

## Health Care Challenges in the States

This issue brief is part of a series that explores promising state efforts to manage health care costs across a range of spending areas.



### ISSUE BRIEF

# Combating Medicaid Fraud and Abuse

Fraud and abuse in Medicaid threaten Americans' health and well-being by draining funds needed for legitimate care and potentially subjecting patients to unnecessary or ineffective tests and treatments. The toll on state and federal budgets is substantial. In 2012, an estimated \$19 billion—or 7 percent—of federal Medicaid funds was absorbed by improper payments, which include fraud and abuse as well as unintentional mistakes such as paperwork errors.<sup>1</sup> Improper payments totaled an estimated \$11 billion—or 9 percent—from states' Medicaid budgets in 2010, the most recent year for which data are available.<sup>2</sup>

Addressing these problems has become more urgent as the program expands to serve more people. In part because of unemployment and other financial hardships caused by the Great Recession, states' Medicaid enrollments grew to 53 million in June 2011, up from 34 million a decade earlier. And many states are preparing to extend coverage with the implementation of the Affordable Care Act in 2014.<sup>3</sup>



Use our database to learn about hundreds of state strategies to reduce fraud and abuse.

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Policymakers are battling Medicaid fraud and abuse with an array of approaches, including efforts to identify providers who are more likely to commit misconduct, strengthen procedures for claim review, and recover improper payments more efficiently. To help lawmakers learn from one another, researchers with the State Health Care Spending Project, a joint initiative of The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, combed through federal data to gather hundreds of standout practices identified by the Centers for Medicare

& Medicaid Services, or CMS, and state agencies. The results are organized in an easy-to-use online database accessible at [www.pewstates.org/Medicaid-fraud](http://www.pewstates.org/Medicaid-fraud). This brief highlights their findings.

### Striking a Balance

States' health care costs continue to grow. Medicaid spending by states alone—excluding federal matching dollars—grew by 315 percent from 1987 to 2011 after adjusting for inflation.<sup>4</sup> These expenses consumed an estimated 20 percent of state general funds in fiscal year 2012.<sup>5</sup> One bright spot, however, was that Medicaid spending per individual grew more slowly, on average, than did private insurance premiums from 2000 to 2009. This trend suggests that much of Medicaid's spending growth resulted from its enrollment gains.

Combating fraud and abuse is essential to the sound fiscal management of Medicaid, but states also should consider potential effects when developing and implementing strategies to curb these problems. A number of state officials have stressed the importance of striking the right balance between eliminating improper payments and avoiding burdens that could discourage honest providers from accepting Medicaid-insured patients. "You could eliminate a lot of fraud by operating Medicaid like a police state. But by treating providers like they are potential criminals, there's

### ABOUT OUR ANALYSIS

The federal Centers for Medicare & Medicaid Services, or CMS, conducts periodic reviews of states' efforts to maintain the integrity of their Medicaid programs and guard against accidental and intentional errors, including fraud and abuse. The agency identifies practices it finds noteworthy and invites states to submit their more effective approaches. This information is used to create a report for each state's review<sup>i</sup> and an annual summary.<sup>ii</sup> We examined 85 CMS reports available online as of February 2013 to compile and catalogue the findings. The CMS reviews, conducted from 2007 to 2012, contain information from all 50 states and the District of Columbia.

NOTE: Some states underwent more than one review during that period.

no way they're going to participate in the Medicaid program," observes Matt Salo, executive director of the National Association of Medicaid Directors.<sup>6</sup>

## Strategies to Combat Fraud and Abuse

Fraud and abuse can be committed by both Medicaid providers and patients. But in the project's review of federal data, researchers found that the vast majority of states' strategies are focused on providers.

Generally speaking, states have three opportunities to reduce fraud and abuse among providers: (1) screening them before and after they are accepted into the program; (2) reviewing claims before they are paid; and (3) reviewing claims after they are paid and recovering any improper payments, a process known as

"pay and chase." Drawing on the reviews of states' practices by the CMS, Pew created the Medicaid Anti-Fraud and Abuse Practices database, which organizes states' approaches by those three categories as well as a fourth that cuts across categories, then further breaks them into 13 subcategories.

The amounts saved or recovered through these practices can vary widely. But as the examples that follow show, effective action can contribute to the broader goal of preserving Medicaid funds for genuine health care needs.

### Provider Screening

A state's first priority must be to maintain a pool of Medicaid providers who follow the rules. To perform this task well, states must vet prospective providers diligently and monitor

## MEASURING MEDICAID'S IMPROPER PAYMENTS

The Improper Payments Information Act of 2002 led to the creation of a national audit, the Medicaid Payment Error Rate Measurement, or PERM, which estimates the percentage of payments that either should not have been made or were made for the wrong amount—everything from 25-cent coding mistakes to fraudulent claims worth millions of dollars.

The most recent PERM estimates, as of November 2012, showed a national error rate of 7.1 percent.<sup>i</sup> Individual states' performance typically varies.<sup>ii</sup>

Some experts, including the National Association of Medicaid Directors, question the accuracy of the measurement, warning that "error rates in some states may be misleading or inflated."<sup>iii</sup>

those already in the program without overburdening them.

Some states require that all providers, including those used by managed care organizations,<sup>7</sup> undergo a centralized enrollment screening process and be cross-referenced against exclusion lists from the federal government, other states, and sister agencies. Kentucky, for example, uses centralized enrollment to ensure that health care providers have not been sanctioned by the state’s medical licensing board or excluded by Medicare or other states’ Medicaid programs.<sup>8</sup> Similarly, Wisconsin prohibits managed care organizations from using providers who have not enrolled through the state.<sup>9</sup> In Texas, the Health and Human Services Commission performs criminal-background checks on all managed care providers.<sup>10</sup> Most states also have periodic provider screenings or reenrollment procedures, and some conduct random audits and on-site visits. “If you don’t let bad providers in, they can’t steal from you,” says Glenn Prager, Arizona’s Medicaid inspector general.<sup>11</sup>

The Affordable Care Act is strengthening these provisions. Under new CMS regulations, states are required to terminate Medicaid providers whose Medicare billing privileges have been revoked by the federal government or who have been terminated for cause by another state. The agency has launched a Web-based application that is meant to facilitate states’ efforts to share such information.<sup>12</sup>

Recent events in Louisiana illustrate the importance of vigorous screening and monitoring. In January 2012, a dentist was found guilty of two felony counts of Medicaid fraud. Barred from participating in Medicaid in 1992, he worked with another dentist in Shreveport from 2005 to 2007 and used the other provider’s identification number to submit false claims.<sup>13</sup>

## FRAUD AND ABUSE DEFINED

Federal Medicaid regulations define fraud as “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.”

Abuse is defined as “provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.”

Source: National Archives and Records Administration, Code of Federal Regulations, Title 42: Public Health Part 455—Program Integrity: Medicaid.

### Prepayment Reviews

States' next line of defense is to carefully review claims before making payment, particularly for types of providers with track records of fraud and abuse. According to the CMS, suppliers of durable medical equipment (e.g., wheelchairs), home health agencies, transportation providers, and personal care services are among the industries that have shown higher rates of misconduct.<sup>14</sup> Claims are run through a series of data checks, which flag those that appear to include incorrect information, lack sufficient documentation, or run counter to the state's Medicaid rules.

Many of the data checks, called edits, detect obvious errors—for example, claims filed before birth or after death, or bills for hysterectomies performed on men. Others ensure that providers are billing for services that Medicaid covers. States also determine whether other payers, such as workers' compensation or Medicare, are liable for the claim. States sometimes give providers a chance to correct any errors or provide missing data, and those who fail to do so receive partial or no payment.

A case in Texas underscores the challenge of keeping up with ever-changing fraud and abuse schemes. Over the past decade, the state has tried to expand dental care for needy children. In 2007, for example, it approved a 50 percent rate increase for dentists to prompt more of them to

treat Medicaid recipients. A subsequent increase in dental and orthodontic expenditures seemed like progress. Spending on orthodontic care rose to \$185 million in 2010—nearly double what it was in 2008.<sup>15</sup>

Subsequent investigations found that several orthodontists were filing claims for children's braces that were not medically necessary and should not have been covered by Medicaid. Additionally, the private contractor that Texas hired to process preauthorization applications gave approvals without appropriate medical review. An orthodontist assisting in the state's investigation estimated that at least 90 percent of the claims she reviewed would not have passed Texas' threshold of medical necessity.<sup>16</sup>

In their CMS reviews, some states highlighted their rigorous prior authorization practices. Nebraska, for example, pointed to its prepayment review process as a success. To help ensure that services are medically necessary and meet all Medicaid requirements before payment, the program integrity office in the state's Department of Health and Human Services frequently requests provider medical records, which are analyzed by staff and medical consultants.<sup>17</sup>

New York requires certain providers to prove that patients were actually at their offices by mandating that patients swipe their benefit cards on every visit. Additionally, select providers (e.g., a

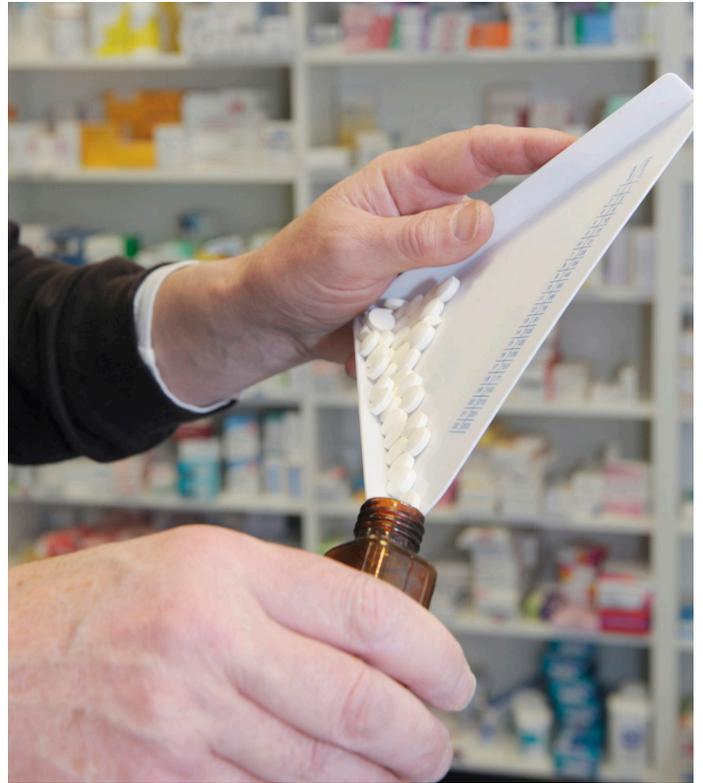
physician ordering a prescription) must post orders to the state's electronic claims system before another provider (e.g., a pharmacy) can process and bill the transaction.<sup>18</sup> These programs generated a combined cost savings of \$683 million from 2008 to 2011.<sup>19</sup>

**Post-Payment Claims Review and Recovery: Pay and Chase**

Even after providers are paid, state officials can analyze claims in search of aberrant trends or billing patterns and use their findings to pursue sanctions, audits, or investigations. Florida, for instance, sends Explanation of Medical Benefits forms on a quarterly basis to all patients for whom providers have billed services and asks recipients to return any they believe to be inaccurate. In fiscal year 2008, this practice identified 22 cases of overpayment and helped recover nearly \$500,000.<sup>20</sup>

Georgia conducted an analysis to identify hospital claims with readmissions within three days of discharge for the same or a related problem; such claims are supposed to be considered the same admission for reimbursement purposes. This effort led to the collection of \$1.5 million in improper payments.<sup>21</sup>

Kentucky's Medicaid program receives data each month from the state's Department of Vital Statistics on people who have died in the past 30



days. Officials use this information to determine whether any claims for recently deceased Medicaid patients or providers were submitted after the date of death. This practice allowed the state to recoup nearly \$300,000 from January 2007 to July 2009.<sup>22</sup>

New Jersey has started employing a Recovery Audit Contractor (RAC)—a private entity that reviews paid claims and earns contingency fees for improper payments it retrieves. The state recovered \$4 million in overpayments and found \$19,000 in underpayments between April 2011 and June 2012.<sup>23</sup> (The Affordable Care Act required that each state Medicaid program use at least one RAC beginning in 2011.)

When overcharges are found, officials feed the information back to claims processors and often coordinate any investigation or prosecution with Medicaid fraud control units which are administered by states but funded jointly with the federal government. These units primarily prosecute wrongdoing, but states may also educate, audit, or sanction a provider or group of providers responsible for repeated errors, inaccuracies, or abuse.

An investigation by Virginia's Medicaid Fraud Control Unit and the FBI resulted in a guilty plea from a woman who submitted hundreds of claims for respite care services that her business had not provided. In January 2013, she received a sentence of 75 months for these and related identity theft crimes and was ordered to return more than \$600,000 to the state.<sup>24</sup>

Investigators in the District of Columbia assisted with the July 2012 fraud conviction of the owner of two local health care companies who collected at least \$7 million by submitting false claims. She routinely billed DC Medicaid for up to 2,910 continuous minutes of care for a single patient in a 24-hour period. (There are only 1,440 minutes in a day.)<sup>25</sup>

The CMS identified a noteworthy approach in Colorado, where the state created a database that stores information about critical events, such as inclement

weather and dates of rule changes, that might influence billing or services. The state first used this database to identify fraudulent activity among home health providers who submitted claims to Medicaid for services and visits during extreme blizzard conditions, when travel to patients' homes would have been difficult.<sup>26</sup>

### Cross-Cutting Practices

Many efforts to ensure program integrity cut across the areas of provider screening, prepayment review, and post-payment review. These practices include coordinating the actions of diverse stakeholders, such as representatives from various state and federal agencies; engaging and educating providers about their responsibilities; and homing in on providers whom states have deemed high-risk.

During its CMS review, Louisiana cited an example of agencies working together effectively. Officials overseeing Medicaid program integrity worked

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with the staff in the state's Mental Health Rehabilitation program to review 131 providers. They looked for problems such as services provided without documentation or by unqualified staff and billings for noncovered services. The state saved about \$65 million through cost avoidance and recovered \$586,000 from 2005 to 2007.<sup>27</sup>

In many states, resources for efforts to fight fraud and abuse are scarce, so experts recommend that they focus on providers who are most likely to engage in unscrupulous practices. California, for example, has conducted analyses to identify types of providers who pose a high risk of submitting fraudulent or otherwise erroneous claims; as a result, it increased its focus on pharmacies and adult day health centers.<sup>28</sup>

To verify that providers were billing for the correct wheelchairs, Georgia sent surveys to patients with pictures of wheelchairs and scooters and asked them to circle the type of equipment they received. Investigators followed up on discrepancies by making on-site visits.<sup>29</sup> The actions of a DC Medicaid provider reinforce the value of such a policy. Between 2008 and 2011, the equipment supplier submitted 100 claims to Medicaid for the most expensive power wheelchair, when in fact, patients had been given more basic, lower-priced wheelchairs.<sup>30</sup>

In 1999, Washington State began an effort to employ technology so it could reduce overpayments and rely less on resource-heavy examinations of medical records and on-site visits. It uses an online tool to help providers carefully review their billings before submitting them. The providers answer a series of questions designed to help identify errors, such as insufficient documentation, before claims are reviewed and potentially rejected by the state. Participation is voluntary, but providers who decline become prime candidates for on-site reviews. These practices help the state stretch its limited resources.<sup>31</sup>

## Conclusion

Billions of state and federal dollars are lost to Medicaid fraud and abuse each year. States have employed an array of policies and procedures to combat the problem, and many of these practices are catalogued in our online database—[www.pewstates.org/Medicaid-fraud](http://www.pewstates.org/Medicaid-fraud)—to help policymakers and other state officials learn about innovative approaches across the country. Stronger strategies to combat fraud and abuse are vital to ensuring that Medicaid's limited resources support legitimate care and better health outcomes for the millions of Americans counting on the program.

## Endnotes

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**'About Our Analysis' box:**

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**'Measuring Medicaid's Improper Payments' box:**

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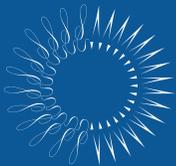
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