care arrangements in order to provide acute care and long-term care services and supports to beneficiaries.

In combination, these trends will result in significant growth in the Medicaid population overall, in Medicaid managed care enrollment, and in federal Medicaid spending.

In addition, as CMS and states develop new health care delivery and payment models, management controls must help ensure accomplishment of goals without creating vulnerabilities to fraud, waste, and abuse.

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The harm created by fraud, waste, and abuse against the Medicaid program is not limited to state and federal funds. Fraud, waste, and abuse can also directly harm beneficiaries.

Physicians who inappropriately prescribe prescription drugs to increase their billings may be placing their patients at medical risk.

If a nursing facility, in order to maximize profits, does not maintain adequate staffing or nutrition, the residents will be at great risk.

Similarly, if a dental clinic performs unnecessary procedures on children in order to generate revenue, the children's health is at risk.

Keeping fraudulent providers out of the Medicaid program in the first place, and identifying them quickly if they do enroll, prevents Medicaid payment for substandard care that puts beneficiaries in harm's way.

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The work of CMS to safeguard the integrity of the Medicaid program comprises a broad spectrum of cooperative activities throughout the agency. The Center for Medicaid and CHIP Services (CMCS) is responsible for setting broad program policy, approving state plans and waivers, and carrying out program and financial management activities related to grant-making with the states.

The Center for Program Integrity (CPI) is responsible for implementation of the Medicaid Integrity Program established under the Deficit Reduction Act of 2005 and the Medicaid program integrity authorities in the Affordable Care Act.

The Office of Financial Management is responsible for the measurement and annual reporting of Medicaid payment error rates through the Payment Error Rate Measurement program.

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The Consortium for Medicaid & Children's Health Operations serves as the regional focal point for CMS interactions with states, territories, and local governments relating to Medicaid and the Children's Health Insurance Program (CHIP), including coordination of program integrity efforts.

The Affordable Care Act created the Federal Coordinated Health Care Office (Medicare Medicaid Coordination Office) within CMS to improve care coordination for Medicare-Medicaid enrollees and eliminate cost-shifting between the Medicare and Medicaid programs and among related health care providers.

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What Constitutes Fraud, Waste and Abuse?

Managed care regulators have a critical role in ensuring that managed care organizations meet their contractual obligations and provide enrollees with the required standard of medical services.

The provision of health care services must be monitored carefully to ensure that individual enrollees are receiving appropriate medical care and to detect any systematic problems in access to or provision of appropriate health care services.

Depending upon the level of intent, abuse and/or fraud occurs when the organization demonstrates a pattern of consistently failing to provide enrollees with appropriate medical care. Furthermore, depending upon the level of intent, examples of abusive and/or fraudulent practices by the organization include the consistent failure to provide an adequate health care network for enrollees, or a pattern of denying enrollees necessary medical care.

By deliberately failing to establish adequate networks, MCOs can jeopardize enrollee access to care. Their enrollment of substandard providers can degrade the quality of care an enrollee receives. Also, managed care fraud can raise State costs despite capitation. For example, if data is manipulated by the MCO to give the appearance of providing services to enrollees that are not truly enrolled within the organization, the MCO may be attempting to receive enhanced future capitation payments. State costs could be increased based on inflated data.

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42 CFR 455.2 defines fraud and abuse as follows:

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

The CMS-sponsored workgroup defined fraud and abuse in Medicaid managed care in the following manner: Medicaid Managed Care Fraud means any type of intentional deception or misrepresentation made by an entity or person in a capitated MCO, PCCM program, or other managed care setting with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person.

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Medicaid Managed Care Abuse means practices in a capitated MCO, PCCM program, or other managed care setting that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to Medicaid, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations for health care.

The abuse can be committed by an MCO, contractor, subcontractor, provider, State employee, Medicaid beneficiary, or Medicaid managed care enrollee, among others.

It also includes beneficiary practices in a capitated MCO, PCCM program, or other managed care setting that result in unnecessary cost to the Medicaid program or MCO, contractor, subcontractor, or provider.

A provider can be defined as any individual or entity that receives Medicaid funds in exchange for providing a service (MCO, contractor, or subcontractor).

It should be noted that Medicaid funds paid to an MCO, then passing to subcontractors, are still Medicaid funds from a fraud and abuse perspective.

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Health care fraud and abuse can occur in many areas, including the following:

- Procurement of the managed care contract
- Marketing, enrollment, and disenrollment
- Underutilization
- Claims submission and billing procedures
- Antitrust violations
- FFS fraud
- Embezzlement and theft

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Procurement of the Managed Care Contract

Falsification of health care provider credentials – This can occur either at the MCO or subcontract levels. Falsification of health care provider credentials can put patients at risk because they may be receiving care from an unqualified, unlicensed, or a debarred provider. This can also occur at the subcontract level, where providers are frequently paid at a FFS rate. Falsification of provider credentials may result in the improper payment for the services of a provider who does not meet the required professional qualifications.

Falsification of financial solvency – An MCO can purport to have sufficient assets to cover claims when, in fact, it lacks financial solvency. This may result in the failure to pay providers at all or in a timely manner, and thereby affect patient care. While most insolvency problems are inadvertent, some, called “bust outs” may be deliberate, e.g., the owners may embezzle the money or claim it as "salaries" or "administrative fees" and then file bankruptcy or simply disappear. Most often, solvency issues will also involve a State’s Insurance Department or other licensing agencies.

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Falsified or an inadequate provider network – An MCO's provider network indicates that it has a sufficient number of providers and/or specialists to accept new patients and to cover the needs of persons enrolled, when in fact, an inadequate network exists. This can result in: (1) over enrollment (more members than the plan can adequately handle, which can lead to inadequate care), and (2) lack of provider availability, or difficulty in an enrollee's ability to access certain types of care. Because networks are very fluid, temporary provider network deficiencies may not be fraud; however, an inadequate provider network may jeopardize the quality of care for all enrollees. Moreover, intentional misrepresentation of the number of providers and/or specialists would constitute fraud.

Fraudulent subcontract – The definition of a fraudulent subcontract is an agreement between parties that contains materially misleading information, which has been pre-dated or post-dated, and/or contains a forged signature or a signature of a person that would not have authority to approve the agreement.

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Fraudulent subcontractor – a provider who has intentionally performed or billed improperly; e.g., intentionally denies appropriate services or intentionally submits false claims. If an MCO does not properly check out a subcontractor's performance and billing history prior to being included in the network, the MCO may be paying for services not provided.

Bid-rigging or self-dealing – involves collusion between State employees and those submitting Request for Proposals and/or contracts. Self-dealing is defined as the award of Medicaid contracts based on friendship or family relationships with those in control of the selection process.

Collusion among providers – occurs when a community's competing providers agree on minimum fees charged and capitation rates accepted. Collusion may also include carving up service areas.

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Contracts with related parties – Contracts with related parties, such as subsidiaries or other entities owned by persons with a financial interest in the health care plan, may provide an opportunity for diversion of funds without the provision of services, or payment of exorbitant amounts for legitimate services. Antitrust violations are also included in this category and can result from efforts to reduce or eliminate competition though the use of illegal tying agreements. Without competition, higher rates and price fixing can occur. Victims can include the MCO, enrollees, or the Medicaid program.

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Marketing Fraud

Misrepresentation to beneficiaries (also known as "Slamming") – An MCO representative fails to properly identify himself/herself as an employee of the MCO, misleading the prospective beneficiary into believing that he/she is actually an employee of the program itself (a State Medicaid agency employee, for example). By enrolling the beneficiary into that one MCO that he or she represents, the beneficiary forgoes the opportunity to enroll in another MCO which is better suited to his or her needs. Another form of misrepresentation occurs when the potential enrollee is misled about the benefits offered by the health plan.

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Misrepresentation to beneficiaries by charging non-existent fees

The marketing representative (MCO employee or independent operators) charges the beneficiary a fee for enrolling when there actually is no charge. The primary victim would be the prospective beneficiary. However, if the Medicaid beneficiary fails to enroll because she or he cannot or will not pay the fee, the MCO is a victim because it loses capitation payments until the beneficiary is properly enrolled. If the marketing representative is not actually affiliated with the State Medicaid agency or an MCO, the enrollee loses not only the fraudulent enrollment fee, but also coverage until properly enrolled.

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Enrollment and Disenrollment Fraud

Enrolling ineligible individuals – All capitation payments made to an MCO for ineligible persons would be improper. An ineligible person could be one who has access to insurance elsewhere, resides in another State or, in many cases, has income or resources that exceed a particular State's limit. If MCO representatives receive a bonus or "bounty" for submitting applications or enrollment forms, there is little incentive for them to watch for, or identify, an ineligible person.

Enrolling nonexistent individuals – All capitation payments made to an MCO for nonexistent persons would be fraudulent. In such cases, the MCO would not bear the cost of providing services, and the full capitation would be profit. Again, this would be most prevalent in an environment where the MCO or independent marketing representative receives a fee for each person enrolled.

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Enrolling nonexistent or ineligible family members – This occurs when the MCO representative is paid "per head" for those individuals that are enrolled. Additional names are added to the application, thus allowing the MCO representative to receive a higher bonus.

"Cherry-picking" or selecting the healthiest segment of the enrollment population – By doing so, the MCO assures itself of higher profits by having to make fewer payments to its providers. Those individuals who are the most ill thus find it difficult to get adequate care, especially those in rural areas where few MCOs exist. Cherry-picking is much more difficult to control in voluntary MCO programs than in mandatory ones because, in the latter, MCOs cannot reject enrollees who are auto-assigned to them. Federal statutes clearly prohibit discrimination on the basis of health status or "cherry-picking".

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Kickbacks for referrals – The MCO pays a kickback to an outside party for potential (usually healthy) enrollees. In this situation, the enrollee may become limited in his choices for prospective MCOs and the MCO can select the healthiest of the referrals.

Disenrolling undesirable members – The MCO uses encounter data to identify and encourage undesirable or unhealthy members to disenroll. By doing so, the MCO reduces the cost of services and improves its profitability.

Failing to notify State of deceased members – By failing to notify the State or its agent in a timely manner that a member has expired or to initiate the proper disenrollment action in a timely manner, the MCO continues to receive a monthly capitation fee, even though the MCO will no longer incur costs for services. Once the date of death is obtained, States should routinely recoup inappropriate payments.

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Beneficiary enrollment fraud – Enrollment fraud is not limited to activities by MCOs or their agents. Beneficiaries may commit fraud against the State by presenting fraudulent Medicaid eligibility information (e.g., understating income or asset levels, or incorrectly claiming to be a resident of the State).

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Under Utilization

Note: Abuse and/or fraud occurs when an organization shows a pattern of failing to provide its members with medically necessary health care services on a timely basis.

Untimely first contact with clients – If an MCO has thirty days to notify an individual of their membership in the organization, but takes longer, the monthly capitated payments received are not used to provide any services.

Delay in reassigning PCP upon an individual's request –The MCO contract allows thirty days to act on a request for a new PCP, but instead takes sixty days, thereby collecting two months of Medicaid payments without providing any services.

Failure to serve individuals with cultural or language barriers – If the MCO contract requires interpreters' and/or cultural competence, an MCO can avoid meeting these requirements by defining away the problem. For example, an MCO's contract could require an unreasonably high concentration of foreign-language clients, which is unlikely to be reached, before having to address cultural or language barriers. As a result, individuals with these barriers may not be adequately served.

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Failure to provide outreach and follow-up care or Federally-required referrals – An MCO or its providers can save expenses by not advertising services, and therefore, enrollees do not receive these services because they do not know they can be provided. An MCO or its providers can also save expenses by not providing outreach and follow-up for contractually-obligated physicals, early periodic screening diagnosis and treatment (EPSDT) screens, initial health assessments, individual health education behavioral assessments, immunizations, referrals to women, infants, and children, and EPSDT follow-up or by not advertising or providing outreach and follow-up for other services provided for under the contract.

Failure to provide managed care beneficiaries comparable services such as those provided to commercial or fee-for-service beneficiaries – An MCO or its providers attempt to diagnose and treat commercial or fee-for-service beneficiaries with more quality services and/or professionalism than managed care beneficiaries.

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Claims Submission and Billing Procedures

Balance billing – The contracting provider or MCO bills the beneficiary directly for the total amount of the bill or for the amount of the charge that the provider has agreed to write off after the MCO has paid.

Inflating the bills for services and/or goods provided – The contracting provider bills the MCO at full FFS rates even though a lower rate was negotiated in the managed care contract.

Double-billing – This occurs when the provider receives more than one payment for the same service and keeps the money.

Improper Coding (upcoding and unbundling) – By using the wrong billing code or unbundling the codes included in a larger, more inclusive set of codes, the contracting provider is able to be reimbursed at a higher rate than if the correct billing codes were used and the services were billed together.

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Billing for ineligible consumers or services never rendered – The provider signs a contract to obtain capitated payments each month for 100 enrollees; however, because of contract wording or a contact inside the MCO, the provider receives payment but is assigned no enrollees.

Beneficiary fraud and abuse – Beneficiaries may abuse the system through inappropriate utilization of services, such as selling narcotics prescribed to them. The fraudulent sale of prescription drugs or medical equipment to others has a high potential for conspiracy between providers and enrollees. Other forms of fraud may include lending an enrollment card to an ineligible person in order for that person to receive health care services to which he or she is not entitled.

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Fee-for-Service Fraud in Managed Care

Billing for unnecessary services or overutilization – A provider who is paid on a FFS basis bills an MCO for office visits, tests, prescriptions, treatments, or other medical services that are unnecessary in order to increase payments.

Double billing – A provider bills an MCO twice (or more) for the same service.

Unbundling – A provider bills an MCO separately for services that are normally billed collectively. By billing the services separately, the provider is reimbursed at a higher rate than if the services were billed together. For example, deliveries are normally billed as a global service, but a provider may try to bill separately for each prenatal visit, the delivery, and post-partum visits. Other examples include unbundling sets of laboratory panel tests or psychiatric tests.

Upcoding – A provider bills an MCO for a more expensive service than was actually performed. Ghost billing or billing for services not provided -- A provider bills for services never performed.

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Embezzlement, Theft, and Related Fee-For-Service Fraud

Embezzlement and theft – Officers of the MCO or subcontracting providers steal or appropriate property entrusted to their care for their own use.

Diversion of funds for medical service to unnecessary administrative costs – Officials in the MCO fraudulently divert corporate funds for personal gains. For example, the MCO pays excessive salaries and fees to owners or their close associates.

"Bust outs" – Premiums are paid to the MCO, but the MCO avoids paying vendors/providers by deliberately declaring bankruptcy. "Bust outs" also occur when management embezzles or steals the money, or other inappropriate diversion of funds occurs.

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Case Studies

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U.S. Attorney's Office

Western District of Pennsylvania

Tuesday, November 27, 2018

TWELVE INDIVIDUALS CHARGED IN EXTENSIVE HEALTH CARE FRAUD CONSPIRACY TO DEFRAUD MEDICAID HOME CARE PROGRAM

PITTSBURGH, Pa. – Ten residents of Western Pennsylvania, a resident of Georgia, and a resident of South Carolina were charged by a federal grand jury in a 22-count indictment related to a years-long conspiracy to defraud the Pennsylvania Medicaid program.

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According to the Indictment, between January 2011 and April 2017, home health care companies owned and operated by the conspirators received more than $87,000,000 in Medicaid payments. During that time, all 12 of the defendants, along with other individuals, participated in a wide-ranging criminal conspiracy to defraud the Pennsylvania Medicaid program which resulted in the payment of millions of dollars in illegal Medicaid payments.

The Indictment sets forth dozens of fraudulent acts by the defendants, including making false claims for services that were never provided, creating fake employees, improperly using consumers' personal identifying information, and falsifying documentation during state audits of the companies. In some instances, the Indictment alleges that the defendants were working at other jobs or living out of the area. In other instances, Medicaid claims were submitted for services for consumers who were actually hospitalized, incarcerated, or deceased.

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U.S. Attorney's Office
District of Columbia
Tuesday, December 18, 2018

Maryland Woman Allegedly Caused Medicaid To Be Billed Hundreds of Thousands of Dollars

Mobolaji Tina Stewart, 57, of Laurel, Md., who was employed as a personal care aide, has been charged with scheming to submit false claims to the District of Columbia's Medicaid program. According to the complaint, Stewart was employed as a personal care aide from January 2014 through her arrest. Under the Medicaid program, personal care aides perform services intended to assist Medicaid beneficiaries in carrying out the activities of daily living. These can include helping beneficiaries get in and out of bed, bathe, dress, take medication, and engage in toileting. To receive personal care services under Medicaid, a beneficiary must obtain a prescription from a doctor.

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Stewart's billing practices drew the attention of the District of Columbia Department of Health Care Finance after she was identified as the second-highest paid personal care aide in 2014 and 2015.

According to the complaint, Stewart caused Medicaid to be billed for more than 24 hours in a given day, for services that she allegedly provided while she was out of the country, and for services that she allegedly provided to a beneficiary who was hospitalized at the time. Based on a review of Medicaid billing claims data, between January 2014 and January 2017, Stewart caused Medicaid to issue payments totaling approximately $434,000, including payments based on fraudulent timesheets.

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U.S. Attorney's Office
Middle District of Tennessee
Friday, December 14, 2018

Former CEO of Nashville Company Charged With Healthcare Fraud and Aggravated Identity Theft

Margaret Fisher, 60, formerly of Nashville, Tennessee, was arrested December 13, 2018, by United States Marshals in Williston, North Dakota and charged with four counts of healthcare fraud and two counts of aggravated identity theft.

The November 7, 2018 indictment charges Fisher—the former CEO of Fishield Behavioral Medical Services, Inc.—with defrauding Medicare and Medicaid programs by submitting false and fraudulent claims. According to the indictment, Fisher fraudulently represented that Fishield patients received psychotherapy services from a healthcare provider, who neither provided nor supervised the alleged services.

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As a result of Fisher's false claims, Medicare and Medicaid sent Fishield reimbursement checks totaling over $1 million. Fisher would endorse the checks by forging or causing the forgery of the healthcare provider's signature.

If convicted, Fisher faces a sentence of up to 10 years in prison on the healthcare fraud charges and an additional mandatory two-year sentence on the aggravated identity theft charges. Additionally, she faces a $250,000 fine on each count. The indictment also contains a forfeiture allegation and seeks to forfeit any property derived from the criminal activity and any and all property used to facilitate the unlawful activity, if convicted.

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U.S. Attorney's Office
District of Connecticut
Thursday, December 13, 2018

Bridgeport Woman Admits Role in Medicaid Fraud Scheme

John H. Durham, United States Attorney for the District of Connecticut, announced that TOSHIREA JACKSON, 49, of Bridgeport, waived her right to be indicted and pleaded guilty December 13, 2018, before U.S. District Judge Victor A. Bolden in Bridgeport to one count of health care fraud.

According to court documents and statements made in court, beginning in January 2012, Jackson and Juliet Jacob operated two businesses, Transitional Development And Training (TDAT), and It Takes A Promise (ITAP), both located at 360 Fairfield Avenue in Bridgeport, which provided social and psychotherapy services. The investigation revealed that Jackson and Jacob used ITAP and TDAT to bill Medicaid for psychotherapy services that were never provided.

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As part of their scheme, Jackson and Jacob used the Medicaid provider numbers of two licensed health care providers who had neither rendered nor supervised any of the psychotherapy services that Jackson and Jacob billed to Medicaid. Jackson, and the two licensed providers, were employees of the Connecticut Department of Mental Health and Addiction Services (DMHAS). The two providers did not authorize Jackson or Jacob to obtain provider numbers for them at TDAT or ITAP, and were not aware that TDAT or ITAP were billing Medicaid as if the providers had personally rendered the psychotherapy services.

The investigation further revealed that, in March 2012, Nikkita Chesney, employed by a health care provider that provided substance abuse treatment, began to steal the personal identification information of Medicaid clients who were patients of her employer. The personal identifying information included the patients' Medicaid identification number, Social Security Numbers and dates of birth. They used the stolen identity information to bill Medicaid for psychotherapy services purportedly provided by TDAT and ITAP, when the Medicaid clients had never received any such services from TDAT or ITAP.

In pleading guilty, Jackson admitted that the scheme involved stealing the identity of more than 150 Medicaid clients. Jackson further admitted that she also billed Medicaid for services to other clients that were never provided to those clients.

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Fraud, Waste and Abuse Detection and Prevention

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Medicaid program integrity efforts can only succeed when the federal government works in partnership with states. States fund their share of the program, and, within federal and state guidelines, operate their individual programs by setting rates, paying claims, enrolling providers and beneficiaries, contracting with plans, and claiming expenditures.

CMS has obligations under federal law with respect to oversight, support and assistance, auditing, and education. CMS carries out its obligations to states while being mindful of the uniqueness of each state's size, resources, delivery systems, and level of risk.

Together, the federal and state governments share accountability for the integrity of the total investment of dollars in the Medicaid program and the extent to which that investment produces value for beneficiaries and taxpayers.

Successfully delivering cost-effective health care to many of America's most vulnerable citizens depends on developing and strengthening effective federal-state partnerships.

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The focus of CMS program integrity efforts in Medicaid is shifting beyond the traditional emphasis on "pay and chase" to prevention of costs due to fraud, waste, or abuse.

Operational experience has taught us that Medicaid funds improperly paid to fraudulent providers are very difficult to recover. Program integrity policy, as reflected in the Affordable Care Act, now emphasizes keeping bad actors out of Medicaid through risk-based provider screening, periodic revalidation of provider enrollment, and temporary suspension of payments while credible allegations of fraud are under investigation by law enforcement.

To improve oversight of providers participating in Medicaid, program integrity policy at both the federal and state level will increasingly rely upon sophisticated analysis of claims and utilization data.

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Program integrity efforts in Medicare have considerable potential to strengthen program integrity in Medicaid, and vice versa. Over 11 million Americans – seniors and younger persons with disabilities – are dually eligible for both Medicare and Medicaid.

A substantial number of hospitals, nursing facilities, pharmacies, physicians, and other providers participate in both Medicare and Medicaid, as do many managed care companies.

This overlap of beneficiaries, providers, and plans creates opportunities to safeguard both programs from fraud, waste, and abuse through the use of data analysis, coordinated audits, and collaboration among state and federal law enforcement agencies in investigations and prosecutions.

State Medicaid programs can benefit from CMS's capacity to analyze Medicare data, as well as from the investigative resources of CMS Medicare contractors. At the same time, when state Medicaid agencies uncover fraudulent, wasteful, or abusive activity in their programs, this information can benefit Medicare program integrity work.

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Provider Screening and Enrollment

A critical provision within the Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, enacted on March 30, 2010) is Section 6401(a) of the ACA, and Section 1866(j) of the Social Security Act (the Act).

CMS implemented these requirements with federal regulations at 42 CFR Part 455 subpart E. These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011.

This regulation, at 42 CFR 455, requires that all participating providers be screened according to their categorical risk level, upon initial enrollment and upon re-enrollment or revalidation of enrollment.

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Provider Audits

Section 1936 of the Social Security Act obligates the CMS to procure contractors to audit Medicaid claims and identify overpayments. To fulfill this statutory requirement, the Medicaid Integrity Program (MIP) has procured Audit Medicaid Integrity Contractors (Audit MICs) to conduct provider audits throughout the country.

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Accurate and complete data can be a powerful source of information for CMS, State Medicaid and public health programs, surveillance and utilization review staff, MFCUs, OIG, MCOs, and Medicaid providers.

Claims and encounter data may be analyzed to detect, investigate, report and prevent fraud, waste and abuse.

Data can also be used to do the following:

- Monitor service utilization, access to care, comparability of care, and quality of care
- Update and evaluate capitation payment rates
- Monitor MCO and provider contract performance
- Manage and enforce managed care contracts

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Additional strategies include the following:

- Conduct regular reviews and audits of operations
- Assess and strengthen internal controls to ensure claims are submitted and payments are made properly
- Educate employees, network providers, and beneficiaries about fraud and how to report it
- Effectively organize resources to respond to complaints of fraud and abuse
- Establish procedures to process fraud and abuse complaints by the MCO
- Establish procedures for reporting information to the State Medicaid agency
- Develop procedures to monitor service patterns of providers, subcontractors, and beneficiaries

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