ANDREW BAILEY
MISSOURI ATTORNEY GENERAL

Medicaid Fraud Control Unit

2024 Recipient of the HHS, Inspector General's Award for Excellence in Fighting Fraud, Waste and Abuse

Arvids V. Petersons – "Arv"
Chief Counsel/Director MFCU
Phone: (573) 751-7192

Arvids.Petersons@ago.mo.gov

Who We Are and What We Do

MFCU Staff

- Chief Counsel/Director
- 5 Attorneys
- 14 Investigators and Investigative Auditors
  - 1 Chief Investigator
  - 1 Chief Auditor
- 2 Nurse Investigators
- 1 Paralegal – Evidence and Litigation
- 1 Data Analyst
- 1 Admin Support

MFCU Structure

- 2 Prosecution Teams
  - 2 Attorneys
  - 6 Investigators
  - 1 Investigative Auditor
  - 1 Nurse Investigator
- 1 Resource/Support Team
  - Chief Counsel/Director
  - Chief Investigator
  - Chief Auditor
  - Litigation Paralegal
  - Data Analyst

No MFCU, No Federal Medicaid Match

Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103–66).

Section 1902(a)(61) of the Act requires a State to provide in its Medicaid State plan that it operates a Unit **[MFCU]** that effectively carries out the functions and requirements described in this part, as determined in accordance with standards established by OIG…CMS retains the authority to determine a State's compliance with Medicaid State plan requirements in accordance with section 1902(a) of the Act.

MFCUs are entities in State government that will conduct a statewide program for investigating and prosecuting:

1) Medicaid provider fraud that occurs in any care setting,
2) Patient abuse or neglect that occurs either in Medicaid-funded health care facilities or in board and care facilities,
3) Fraud in the administration of the Medicaid program, and
4) Conduct or assist with investigations of provider fraud in any and all federal health care programs.

- Assist:
  - Local Law Enforcement & Prosecutors
  - Federal Prosecutors and Investigators

Medicaid Funds Flow Through Other State Agencies

- Department of Health & Senior Services
  - Senior & Disability Services
    - Home and Community Based Services
      - *Personal Care*
      - *Adult Daycare*
    - Senior Services
    - Adult Protective Services
  - Licensing & Regulation
    - Nursing Home & Long-Term Care
      - *Long-Term Care Facility Complaints*
    - Hospital Licensure and Regulation
    - EMS
  - Public Health
    - AIDS
    - Vaccines for Children
- Department of Mental Health
- Department of Elementary and Secondary Education

What is Medicaid Fraud?

- Health care fraud is a real concern
  - Missouri Medicaid Budget in SYF 2025 = **$17.2 Billion**
  - FBI estimates that 3% to 10% of healthcare spending is fraudulent
    - *Fraud/Waste/Abuse is estimated to be between $516 Million and $1.72 Billion*

- Bottom Line Question: ***Did Medicaid get what it paid for?***

- Medicaid fraud occurs when a provider **knowingly misrepresents the services rendered** and thereby causes a false claim for payment to be submitted to Missouri Medicaid (a.k.a., MO HealthNet)

What is Medicaid Fraud?

- **Knowing/Knowingly** (§191.900, RSMo) is that a person, with respect to information:

  (a) Has actual knowledge of the information;

  (b) Acts in deliberate ignorance of the truth or falsity of the information; or

  (c) Acts in reckless disregard of the truth or falsity of the information.

  - Use of the terms **"knowing"** or **"knowingly"** shall be construed to include the term **"intentionally"**, which means that a person, with respect to information, intended to act in violation of the law;

Medicaid Fraud Statute

§191.905, RSMo:

1. No health care provider shall **knowingly make or cause to be made** a false statement or false representation of a material fact in order to receive a health care payment.

- Services not provided
- More services than actually provided
- Medically unnecessary services
- Lie and/or omit statements to Medicaid during provider enrollment periods that would have otherwise excluded provider from participation in the program.

2. No person shall knowingly solicit or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in case or in kind in return for…

- Bribe
- Kickback
- Providing a recipient something free in return for using your services
- Agreeing not to charge a co-pay
- Inducing another healthcare provider to refer patients to you for services

Medicaid Fraud Statute Cont.

§ 191.905.6, RSMo: No person shall knowingly abuse a person receiving health care.

- **Physical Abuse** is the non-accidental use of force against an elderly/vulnerable person that results in physical pain, injury, or impairment. Such abuse includes not only physical assaults such as hitting or shoving but also the inappropriate use of drugs, restraints and confinement.

- **Sexual Abuse** is contact with an elderly/vulnerable person without their consent. Such contact can involve physical acts, but activities such as showing an elderly/vulnerable person pornographic material, forcing the person to watch sex acts, or forcing him/her to undress are also considered sexual abuse
  - **§ 566.115 (felony) .116 (misdemeanor), RSMo:** Sexual conduct with a nursing facility resident or a vulnerable person – A person commits the offense of sexual conduct with a nursing home resident or vulnerable person if he/she has sexual intercourse or deviant sexual intercourse with a resident if he/she is a facility employee. ***Consent is not a defense.***

Medicaid Fraud Statute Cont.

§ 191.900, RSMo:

Abuse = the infliction of physical, sexual or emotional harm or injury.

Includes the taking, obtaining, using, transferring, concealing, appropriating or taking possession of property of another person without such person's consent

- **Financial exploitation:** a person obtains control over the property of an elderly or disabled person with the intent to permanently deprive the elderly or disabled person of it thereby benefiting the offender or detrimentally affecting the victim.

Medicaid Fraud Statute Cont.

§ 191.905, RSMo – Other Crimes:

8. Any natural person who willfully prevents, obstructs, misleads, delays, or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of sections 191.900 to 191.910 is guilty of a class E felony.

- Providers are most commonly prosecuted for obstruction for altering patient records.

- Examples Include:
  - Creating records in response to a subpoena
  - Altering EVV records to reflect inflated billings

Source of Cases

- Referrals
  - Missouri Medicaid Audit and Compliance Unit (MMAC)
  - Managed Care Organizations (MCOs)
  - Licensing boards
    - Healing Arts
    - Nursing
  - State agencies administering Medicaid Programs
  - Local Law Enforcement
  - Federal Law Enforcement
  - Other States
  - **RSMo § 198.093**
    - "Right to sue" – the complaining party (plaintiff) must report Long-Term Care resident's abuse/neglect to AGO within 180 days of alleged injury.
- AGO's MFCU Hotline –phone or email
  - Whistleblowers
  - Concerned Citizens
- Self-Generated Referrals
- Data Mining

MFCU Process

- Once the referral is submitted, MFCU decides whether to open a case or not.
  - Once a case is opened, it is assigned to a Team consisting of **2 attorneys** and **6 investigators.**
    - Medicaid Claims Analysis
    - Subpoena Documents
      - Grand Jury Subpoena
      - AG Subpoena
    - Record collection
      - Bank records
      - Cash App
      - Electronic Medical Records
    - Search Warrants
    - Interviews
- The results of the investigation dictate the next steps

Medicaid Fraud Penalties

§ 191.905, RSMo – Monetary Penalties

In addition to jail time, monetary penalties are also ordered in Medicaid Fraud cases.

- Shall pay restitution for the funds stolen – this is the amount of the fraudulent claims, it repays what was taken;

  Plus

- A person shall be liable for a civil penalty of not less than $5,000.00 and not more than $10,000.00 for **each separate act** or false claim, plus **three times the amount of damages.**

Monetary Penalties- Example

State v. Spilton, 315 S.W.3d 350 (Mo. 2010) - Decided by Missouri Supreme Court 8-0 (a.k.a., unanimous decision):

Example: **Restitution** = $1,022.74 for personal care services not provided

- **Treble damages (X3)** = $3,068.22; and
- **A penalty of $5,000-$10,000 for each false claim**
  - Defendant submitted false claims for 26 days
  - **26 false claims x $5,000.00** = $130,000.00 or
  - **26 x $10,000.00 = $260,000.00** total penalties
  - Plus investigation and prosecution costs

Restitution + Damages + Penalty + Costs = Total Liability

$1,022.74 + $3,068.22 + $130,000.00 or $260,000.00 =

Defendant faces monetary consequences of between $134,090.96 and $264,090.96 + Investigation/Prosecution costs

Unintentional False Claims

§ 191.905.14 - Civil Action against any person who shall receive a health care payment as a result of a false statement…The person shall be liable for up to double the amount of all payments received by that person based upon the false statement and the reasonable costs attributable to the prosecution of the civil action.

State v. Spilton, 315 S.W.3d 350 (Mo. 2010) - Decided by Missouri Supreme Court 8-0 (a.k.a., unanimous decision):

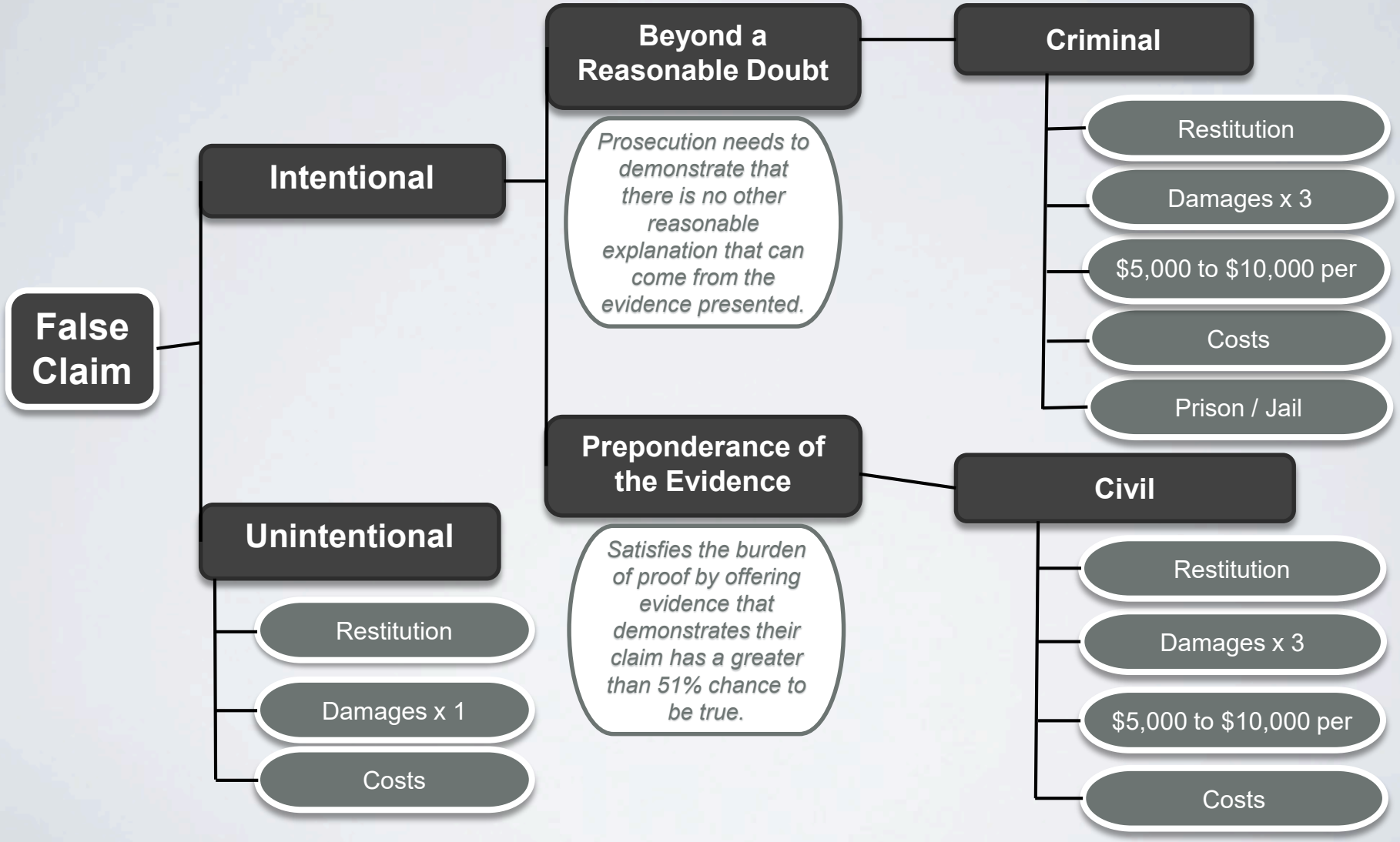
Restitution = $1,022.74 for personal care services not provided

- **Damages (X1)** = $1,022.74; and
- Investigation and Prosecution Costs

Restitution + Damages + Costs = Total Liability

$1,022.74 + $1,022.74 + Investigation/Prosecution costs

Medicaid Fraud Case Analysis



Charges Filed in Medicaid Fraud Cases

Medicaid Fraud (§191.905) is not the only charge MFCU investigates and prosecutes. Commonly filed charges in addition to Medicaid Fraud:

- Criminal
  - Forgery
  - Stealing by Deceit
  - Identity Theft
  - Abuse of a person receiving health care
  - Financial Exploitation
  - Money Laundering

Consequences of a Fraud or Abuse Conviction

Individuals and entities can be excluded from all federally funded health care programs by the OIG

- OIG maintains an Exclusion List
  - Mandatory – Conviction: Medicare, Medicaid or Health Care Fraud; Resident abuse or substance abuse
  - Permissive – Discretionary for a variety of licensure actions and misdemeanor convictions

- Other Consequences
  - Discipline from licensing board
  - Placement on the Employee Disqualification List (EDL)
  - Suspension from Medicaid

Types of Fraud

- **Fraudulent Enrollment "Straw Owner"**
  - Owner or manager is excluded or otherwise ineligible to be a Medicaid provider and hides behind someone to become a provider
- **Services Not Provided**
  - Billed Medicaid for services but in reality no services were provided
  - Personal Care Services often involves "Check Splitting" – Attendant and Recipient agree to share the Medicaid payments received for fraudulent billing
    - Charge both the Attendant and Recipient with Fraud
- **Ineligible Attendant "Straw Attendant"**
  - FCSR disqualified, EDL disqualified
  - Charge both the Company owner for employing an ineligible attendant and Attendant because he/she knew they weren't eligible to provide services
- **Identity theft**
- **Billing for more services than actually provided – EVV does not support billing**

Types of Fraud

- Billing to the care plan
- Billing to the Authorized Amount
  - DME is authorized to provide 120 catheters a month. Prior authorization is good for 1 year. DME provider bills for the full 120 catheters/mo regardless of recipient's actual need.
- Pharmacy
  - Billing and Not Filling
  - Billing for Brand Name but providing generic
  - Billing for homemade compounded drugs
- Upcoding
- Unbundling
- Medically Unnecessary Services
- Worthless Services
- Billing Medicaid for supplies paid for by others

Abuse Types

- **Physical contact – assault-type conduct**
  - A healthcare provider (e.g., PCA, CNA, attendant, therapist) offensively touches the Medicaid Recipient
- **Verbal abuse**
  - Calling the recipient offensive names
    - Need to establish the recipient suffered emotional harm
- **Taking the nursing home residents' money**
  - Taking the $50 monthly allowance for personal items
- **Stealing money the family or other entity provides for the resident**
  - Diverting benefits
    - COVID relief
    - SSA

Abuse/Neglect

- Neglect is the refusal or failure to carry out a care-giving responsibility such as failure to provide food, medicine, or other services associated with daily living needs.
  - Neglect is also abandonment and can be active or passive
  - Active Neglect is the intentional failure to fulfill a caregiving responsibility
  - Passive Neglect is the unintentional failure to fulfill a caregiving obligation. There is no willful attempt to inflict distress on the victim. In many situations, it is the result of well-meaning family members or friends who take on the responsibility for a frail victim but who are incapable of meeting that person's needs.

Abuse Types

- Seeing an increase in stealing from in-home service recipients
  - Stealing money and/or property
    - Forging deeds
    - Pawning personal possessions
  - Stealing food stamps
  - Stealing Medications
    - Opioids
- Taking the recipient out of a long-term care facility and bringing them home to “provide” in-home services
    - Financial exploitation – getting SSA, using food stamps
    - Physical neglect – billing for personal care services but not doing anything
    - Medical neglect – not ensuring the recipient sees healthcare providers
- Bullying – intimidation or harassment that causes the individual to fear for his/her safety

Signs of Abuse

- Patient Harm
  - Broken bones
  - Unexplained bruising
  - Pressure Sores
    - Get worse
    - No treatment or medications recorded
  - Dehydration
  - Malnutrition
  - Elopement
  - Falls
  - Restraints
    - Physical – ligature marks
    - Chemical – overmedicated

Signs of Abuse

- Non-verbal signs of emotional abuse
  - Acting out
  - Ignoring the person
  - Regression in “skills”
  - Isolation from friends or activities
  - Recoiling or withdrawing when the abuser walks into the room
  - Threatening, intimidation, yelling, belittling, or controlling by the caregiver
  - Behavior from the elder/vulnerable person that mimics dementia such as rocking, sucking, or mumbling to oneself
  - Habitual blaming or scapegoating
  - Fear of the abuser
    - Alzheimer patient becomes agitated when the abuser walks in

Consequences of Abuse/Neglect

- Deterioration in health
- Cognitive decline
- Change in “personality” or demeanor
- Increase in hospitalization and mortality
- Depression
- Suicide
- Anxiety
- Isolation
- Fear
- Diminished sense of control
- Helplessness
- Diminished quality of life and independence

Financial Exploitation

- §570.145, RSMo, illegal use of a senior or disabled adult's resources for another person's gain or profit

- Victim Characteristics
  - Isolated socially or physically
  - Not necessarily wealthy
  - Does not have a guardian or conservator but has difficulty with financial matters
  - May be dependent on caregiver, someone "looks" after the person
  - Can't comprehend that abuser may be family or caregiver
  - Afraid to report the exploitation for fear the caregiver may leave them alone

Signs Financial Exploitation

- §570.145, RSMo, illegal use of a senior or disabled adult's resources for another person's gain or profit
  - Pre-signed checks
  - Significant withdrawals from the elder/vulnerable person's account
  - Abuser accompanies the "victim" to the bank and stays close
    - Will not let others talk to the "victim" without being present
  - Sudden changes in the "victim's" financial condition
  - Items or cash missing from the "victim's" household
  - Suspicious changes in Wills, Power of Attorney, Titles and Policies
  - Addition of names to the "victim's" signature card
  - Unpaid bills or lack of medical care
  - Financial activity the "victim" didn't do such as ATM withdrawals
  - Unnecessary services, goods or subscriptions
  - Fear that the abuser will abandon them

MFCU Results

❖ HHS, OIG Excellence in Fighting Fraud, Waste, and Abuse for FFY 2023 Award –

- Since January 1, 2023
  - ➢ Filed 83 Criminal Cases
    - 78 Fraud Indictments
    - 4 Patient/Resident Abuse Indictments
  - ➢ 54 Convictions with ordered restitution, fines and penalties of $2,551,789.36
  - ➢ Civil Cases
    - 17 Civil settlements with $11,026,301.87 in settlement payments

Questions?

Arvids V. Petersons – “Arv”
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