



March 16, 2005

## **Missouri Should Adopt State Version of Federal False Claims Act**

**Jennifer Hill**  
**Director of Health Policy**

### 93rd Missouri General Assembly addresses fraud, waste and abuse

Recent allegations regarding the level of waste, fraud and abuse in the Missouri Medicaid system have been primarily charged against individuals. According to the House Social Services Appropriations committee there will be savings of \$29 million from re-verification. This assumes that a large number of Medicaid recipients are not “legally” qualifying for the system. This level of “savings” assumes that a large amount of children and adults would be removed from the Medicaid system. The \$29 million dollar cut would correlate with 27,462 Medical Assistance Adults, or 86,309 kids in the CHIP program losing coverage.

Proposals to tighten the eligibility process have been made in SB 539, ostensibly to reduce the fraud problem. The \$29 million represents these changes and we know that up to 86,000 children could lose their coverage if the bill passes as it will have controlling authority over the budget. (The Fiscal note for this bill assumes only 13,609 cases will be closed, it is not clear how they came to this number.) No new additional staff will be provided so current staff will be required to bring the entire caseload into compliance.

### Where the Fraud is

The real problem with Medicaid fraud is with the providers. Even with advanced computer programs such as the Medstat fraud detection system put in place by the Division of Medical Services, a successful MFCU in the attorney’s general office, and enhanced income verification in the Division of Family Services the state will have to make a more concerted effort to stop provider fraud. The majority of scholarly research on the issue including GAO, (General Accounting Office) studies conclude that Medicaid fraud by providers is grossly underestimated and losses inadequately recouped.

Fraud occurs in fee for service and managed care programs. Many losses are a result of:

- Provider Overpayments
- Provider false claims for reimbursement
- Provider Kickbacks
- Overcharging by the Pharmaceutical Industry

The only estimate of the cost to provider fraud is the now notorious 1994 OIG testimony to the US Congress. At that time the OIG estimated that Medicaid provider fraud was as high as 10% of all payments in Medicaid. The OIG still claims the Medicaid program is in danger of billions in fraud and needs further study and more enforcement.

Currently the Federal False Claims Act is the primary enforcement tool to avoid and detect fraud in the federal Medicare Program. The same standards can be applied at the Federal Level to Medicaid. One of the most important elements of the FCA is the qui tam provision. This provision allows for whistleblowers to participate in lawsuits against offenders and provides a portion of the settlement to the whistleblower as well. In the first quarter of 2005 enforcement of the FCA has resulted in settlements and judgments of over \$730 million. Most of these were health care fraud, although the FCA applies to other government contracts as well.

Medicare fraud collections currently are at least 12 times that of Medicaid fraud collections. Yet, according to “Reducing Medicaid Fraud, The Potential of the Federal False Claims Act” there is no reason to assume that Medicare simply has more fraud. For a variety of reasons Medicaid fraud is more difficult to determine and the federal law does not allow those bringing actions against Medicaid providers to receive any of the settlement.

Some of the reasons that Medicaid fraud is not prosecuted as vigorously as Medicare fraud include:

- It is more difficult to apply the FCA to Medicaid due to the federal & state partnership structure of Medicaid,
- States need the whistleblower provisions including incentives to encourage participation,
- Medicare has a larger federal investment,
- MFCU’s tend to focus on criminal, not civil matters, and

- Reluctance to pursue nursing facility fraud due to the possibility of undermining the viability of the facility that cares for poor and fragile citizens.

## States which have False Claims Acts

Eleven states including Texas, Illinois, Tennessee, California and Florida have passed state versions of the FCA. Provisions within those bills allow for the whistleblowers to share in the state portion of the settlement. Texas has a state version of the FCA and has had considerable success in settlements. They have specifically gone after the pharmaceutical industry and have received at least \$45.5 million in settlements, with an annual budget of about \$500,000. In 1995 and 1997 Texas passed two anti- fraud bills that strengthened civil penalties and added qui tam provisions.

## Missouri needs stronger enforcement of Medicaid provider fraud

Missouri must consider the advantages of passing a state version of the FCA and increasing the state investment in the MFCU's so that Medicaid provider fraud can be stopped. The following represent the current collections of false claims in Missouri: MFCU Collects Restitution from the cases that it prosecutes, and national cases as well.

FY 2000 – 2004

\$7,298,285 National Settlement Collections  
\$1,106,029 State Ordered, Non-National Settlements  
\$8,395,314 Total Reported Collections

Program Integrity also recovers overpayments. In FY 2004 they identified \$1,350,000 in over payments and collected \$1,060,000 of that amount.

The qui tam provisions in the FCA are central to increasing the reporting of fraud. Provisions that protect the whistleblowers and allow them to share in the settlement are critical to the reporting that leads to large settlements. We can see that there is potential by the current size of collections, and new cases of Medicare and Medicaid fraud are being uncovered in Missouri. Evidence of this is the recent suit filed by the US District Attorney for the Eastern District of Missouri is questioning physician payments and pharmaceutical services provided to patients by Davita a kidney dialysis provider.

### *Sources of Information:*

*Oversight Division, Committee on Legislative Research, Program Evaluation, Medicaid Fraud Follow-up  
Oversight Division, Committee on Legislative Research, Program Evaluation, Application Process and  
Eligibility Verification of Medicaid*

*U.S. Department of Health and Human Services, Semiannual Report to Congress, Office of Inspector  
General, Oct. 1, 2003-March 31, 2004.*

*Reducing Medicaid Fraud, The Potential of the Federal False Claims Act, Andy Schneider, Medicaid  
Policy LLC for Taxpayers Against Fraud, June 2003.*

*TAF Education fund, The False Claims Act Legal Center, False Claims Act Update and Alert,  
[www.TAF.org](http://www.TAF.org), January 18, 2005, March 15, 2005.*

*"Texas Goes after Big Pharma", The Texas Observer, Robert Bryce, March 4, 2005.*