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Medicaid Program Integrity: Fighting Fraud, Waste and Abuse

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Fraud, waste and abuse in the Medicaid program divert taxpayer dollars that otherwise would be spent on legitimate health care. These practices also can subject patients to ineffective, unnecessary or even harmful testing and treatments. In order to ensure proper expenditure of public funds and improve the quality of health care, states are at the forefront of preventing, detecting and deterring improper practices and payments.

According to the Government Accountability Office, Medicaid may be vulnerable to fraud and abuse due to lack of adequate fiscal oversight. The full extent of inappropriate spending cannot be measured precisely, but the Centers for Medicare and Medicaid Services (CMS) estimates that improper payments cost states and the federal government billions of dollars annually. As health care costs continue to rise and many states prepare to expand Medicaid in 2014, ensuring appropriate use of public funds remains an important issue.

Although both providers and beneficiaries may inadvertently or purposely defraud the system, states often focus their efforts on providers because they typically account for the bulk of improper spending. A new report and interactive database developed by the Pew Center on the States, based on federal data, separates these efforts into three categories: screening providers and beneficiaries before enrolling them in Medicaid; reviewing claims for suspicious patterns before payment; and reviewing claims after they are paid, then attempting to recover those deemed improper.

Recognizing the importance of prevention, states are increasing their efforts to screen providers by verifying licenses, making unscheduled visits to medical sites to confirm the provider is legitimate and conducting criminal background checks, among others. States also are attempting to identify, analyze and prevent suspicious Medicaid billing patterns before making payments rather than attempting to recover funds after payments are made.

State Action

In most states, primary responsibility for combating fraud and abuse rests with the state Medicaid agency and the Medicaid Fraud Control Unit, although some states also rely on state attorneys general, state auditors or a designated Medicaid inspector general. Here are some of their strategies.

Did You Know?

- Medicaid fraud, waste and abuse cost states and the federal government billions of dollars annually.
- Many states are working to identify and prevent inappropriate payments *before* Medicaid claims are paid.
- In at least nine states, independent offices lead Medicaid program integrity efforts.

DEFINITIONS

Fraud: Purposely deceiving Medicaid for unauthorized financial gain.

Waste: Generally unintentional, waste includes over-use of services, misuse of resources and unintentional billing errors.

Abuse: Providing unnecessary medical services or engaging in questionable business, fiscal or medical practices.

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Creating an Office of Medicaid Inspector General. Arizona, Florida, Illinois, Kansas, Michigan, New Jersey, New York, Texas and Utah have established independent offices to ensure Medicaid program integrity. Many have achieved considerable savings. Utah's Office of Inspector General of Medicaid Services, for example, recovered or prevented around \$10 million in improper payments in its first year alone and currently is pursuing an additional \$18.7 million. According to its 2010 annual report, the New York Office of Medicaid Inspector General recovered more than \$450 million in inappropriate payments. The Texas Office of Inspector General reports recovering more than \$466 million in 2011.

Using Technology. While some states are only beginning to explore the benefits of advanced technologies, a few already are using and improving these systems. In 2012, Washington passed HB 2571, requiring the Health Care Authority to seek information about the potential of predictive modeling technologies to help maintain program integrity. Such technology analyzes Medicaid billing patterns, provider and beneficiary information, and other data to detect fraudulent activity.

In 2007, the Illinois Office of Inspector General used a \$4.85 million federal Medicaid Transformation Grant to develop its Dynamic Network Analysis system. Initially designed to eliminate fraud in a few select areas, the system identifies issues such as duplicate and improper billing, and led to policy changes that effectively shut down such schemes. The state, for example, cut \$25 million in improper group psychotherapy payments and \$50 million in group transportation services.

Using CMS' Advanced Planning Document process, Texas secured matching federal funds to develop and deploy highly advanced graph pattern analysis technology. As stipulated by funding requirements, the system integrates with the Texas Medicaid Management Information System to identify suspicious billing patterns. Although federal matching funds are available for planning, developing and operating new technologies, this option requires significant state investment.

Requiring Reports. Many states require agencies responsible for Medicaid integrity to submit annual reports that document activities such as total investigations of provider fraud, criminal complaints, monetary recoveries and cost avoidance. A 2012 Colorado law requires the state Department of Health Care Policy and Financing and the attorney general to submit reports on beneficiary and provider fraud, respectively.

Federal Action

The Patient Protection and Affordable Care Act (PPACA) contains various provisions aimed at improving government capacity to promote Medicaid program integrity, including stricter screening requirements for providers and new enforcement authority. States now may suspend Medicaid payments to providers where there is a credible allegation of fraud; impose temporary moratoria on new providers; and terminate providers whose billing privileges have been revoked by Medicare or another state Medicaid program. The act also creates new opportunities for coordinating programs among states, enhances data sharing, expands overpayment recovery efforts, and makes federal funding available to help states create or enhance their Medicaid Management Information Systems.

As the federal agency responsible for Medicaid administration, CMS works closely with states to implement these and other new programs. In addition, although many states already are pursuing predictive analytics technologies, section 4241 of the Small Business Jobs Act of 2010 requires CMS to expand such a system for identifying and preventing improper payments to Medicaid and the Children's Health Insurance Program by April 2015.

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Medicaid Fraud and Abuse
State Strategies to Fight Medicaid Fraud and Abuse

Other Resources

Medicaid Anti-Fraud and Abuse Practices, Pew Center on the States
Affordable Care Act Provisions: Program Integrity, Medicaid.gov