Quality, Waste and Abuse in the Medicare and Medicaid Programs

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Dallas, Texas
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IPRO provides a full spectrum of healthcare assessment and improvement services that foster the efficient use of resources and enhance healthcare quality to achieve better patient outcomes.
### Overview

- Understanding what the definitions of waste and abuse are and how the quality of care provided must meet professional recognized standards of care;

- A discussion of the various government contractors auditing providers;

### Overview (Continued)

- Examples of cases that are not medically necessary, inappropriate and/or insufficient documentation to support services billed

- Quality of care issues and medical errors that do not meet professionally recognized standards
Definitions

- **Fraud:** Intentionally attempting to deceive or execute a scheme to falsely obtain money or other benefit from a health care program
- **Waste:** Spending that can be eliminated, including over-utilization of services, without reducing quality of care
- **Abuse:** Improper practices inconsistent with sound business or medical practices that result in unnecessary costs

Fraud is distinguished from abuse and waste in that, in the case of fraudulent acts, there is clear evidence that the acts were committed knowingly, willfully, and intentionally or with reckless disregard!
A Trillion Dollar Issue

Total annual health care spending in the U.S.:

- Quality waste
  - Overuse, underuse, and ineffective use
- Inefficiency waste
  - Redundancy, delays, and unnecessary process complexity

*Peter Orszag's address to the annual meeting of the Retirement Research Consortium, August 7, 2008. [http://cri.bc.edu/events/2008_conference_agenda_and_papers.html](http://cri.bc.edu/events/2008_conference_agenda_and_papers.html)

Categories of Healthcare Waste

- Preventable Conditions and Avoidable Care 6%
- Lack of Care Coordination 6%
- Provider Inefficiency and Errors 12%
- Administrative System Inefficiencies 17%
- Fraud and Abuse 19%
- Unwarranted Use 40%

*White Paper, Where can $700 Billion in waste be cut annually?*, Robert Kelly, Thomson Reuters, 10/09
Quality, Waste and Abuse

Government Agencies and Contractors

- Pursuing more quality-related false claims and other actions related to:
  - Services not rendered,
  - Providing medically unnecessary services,
  - Services not rendered as prescribed,
  - Substandard care,
  - Medical errors (serious adverse events), and/or
  - Inaccurate reporting of quality measurement data

Federal Level:
- MACs,
- RACs,
- ZPICs, MEDICs
- MICs,
- OIG and
- Department of Justice
- Veterans Administration

State Level:
- Medicaid SSA
- Attorney General
- MFCUs, and
- OMIGs
- Medi-Medi Project
**Government Agencies and Contractors**

- **Medicare Administrative Contractors (MAC)**
  - Improved Beneficiary Services
  - Identify new areas of audit focus
  - Medicare match hospital and physician claim data
    - Fifteen A/B MAC Jurisdictions – Includes Home Care and Hospice
    - Four specialty MACs – DME

- **Medicare Drug Integrity Contractors (MEDIC)**
  - Responsible for Part D
  - MEDICs to oversee Part C plans

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**Government Agencies and Contractors**

- **Medicare Recovery Audit Contractors (RACs)**
  - Region A: Diversified Collection Services (DCS); CGI; Connolly, Inc.; Health Data Insights.
  - Responsible for identifying improper payments not detected through existing program integrity efforts

- **Zone Program Integrity Contractors (ZPICs)**
  - Replaces Program Safeguard Contractors (PSCs)
  - Get Data-mined referrals and conduct coding, overutilization and medical necessity audits
Medicaid Integrity Contractors (MICs)

- Audit and Review Medicaid providers
  - Identify overpayments, provide education
  - Data mining and fraud/abuse research
  - Establish procedures/protocols for detection and identification of overpayments (i.e., algorithms, queries, models)
  - Develop fraud and abuse library to identify best practices

- Review MICs: Thompson Reuters, AdvanceMed
- Audit MICs: IPRO, Health Integrity, HMS

Single State Agency (SSA)

Oversees the Medicaid Program

- Each State Medicaid agency has a program integrity (PI) program
  - Includes methods for identifying and investigating suspected cases and referring them to law enforcement
  - States must investigate, resolve and recover overpayments made to providers
  - Refer cases to the State MFCU or other law enforcement agency
### State Agencies: Medicaid Fraud Control Unit (MFCU)

- Reviews referrals it receives from SSA to determine whether the issues involved merit criminal and/or civil investigation.
- Conducts investigation and prosecution of health care providers.
- States must meet Federal requirements.
- States have flexibility in the design and execution of their programs.

### Medicaid Inspector Generals (OMIG)

- Coordinates fraud, waste and abuse control activities within executive agencies and recommends legislative, policy and structural changes needed to strengthen the integrity of the program.
- Through audit, investigative, fraud detection and enforcement efforts, recovers state funds that have been inappropriately claimed.
- Currently in: Texas, New York, New Jersey, Kansas, New Mexico, Florida, Georgia and Illinois.
Medicaid Inspector Generals (OMIG)

- Assure that providers meet program quality standards for Medicaid enrollees in a system free of waste, fraud and abuse.
- Recover overpayments and pursue civil and administrative enforcement actions against those who engage in fraud, waste or abuse or inappropriate acts perpetrated.
- Currently in: Texas, New York, New Jersey, Kansas, New Mexico, Florida, Georgia and Illinois.

Contractor Reviews of Medical Necessity

- To determine the medical necessity and appropriateness of treatment rendered.
- Make claim determinations involving coverage, causality and/or need for treatment
- Review proposed treatment for medical appropriateness, necessity and eligibility
- Reviewed according to nationally criteria to ensure appropriate level of care and frequency, and guidelines for coverage eligibility
Serious Adverse Event – Medical Errors

- Surgery performed on wrong patient or body part
- Wrong surgical procedure on a patient
- Retention of a foreign object in a patient after surgery or other procedure
- Disability associated with a medication error
- Disability associated with a reaction to administration of incompatible blood or blood products

Serious Adverse Event – Medical Errors

- Disability associated with use of contaminated drugs, devices, biologics
- Disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
- Disability associated with intravascular air embolism
- Disability associated with an electric shock while being cared for in a health care facility
Serious Adverse Event – Medical Errors

- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance
- Disability associated with a burn incurred from any source while being cared for in a healthcare facility

Submitting False Claims (FCA)

- Five Nursing Homes in Missouri admitted to criminal and civil fines
  - Staffing NOT sufficient to provide adequate care
  - Wound care was NOT provided
  - Medications NOT provided
  - Medical Records falsified
  - Claims submitted for services NOT provided
### Submitting False Claims (FCA)

<table>
<thead>
<tr>
<th>Michigan Health System</th>
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<tr>
<td>Billing Medicare for higher levels of service than were actually rendered to patients</td>
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<tr>
<td>Unreasonable and unnecessary hospital admissions</td>
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<tr>
<td>Overbilled for evaluation and management services provided to cardiology patients.</td>
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<th>Minnesota Hospital</th>
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<tr>
<td>Unreasonable and unnecessary hospital admissions</td>
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<tr>
<td>Kept or admitted to acute care when not medically necessary</td>
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<th>New Jersey Hospitals</th>
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<tr>
<td>Fraudulently inflated its charges to obtain enhanced reimbursement</td>
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<td>Inflated charges to obtain cost outlier payments</td>
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## Managed Care Organizations

- **Not Exempt From False Claims Act:**
  - Underutilization, such as a failure to provide a category of care to a group of patients
  - Use of personnel lacking appropriate training or credentials
  - Inducement to network providers to deny needed care
  - Knowingly denies benefits (e.g., "cherry-picks").

## What YOU Can Do

- **Conduct baseline assessment of risk areas:**
  - Inappropriate or insufficient treatment and services to address clinical condition
  - Inadequate staffing levels or insufficiently trained or supervised staff to provide medical, nursing and related services
  - Failure to properly prescribe, administer and monitor prescription drug usage
  - Failure to provide medically necessary services and/or get appropriate consent
What YOU Can Do (Continued)

- Failure to provide appropriate services to assist with activities of daily living
- Assure that staff have the appropriate credentials to provide services
- Assure the accuracy of publicly reported data

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