Medicare Targets Infusion Fraud

Medicare officials have launched a 2-year demonstration project aimed at preventing infusion fraud schemes in South Florida, where medical fraud has been on the rise.

Under the project, the Centers for Medicare and Medicaid Services is requiring infusion providers operating in several South Florida counties to reapply to be qualified Medicare infusion therapy providers. Those who fail to reapply within 30 days will have their Medicare billing privileges revoked.

Infusion therapy providers also will have their billing privileges revoked if they fail to report a change in ownership or have employees or owners who have committed a felony. Even those providers who reapply successfully may face increased scrutiny from CMS, including site visits.

"Prevention is the most important course here as we move to deal with those who are committing fraud against the program," Herb Kuhn, CMS acting deputy administrator, said during a press conference to announce the project.

The project is similar to other fraud prevention efforts recently launched by CMS. The agency is currently conducting demonstrations to root out fraudulent billing by durable medical equipment suppliers in South Florida and Southern California and among home health agencies in greater Los Angeles and Houston.

Although these projects focus on specific geographic areas, they provide a chance for CMS to test ideas that could be applicable across the country, Mr. Kuhn said, adding that he expects these projects to help the agency develop new tools to catch individuals if they try to relocate fraudulent schemes from one part of the country to another.

South Florida has already been the site of a string of prosecutions this year for fraud involving durable medical equipment and infusion therapy. Since March, the Department of Justice and the assistant U.S. attorneys from the Southern District of Florida have filed 47 indictments against individuals and entities that are alleged to have collectively billed Medicare more than $345 million in fraudulent charges.

The fraudulent billing comes in various forms. For example, in some cases the billing is done on behalf of fictional clinics or fictional patients. In other cases, patients may be infused with saline or another substance instead of the drug that is being billed to Medicare.

—Mary Ellen Schneider

Tiered Plans Cut Drug Use, But Enrollees Spend More

BY MARY ELLEN SCHNEIDER
New York Bureau

Cost-containment strategies, such as tiered drug plans, reduce overall prescription drug utilization and increase the use of generics, according to an analysis of prescription drug use by Medicare-eligible retirees.

But even with decreased utilization, individuals enrolled in three-tiered drug plans, which charge higher copayments for certain medications, spent more money out of pocket than did individuals enrolled in single-tiered plans.

Individuals who were enrolled in single-tier drug plans spent about $245 a year, compared with $469 spent by individuals enrolled in multitiered plans.

The study, conducted by researchers at Mathematica Policy Research Inc. and RTI International, included 352,760 Medicare beneficiaries with employer-sponsored drug coverage and dependent spouses aged 65 or older. The researchers analyzed five employer-sponsored drug plans: two with a single copayment tier, and three with a three-tiered structure.

The study is further confirmation that the retiree population is sensitive to price, Boyd H. Gilman, Ph.D., one of the study authors and a senior researcher at the Cambridge, Mass., office of Mathematica, said in an interview.

"They do respond to price, but we don't know what that means in terms of health outcomes," he said.

On average, individuals in single-tiered plans filled 46 prescriptions a year, compared with 38 prescriptions among those enrolled in three-tiered plans. But enrollees in singled-tiered plans used fewer generics, the researchers found.

Nearly 39% of the drugs purchased under single-tier plans were generics, compared with nearly 44% in three-tiered plans. Both findings were statistically significant.

The average annual expenditures by the drug plan per enrollee were higher in single-tiered plans, whereas enrollee out-of-pocket costs were higher among those enrolled in three-tiered drug plans, despite their lower drug utilization.

Drug plans spent about $1,943 per individual in single-tiered plans, versus $1,354 in three-tiered plans. Individuals enrolled in single-tier plans spent about $245 a year, compared with $469 spent by individuals enrolled in multitiered plans. These results were also statistically significant.

When they examined trends among individuals who filled prescriptions for chronic conditions, the researchers found that cost containment strategies had less of an effect on prescription drug use. Total expenditures and the number of prescriptions filled were still lower among beneficiaries enrolled in three-tiered plans, but to a lesser extent than when these individuals filled prescriptions for episodic care.

The findings were published online in the journal Health Services Research (Health Serv. Res. 2007 Sept. 11 [Epub doi:10.1111/j.1475-6773.2007.00774.x]). The study was funded by an internal grant from RTI International. ■

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