Health Care Fraud

Challenges to Medicare, Medicaid and Commercial Plans

October 5, 2018

Susan Hayes, CPhT., MCJ, AHFI
Pharmacy Investigators and Consultants
Defining Health Care Fraud

• Health Care fraud is a complex white collar crime involving a single player to complex organizations:
  • A single patient, provider, physician or insurer
  • Institutions in the health care industry

• Any act involving a health care or reimbursement for health care services or products and which is performed for unlawful financial gain

• Can include drug diversion (theft) by employees (nurses, physicians, pharmacists, techs, PBM personnel)
  • Estimated 37,000 hospital personnel are impaired on any given day according to the International Health Diversion Association

“Between $70 billion and $234 billion is essentially stolen from the American public through health care fraud schemes annually.”

– National Health Care Anti-Fraud Association, June 2009

https://www.nhcaa.org/docs/nhcaa/PDFs/Member%20Services/Fighting%20Health%20Care%20Fraud_NHCAAJune2009.pdf
Statutes and Laws: Health Care Fraud

- Federal Statutes
  - False Claims Act, False Statement Act, Social Security Act, Federal Mail and Wire Fraud, Health Care Fraud, Theft/Embezzlement with Health Care, Civil False Claims Act, Civil Monetary Penalties Law

- State Statutes
  - IL Sec. 17-6 State Benefits Fraud (720 ILCS 5/17-6)
Professional Violations and Penalties

- Professional Board Infringements
  - Physicians—(225 ILCS 60/) Medical Practice Act of 1987
  - Nurses—(225 ILCS 65/) Nurse Practice Act
  - Pharmacists—(225 ILCS 85/) Pharmacy Practice Act.

- Contract requirements, traditional fraud

- All of these laws and statutes carry jail time (many up to 20 years), restitution (some treble damages) and loss/sanctions against licensure
601 individuals were arrested on June 28, 2018

- 165 doctors, nurses and other licensed medical professionals
- More than 1,000 law enforcement agents in at least 30 states
- About $2 billion in false billings, including for the prescription and distribution of opioids
- 162 of the defendants were charged with opioid related crimes
- Narcotics officers have arrested schoolteachers, doctors, nurses and fellow law enforcement personnel involved in the schemes
Florida is the perfect storm:
- Pharmacy technicians can own pharmacies for $105 and a two week course
- South Florida has the highest density of Medicare and Medicaid recipients

New York is the largest state that does not regulate pharmacy technicians:
- No license also for Pennsylvania, Wisconsin, Delaware, Colorado and Hawaii

Technicians do not need to be licensed in Canada but “highly encouraged” by employers
According to think-tank Poneman Institute, medical identity theft costs members $22,000 and affects 1.85 million Americans.

There is no specific law directed at Medical identity theft.

Member Identity Theft is a Concern
Research to be presented at the American Society of Criminology suggests that when pharmacist make pharmacoethical decisions six themes emerged:

- If it’s a patient I know, and not a “dangerous” drug, I’ll bend or break the rules . . .
- Especially if it is an “emergency.”
- If you document the problem, you are off the hook for liability, even if it is wrong
- We don’t need policies, we have professional judgment
- Costs don’t matter, profits don’t matter, do what the patient wants
- Pharmacists take shortcuts because they have to regardless of the law, may change a prescription illegally, may complete forms for physicians

Hayes, S. (2017). Blinded By the White: Can pharmacists see fraud or has pharmacy curricula left them in the dark? American Society of Criminologist, October 2018 meeting
Detecting Fraud is Complex

- Issues at play:
  - Data discombobulation
  - Lack of technical expertise (clinical, law enforcement, legal, technical)
  - Cost versus benefits

- Hundreds of hours were devoted to the DOJ takedowns

- Don’t just look for controlled drugs—talented criminals know how to submit claims without you noticing

- Many of the large cases take complex teams: Statistical analysis, investigations, prosecution/litigation
Each field of “active” data is tagged.

A score is developed based on that data element’s distance from the mean for that data field and assigned an “actor.”

Certain data fields are weighted more heavily than others.

Every score is accumulated and a fraud score is developed for each “actor.”

Fraud is detected and investigated

Unsupervised (queries) and Supervised (AI) used
Detecting Bad Actors

- **Actors**
  - Pharmacy
  - Prescriber
  - Patient

- **Metrics**
  - Claim volume
  - Excess supply of drugs
  - Maximum refills for patients
  - Prescriber and Pharmacy location
  - Quantity of dispensed drugs
  - Distance between pharmacy and prescriber

- **Statistical Techniques**
  - Univariate/Multivariate outlier Detection
  - Correlation
  - Clustering
  - Association and sequence

- **Output**
  - Interpret Results
  - Flag anomalous activity

- **Score Actors**
- **Identify Probable Fraudulent Actors**
  - Flagged data ready for supervised learning after investigations
What Can Health Plans Do?

• Talk to PerformRx
  • Coordinate efforts between medical SIU units and PerformRx
  • Balance investigations and access
  • Many providers who commit fraud also have valued patients with little or no alternative locations
  • Request credentialing information or standards
    • What are PerformRx’s internal standards for pharmacy network participation?
    • What would you like PerformRx’s internal standards for participation?
      • Pharmacist never been sanctioned?
      • Pharmacy never been sanctioned?
      • Pharmacy in business for 6 months?
      • Consistent volume or reason for increase?
Ask These Questions:

- What claims have been audited and why?
  - Was there true fraud or “bookkeeping” errors?
- Were medical and pharmacy and HSA claims combined for detection purposes?
- What staff is dedicated to detecting and resolving fraud?
- What is the credentialing process for pharmacies, medical providers?
  - How does this differ from individual practitioners and “chain” medical providers?
• If your plan wants to make any in-roads to fraud, you MUST have a transparent and pass through contract FOR MEDICAL AND PHARMACY PROGRAMS
  • Pass through pricing in pharmacy and medical
  • Ensure your contract is transparent
  • Ensure you have audit rights
  • Ensure that your PBM will audit a retail pharmacy at your request
  • Ensure all pharmacies are included in the FWA audits
    • Mail Order
    • Specialty
    • Your own health plan pharmacies

It Starts with the Contract
Why SOME PBMs are Not Concerned

• Traditional undisclosed spread pricing means spread is taken on fraudulently submitted claims
• Plans aren’t asking about it
• PBMs don’t do anything about it
• PBMs can’t make money off of fraud programs
• PBM’s lobbyists (PCMA) advocate the ability to audit pharmacies without the mandate to reimburse employers (spread pricing)
• PerformRx DOES NOT turn a blind eye to fraud

Develop Policies and Procedures

- What are you going to do with providers in the network that commit fraud?
  - Kick them out of the network, make it someone else’s problem
  - Do you have the clout to do so with your medical carrier and PBM

- What are you going to do with patients that commit fraud?
  - Fire them, make them someone else’s problem
  - Do you want to be prosecuting your employees?
  - Do you have an ethics policy for employees?

- What are you going to do with vendors that allow fraud to be committed?
  - Continue on, they all do it
  - Find ones that mitigate it
  - Do you have an ethics policy for providers?
Wilhem’s Fraud Cycle

Wilhem’s premise is that all phases in the fraud life cycle have to be properly addressed. Prevention without detection or policy without deterrence will not work—and all revolve around an IT solution.

Invest in Some Specialized Services

• Statistical analysis
  • If your IT department does not have the resources, hire a data scientist

• Investigation services
  • What is the difference between auditing and investigating?
    • In Illinois, it is outside the scope of an auditor to go “beyond the claim”
  • Detection services now encompass the medical community
  • Classic “worker’s comp” detection is now being performed for medical/pharmacy case investigation

• Legal services
  • You may need an attorney with health care law expertise to determine what is and what is not against the law
Key Takeaways

• Health care fraud is complex, detection is difficult, the problems are exacerbated by the even more complex opioid crisis

• You need to develop policies and procedures so you have a direction with your vendors/carriers, patients and the medical community

• If you want to mitigate fraud, you may have to invest in some specialized services such as IT, detection, legal