The Vermont Legislative Research Shop

Medicaid: Fraud and Abuse

According to the FBI's conservative estimate, Medicaid loses 10 cents on every dollar it spends to fraud and/or abuse. Medicaid is a vulnerable target due to the large sums of money and vast number of providers involved. It has also become a popular target for organized crime syndicates due to the low rates of prosecution for the crime on the State and Federal levels.[1]

Historically, the role of fraud and abuse in rising Medicaid costs prompted Congress to enact the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public Law 95-142), requiring states to establish Medicaid Fraud Units with the assistance of Federal funding. These units investigate fraud and abuse on the part of providers, while recipient fraud cases are left in the hands of local authorities.[2]

Common Medicaid "Rip Offs"

A list composed by the Centers for Medicare and Medicaid Services (CMS) highlights 11 of the most common Medicaid "Rip Offs"; these include:

- Billing for "phantom patients" who did not really receive services.
- Billing for medical services that were not provided.
- Billing for old items as if they were new.
- Billing for more hours than there are in a day.
- Billing for tests that the patient did not need.
- Paying a "kickback" in exchange for a referral for medical services or goods
- Charging Medicaid for personal expenses that have nothing to do with caring for a Medicaid client.
- Overcharging for health care services or goods that were provided.
- Concealing ownership in a related company.
- Using false credentials.
- Double-billing for health care services or goods that were provided.[3]

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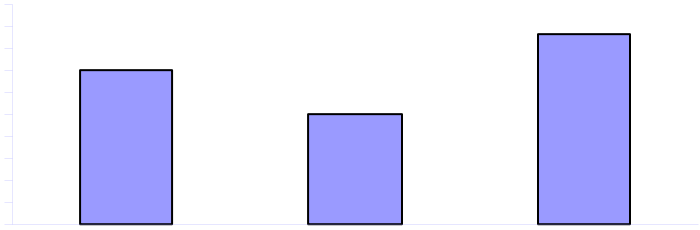
[1] Office of the Attorney General: State of South Carolina. "Let's STOP Medicaid Fraud." 2005. http://www.scattorneygeneral.org/public/medicaid.html. Accessed March 31, 2005.
[2] Office of Attorney General: Attorney General Tom Corbett. "Protecting Pennsylvania Families." No date specified. http://www.attorneygeneral.gov/cld/medicaid.cfm. Accessed March 31, 2004.
[3] Centers for Medicare and Medicaid. "Most Common Medicaid 'Rip Offs'." September 16, 2004. http://www.cms.hhs.gov/states/fraud/backgrnd.asp. Accessed March 31, 2005.

State Reported Approaches to Prevent and Detect Improper Payments

Measures applied to all providers

Figure 1 details the actions taken by individual states to prevent fraud on the part of providers. A description of each policy may be found below.



North Carolina contacts inactive accounts after twelve months and deactivates the account if they have not received confirmation of activity and approval within thirty days.[5]

Measures applied to high-risk providers

Figure 2 illustrates measures being taken by some states in order to minimize fraud risk for high risk providers.

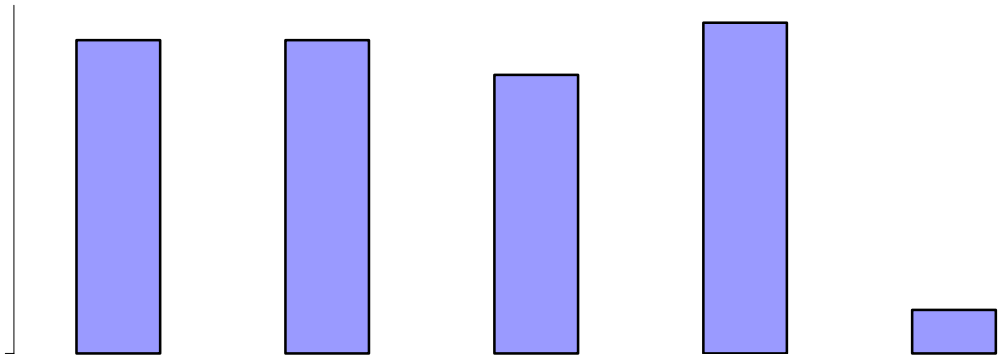
Intensified claims review or auditing: States verify the billings providers make and the services they provide during certain periods.

Targeted provider information: Twenty-four states use contractors to review claims either before or after the payments are made. New York, Ohio and Texas reported saving an estimated $24.9, $14 and 18.9 million respectively due to targeted reviews of part time clinics, midwives, and mobile radiology services and physicians assistants.[7]

Time-limited enrollment: see above[8]

Types of technology used

Figure 3 shows the number of states using several different technologies to detect fraud and abuse. A more detailed explanation of each type of technology may be found below.



Data matching or modeling: Data matching or modeling are techniques that allow comparisons of providers within specialties to determine normative patterns in claims data so that aberrant patterns can be identified

Smart technology: Smart technology is software that analyzes patterns in claims data that feeds the information back into the system to identify new patterns[9]

Prescription drug controls

Figure 4 illustrates the number of states taken specific actions through prescription drug controls order to combat Medicaid fraud and abuse. A more detailed description of each action type

Other

Figure 5 details miscellaneous actions taken by some US states to aid in detecting and preventing

Federal and Private Support

The Centers for Medicare and Medicaid Services

CMS, formerly the Health Care Financing Administration (HCFA), began to focus on assisting states with combating Medicaid fraud and a

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he Alliance aims to assist states with fraud and abuse prevention in a number of ways,

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n order to facilitate the sharing of fraud and abuse prevention strategies and information

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axpayers Against Fraud

axpayers Against Fraud (TAF) is a nonprofit advocacy organization based in Washington D.C.

AF also operates a 501(c)(3) nonprofit organization named the Taxpayers Against Fraud

each

The report, "Reducing Medicaid Fraud: The Potential of the False Claims Act", highlights a number of conclusions and recommendations based on data compiled between the fiscal years 1997 and 2001.

Not all states' FCAs entitle whistleblowers to a portion of the state's recovery, states with false claims statutes that allow for whistleblowers to enjoy a portion of the recovery provide a much larger financial incentive for whistleblowers. States with a more aggressive anti-fraud policy on behalf of both the state Attorney General's office and the Medicaid Fraud Control Unit (MFCU) tend to be more likely to successfully prosecute with the help of a whistleblower.[18]

Based on these conclusions, the author, Andy Schneider, makes a number of recommendations to control Medicaid fraud on both the state and federal level. The recommendations for the state are as follows:

> States that have not already done so should enact state false claims acts patterned on the FCA in order to increase the incentives for whistleblowers to pursue Medicaid fraud (whether or not Congress increases federal matching funds for such states…)
>
> States should increase the state resources (and matching federal funds) they in [MFCUs] in order to expand the capacity of those units to investigate and prosecute civil fraud cases.[19]

Compiled at the request of Representatives Mark Larson and Wendy Wilton by James Pasch, Jaye Samuels, and Jennifer Duffy under the Supervision of Professor Anthony Gierzynski on April 5, 2005.

Disclaimer

This report has been prepared by undergraduate students at the University of Vermont under the supervision of