SB XX False Claims Act Amendments (Sen. McAdams)
A Proven Tool to Report and Prevent Fraud in Utah Medicaid

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Summary

Fraud and abuse within the state's Medicaid program is an ever increasing concern for Utah policymakers. Last year, the Utah Legislature's auditor general estimated $20.2 million in losses due to fraud, including $5.8 million in state funds. Some of these funds could be recovered through more aggressive fraud recovery efforts.[i] However, for many reasons, fraud prevention is difficult. First, the Department of Health and Attorney General's office do not have sufficient resources in terms of staff, technology, and statutory tools to effectively combat fraud. Further, as Utah Medicaid moves away from fee-for-service payment methods to new capitated payment methodologies, the traditional tools may not be as effective. Utah is ready for new ways to combat fraud and abuse going forward.

Background

In 2007, the U.S. spent nearly $2.3 trillion on health care; the National Health Care Anti-Fraud Association (NHCAA) estimated that on the low end, 3% of all health care spending—or $68 billion of

Frequently Asked Questions

Is Medicaid fraud a problem in Utah?

Utah Medicaid is a $2 billion business, with the state paying $500 million and the federal government covering the remaining $1.5 billion. The legislative auditor estimated that Utah could save about 1% of those costs ($5 million in state funds) by strengthening fraud prevention efforts.

Why do payment reforms call for different tools to combat fraud?

The traditional fee-for-service payment model requires a provider to submit a bill for reimbursement to the state for every service they provide a Medicaid client. Each transaction effectively provides the state with a documented record of the care provided to clients, and can be easily examined using computer systems that are programmed to detect fraud.

Payment reforms generally involve paying a provider a capitated fee to provider *all* needed care to a Medicaid client. These methods reduce the Medicaid bureaucracy to be sure, but they also reduce the state's oversight capabilities.

that total—is lost to fraud in a typical year.[ii] Other estimates by government agencies place fraud-related losses as high as 10%, or $230 billion dollars per year.[iii] It does not appear that Utah is immune to healthcare fraud. As the legislative auditor noted in last year's report, no geographic area of the country appears any *less* susceptible to this type of crime.[iv]

While fraud occurs throughout the entire health care system, there are several reasons that combating fraud in Medicaid is more difficult. First, the inherently vulnerable populations served by Medicaid make easier targets or in some cases unwitting accomplices to fraud that is typically perpetrated by health care providers.[v] Thus fraud tends to be more prominent in Medicaid simply because it serves populations that are least likely to notice.[vi]

Second, to effectively combat fraud the state must invest in attorneys and highly trained investigators who understand the complex world of healthcare financing, quality standards, and tax law. With a staff of only 11, including a new Medicaid Inspector General, 2 assistant attorney generals, five investigators, the Utah Medicaid Fraud Control Unit has too few attorneys and not enough investigators specially trained in healthcare finance to effectively minimize fraud in Utah Medicaid.[vii] The Director of Utah's MFCU believes that without additional resources to hire and train personnel, the MFCU will never be able to truly prevent the level of fraud that the legislative auditor suggests is occurring.

Third, payment reforms may make it even more difficult for the state to combat fraud. As the state moves away from fee-for-service payment methodologies to capitated payment systems like Medicaid managed care and accountable care organizations, analytical computer systems that the state has traditionally used to examine provider billing for fraud will become ineffective because provider will no longer be submitting bills for services rendered.[viii]

A Proven Tool to Prevent Fraud in Utah: False Claims Act

One way to strengthen fraud prevention in Utah without greatly growing government is by supplementing state investigative, analytical and legal work with powerful litigation and statutory tools. One of the most effective tools used at the federal level to combat health care fraud is the False Claims Act. Called "Lincoln's Law" because President Lincoln requested its enactment to fight Civil War contractors who were defrauding the Union, the False Claims Act prohibits the submission of false claims to the government and imposes *treble* damages (3x actual damages) to help deter violations. Some of the most important provisions of the False Claims Act are its *qui tam* provisions: Not only is the Attorney General authorized to sue under the Act; it also encourages private whistleblowers to file suits and entitles them to a

share of the recovery—a powerful financial incentive for people to come forward and share knowledge of the waste of taxpayer dollars with investigators.

The Deficit Reduction Act of 2005 (DRA) provides a financial incentive for states to enact false claims acts that mirror the federal version of the law. If the state's false claims act is determined to meet the DRA's requirements, the state is entitled to an increase of 10% points in the state federal medical assistance percentage (FMAP) on any funds recovered using the state's false claims act. That's real savings for Utah's cash-strapped Medicaid program.

To qualify for the incentive under the DRA, a state must enact a law that meets the following requirements:

- Establish liability to the state for false or fraudulent claims described in the False Claims Act (FCA) with respect to any expenditures related to state Medicaid plans described in section 1903(a) of the Act;

- Include provisions that are at least as effective in rewarding and facilitating *qui tam* actions for false or fraudulent claims as those described in the FCA;

- Require that the plaintiff give the state 60 days to intervene in the case before proceeding with the case on its own;

- Contain a civil penalty that is not less than the amount of the civil penalty authorized under the FCA.

Senate Bill XX does all of these things. Since the passage of the DRA, 14 states, including Texas, Tennessee, Virginia and Georgia, have enacted false claims acts that meet this standard.[ix]

A state must be careful in how they draft their false claims act, however, to meet the DRA standards. Eight states (including Colorado) have had their false claims acts rejected by the Department of Justice as not being as effective in rewarding and facilitating *qui tam* as the federal version of the law.

Conclusion

As Utah wrestles with competing demands on limited general revenues it will be essential to capture all potential savings within the Medicaid program. Senate Bill XX creates a False Claims Act provision for Medicaid, freeing up valuable taxpayer dollars for patient care and provider reimbursement rates.

Medicaid fraud hits close to home

When my wife was finally diagnosed with bladder cancer, it was too late for treatment. Fortunately she was able to spend her last few months from diagnosis to death at home surrounded by family and visiting friends.

Eventually she needed a hospital bed, wheelchair, portable toilet, and other basic medical supplies. We found a medical supply company in the area that had everything we needed—and they were prepared to bill Medicaid and Medicare.

After some weeks in and out of the hospital, my wife finally died. In the blur of arrangements for her final disposition, it fell on my daughter to return all the medical supplies. Though the supplies were fully covered by Medicare and Medicaid, I asked for a copy of the bill. It showed thousands of dollars of additional supplies we had never used and days of rental beyond our actual rental period.

I showed it to my brother: and he agreed: this was a case of fraud, plain and simple. Maybe the owner thought we (and who knows how many other families), wouldn't notice, particularly in our time of distress? Or, why would we turn them in, when it's not even our money at stake? We called the Feds and turned him in and were pleased to receive a portion of the recovered funds as a reward.

-Irving H.

[i] State of Utah Office of the Legislative Auditor, A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program, August 2009.
[ii] Sara Rosenberg, Nancy Lopez, Scott Stifler, *Healthcare Fraud,* October 2009
[iii] *Id.*
[iv] See note 1.
[v] Sara Rosenberg, Nancy Lopez, Scott Stifler, *Healthcare Fraud,* October 2009
[vi] Nancy Lopez, Scott Stifler, Sara Rosenberg, *Health Insurance Fraud: An Overview*, June 2009.
[vii] National Association of Medicaid Fraud Control Units, Medicaid Fraud Control Unit Survey, 2009.
[viii] Sara Rosenberg, Nancy Lopez, Scott Stifler, *Healthcare Fraud,* October 2009.
[ix] National Association of Medicaid Fraud Control Units, Medicaid Fraud Control Unit Survey, 2009.