Feds Report $4.3 Billion in Fraud Recoveries

Saves $8.10 for every dollar spent

By Nancy Aldrich and Bill Benson

Health Benefits ABCs

There were $4.3 billion in health care fraud recoveries in fiscal year 2013, up from $4.2 billion the prior year, according to the annual HCFAC (Health Care Fraud and Abuse Control) Program Report from the departments of Health and Human Services (HHS) and Justice, released in March. Those funds were deposited with the Department of the Treasury and the Centers for Medicare & Medicaid Services (CMS), transferred to other federal agencies administering health care programs, or paid to private persons (such as realtors who filed suits on behalf of the federal government under qui tam provisions of the False Claims Act) during the fiscal year.

Of the $4.3 billion in recoveries, the Medicare Trust Fund received transfers of $2.8 billion and the U.S. Treasury received transfers of $576 million in federal Medicaid money. The Department of Veterans Affairs, TRICARE, and other programs also received recovered funds.

Every dollar spent on health care-related fraud and abuse investigations reaps $8.10 in recoveries, the departments of HHS and Justice reported. That is the highest three-year average return on investment in the 17-year history of the HCFAC program.

The departments credited this success to the Health Care Fraud Prevention & Enforcement Action Teams (HEAT), new provider enrollment screening, computer analytics that identify fraudulent billing before it is paid, and civil False Claims Act enforcement. Under the new screening requirements, all 1.5 million Medicare providers and suppliers are being revalidated. As of September 2013, more than 535,000 providers were subject to the new screening requirements, which led to more than 225,000 losing the ability to bill Medicare. Since the Affordable Care Act went into effect, CMS has revoked the abilities of an additional 14,663 providers and suppliers to bill the Medicare program because they had felony convictions, were not operational at the address CMS had on file, or were not in compliance with CMS rules.

SMP Actions Save $6.2 Million

The report also flagged the success of the SMP program, noting that during 2012, SMP projects held 10,032 community outreach education events reaching more than 996,000 people and were responsible for more than 188,199 media airings to increase beneficiary awareness about issues related to Medicare fraud. In addition, more than 449,500 beneficiaries were educated through 14,748 group educational sessions conducted by SMP programs in local communities.

SMP projects nationwide received 86,331 inquiries for information or assistance in 2012 from or on behalf of

continued

beneficiaries. This included receipt of 2,270 complex issues – i.e., beneficiary complaints requiring further research, assistance, case development, and/or referral – that resulted in $27.5 million referred for further action. SMP projects reported that 1,748 complex issues were resolved for beneficiaries during 2012. During this period, the HHS Office of Inspector General documented that $133,971 in health care expenditures were avoided and nearly $6.2 million in Medicare, Medicaid, and other savings resulted from actions taken by the SMP program.

The HCFAC report is online at http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf.

Medicaid Fraud Update

In the Medicaid arena, the HHS Office of Inspector General (OIG), in its annual report for 2013, found that state Medicaid Fraud Control Units (MFCUs) recovered nearly $2.5 billion in fiscal year 2013 as a result of criminal ($969 million in recoveries) and civil ($1.5 billion in recoveries) investigations. MFCUs, created by federal law to investigate and prosecute Medicaid fraud, are funded 75 percent by the federal government and 25 percent by the state.

Criminal Convictions. Seventy-four percent of the 1,341 criminal convictions were related to Medicaid fraud and included things such as health care fraud, conspiracy to commit fraud, false statements, grand larceny, and kickbacks. The remaining 26 percent of convictions were related to patient abuse or neglect. The most frequent category of criminal convictions involved home health agencies. Criminal recoveries are relatively stable from year to year, the OIG said.

Civil Settlements. Sixty-two percent of the 879 civil settlements and judgments in 2013 involved pharmaceutical companies. The civil recoveries represented a 42-percent decline from 2012; however, recoveries were exceptionally high in 2012 due to large global pharmaceutical cases being settled.

The MFCU annual report, released in March, can be found online at http://oig.hhs.gov/oei/reports/oei-06-13-00340.pdf.

HCFAC Budget

Meanwhile, the administration's fiscal year 2015 budget proposal, released in March, would increase discretionary spending by 9 percent, from $294 million to $319 million, for the HCFAC account. Most HCFAC spending (estimated $262 million) would go for CMS program integrity work, with the remainder of the funding split between the HHS Office of Inspector General (about $28 million) and the Department of Justice (about $28 million).

This newsletter was made possible by grant number 90NP0001 from the U.S. Administration for Community Living (ACL), Administration on Aging (AoA), and was prepared by the National Consumer Protection Technical Resource Center, more commonly known as The Senior Medicare Patrol (SMP) Resource Center.