HHS Pursues Mandate to Clamp Down on Fraud

BY ALICIA AULT

Physicians may find themselves under increased scrutiny as a result of provisions in the Affordable Care Act—one of the health reform laws—giving government agencies new funding and enforcement powers to go after fraud and abuse.

The Affordable Care Act will require providers and suppliers to meet new compliance criteria, said Daniel Levinson, inspector general for the Department of Health and Human Services. After the criteria are issued, his office will provide training to health care providers, he added at a briefing.

HHS Secretary Kathleen Sebelius said that the Affordable Care Act provides $600 million over the next 10 years to combat fraud and abuse. In 2009, the federal government recovered $2.5 billion in fraudulent Medicare payments, officials said at the briefing.

Potential Medicare or Medicaid providers will be categorized as at high, medium, or low risk of fraud at the time of enrollment. More face-to-face checks will be used to verify a provider's legitimacy, Ms. Sebelius said. The law increases penalties for fraud, and puts more emphasis on real-time detection of fraud and abuse, she noted, as opposed to the current "pay and chase" model.

The HHS and the Department of Justice also will be adopting strategies used by credit card companies to flag aberrant charges and stop fraud in its tracks. "For years, we've tolerated health care fraud," she said. "We've accepted that with any big enterprise there was going to be some waste and abuse, but those days are coming to an end. As we try to bring down skyrocketing costs across our health care system, we can't afford to ignore the billions of dollars we lose to fraud and theft," she said.

In 2009, the federal government received about $1.6 billion in settlements and judgments from hospitals, health care providers, drug and device makers, and non–health providers found to have illegally billed federal health care programs. With penalties and settlements, $2.5 billion was returned to the Medicare Trust Fund and $441 million to Medicaid, according to the Health Care Fraud and Abuse Control Program Report.

A total of 583 individuals were convicted of health care fraud in 2009. On the civil side, the Department of Justice opened 886 new investigations and had 1,155 civil fraud matters pending.

Physicians were among those convicted or fined for fraud and abuse schemes, including a California physician who paid $2.2 million to settle allegations that between 2002 and 2006, he allowed his universal provider identification number to be used to bill Medicare for respiratory therapy. A Kansas cardiologist paid $1.3 million to settle allegations that his group submitted claims for services not provided.

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Ms. Sebelius and Attorney General Eric Holder highlighted efforts by the Health Care Fraud Prevention and Enforcement Action Team (HEAT) Medicare Fraud Strike Force, which was formed in 2007 to address durable medical equipment fraud and abuse in south Florida.

The strike force has been expanded to focus on potential hot spots of potential fraud, identified by claims patterns. Los Angeles, Detroit, and Houston were added in 2009. The strike force now also operates in Brooklyn, N.Y.; Baton Rouge, La.; and Tampa.

New types of scams are emerging as criminals try to take advantage of seniors who may not understand the health reform laws. Scam artists have gone door-to-door in some states selling bogus "ObamaCare" policies, or asking Medicare beneficiaries for identifying information to issue "new Medicare cards," Ms. Sebelius said.

Other scams are tied to the issuance of rebate checks to Medicare beneficiaries whose Medicare Part D drug expenditures push them into the so-called doughnut hole that limits coverage, she said.

The HHS is working with advocacy organizations to educate laypeople who can train their peers how to recognize illegal schemes, she said. ■

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Cancer Costs Double in 18 Years

The cost of treating cancer doubled over nearly 2 decades, and treatment has shifted to outpatient settings, according to a study from the Centers for Disease Control and Prevention. However, cancer accounts for about 5% of overall health care spending, a percentage that hasn't changed since 1987 despite the advent of more expensive cancer drugs, according to the study, published in the journal Cancer. The researchers determined that the increase in cancer costs—to $48.1 billion in 2005—came largely from the growing number of cancer patients. The share paid by private insurance increased and that paid out-of-pocket by patients fell. Medicare continued to pay about one-third of total treatment costs, the study found.

Bonuses Risk Medical Disparities

Rewarding primary care physicians for providing better care to patients could widen medical disparities experienced by poorer people and minority groups, according to a RAND Corp. study. Published in the journal Health Affairs, the research suggests that the average-size medical practice serving a vulnerable population would receive $7,100 less annually because of existing gaps in quality of care. "If you don't watch where the money goes, pay-for-performance programs have the potential to make disparities worse," lead author Dr. Mark Friedberg, an associate scientist at RAND, said in a statement.

Health Information Grants Set

Fifteen communities are splitting about $220 million in grant money from the Department of Health and Human Services to build health information technology infrastructures and capabilities. The Beacon Community grants provide funding to "communities at the cutting edge of electronic health record adoption and health information exchange," the HHS said. Delta Health Alliance in Stoneville, Miss., received $14 million to electronically link systems for care management, medication therapy, and patient education in diabetes, while the Indiana Health Information Exchange in Indianapolis, the largest health information exchange in the country, received $16 million to improve cholesterol and blood sugar control in diabetic patients and to reduce hospital readmissions through telemonitoring. The program is intended to demonstrate the advantages of health information technology.

Doctors Still Poor on Food Advice

Only about half of obese adult Americans were told by their doctors to cut down on fatty foods in 2006, a number that hasn't changed significantly since 2002, according to the Agency for Healthcare Research and Quality. The problem is especially acute in minority populations, the AHRQ said. Obese Hispanic patients received advice on healthy eating from their physicians only 42% of the time, while obese black adults received advice 45% of the time. White adults received healthy eating advice 52% of the time. In addition, doctors were less likely to tell poor obese adults and those who did not finish high school to cut down on high-fat, high-cholesterol foods, regardless of race or ethnicity, when compared with advice to higher-income and better-educated counterparts. Black and Hispanic adults have higher obesity rates than whites, as do poor adults and those with limited education, the study noted.

Blues Plan Rewards Primary Care

Pennsylvania-based Independence Blue Cross said it will invest an additional $47 million to supplement compensation to the 1,800 primary care physicians participating in its network in an effort to improve quality of care. More than $33 million of the added investment will enhance an incentive program for "better care, not more care," the health plan said. Independence will increase the base amount it pays primary care physicians by an average of 10% and will reward physicians who improve quality on measures such as cancer screenings, immunizations, and asthma management. With the new funds, primary care physicians can double their incentive earnings over 2009, according to Independence. Practices that meet some or all of the core requirements for a "patient-centered medical home" and physicians who provide effective coordination will receive additional compensation, Independence said.

Providers Asked to Find 'Bad Ads'

The Food and Drug Administration has launched a program to get health care providers to detect and report misleading drug ads. The "Bad Ad" program seeks to educate health care providers about their role in ensuring that prescription drug advertising is truthful and not misleading, the FDA said. Initially, FDA officials will meet with providers at selected medical conventions and will partner with a handful of medical groups to distribute educational materials. The agency said it will then expand its collaborations with medical societies. The FDA announcement encouraged health care professionals to report a potential violation in drug promotion by sending e-mails to badad@fda.gov. Reports can be submitted anonymously, but the FDA is asking providers to include contact information so that staff members can follow up.

—Jane Anderson