Medicaid Cost Containment: Combatting Fraud & Abuse

What is fraud and abuse?

$22 Billion:
Medicaid improper payments FY2011

- **Fraud**: misrepresentation of services rendered
- **Abuse**: practices that, either directly or indirectly, result in unnecessary costs to the program
- **Waste**: inaccurate payments for services, such as unintentional duplicate payments
Legislative Milestones

1965
- Medicaid enacted: Social Security Amendments of 1965
- Improve access to health care for low-income families with children, and blind or disabled individuals

1977
- Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977
- Established MFCUs

2005
- Deficit Reduction Act of 2005
- First comprehensive Federal strategy to prevent and reduce fraud, waste and abuse

2010
- Affordable Care Act & Others
- Strengthened provider enrollment, screening, sanctions

The Process: Finding and Fighting Fraud

- Provider background checks
- Random audits
- Ongoing monitoring
- Provider agreements

Claims Processing & Pre-payment Edits
- Automatic edits
- Point of service verification
- Documentation reviews

Post-payment Analysis and “Pay & Chase”
- Data analysis
- Referrals to MFCUs
- Investigations and recoveries
- Provider sanctions
- MCO oversight
Key Players & Programs

Federal
- CMS Medicaid Integrity Program
- HHS - Office of the Inspector General
- Health Care Fraud & Abuse Control Program (HHS – DOJ)
- Health Care Fraud Prevention and Enforcement Action Team (HHS – DOJ)
- Department of Justice, Office of the Inspector General
- Administration on Aging Congress
- GAO
- GSA - Excluded Parties List System (EPLS)

Federal-State Programs
- Medicaid Integrity Contractors (MICs)
- Medicaid Recovery Audit Contractors (RACs)
- Medicare-Medicaid Data Match Program (Medi-Medi)
- Medicaid Integrity Institute (MII)
- Medicaid Eligibility Quality Control Program (MEQC)
- Payment Error Rate Measurement (PERM)

State
- Medicaid Agencies
- Medical Licensing Boards
- Office of State Auditors
- Government Accountability Offices
- Medicaid Inspector Generals
- Attorney Generals
- Medicaid Fraud Control Units (MFCUs)
- District Attorneys
- State Legislatures
- Health Care Providers
- Consumer & Taxpayer Advocates
- Managed Care Organizations

Federal-State Issues

- State staff report:
  - Lack of coordination in programs and efforts
  - Need for more data sharing
  - Federal match for program integrity: 50%
  - Burdensome recovery process for overpayments
  - Burdensome oversight, reporting and measurement requirements
State Recommendations

- Invest in staff, training and technology
- Increase provider accountability
- Coordinate with stakeholders (e.g., sister agencies, bordering states, MCOs, providers)
- Leverage federal resources
- Target initiatives to most vulnerable regions and sectors (e.g., DME, home health, ambulance)
- Move away from “pay and chase”

How States are Improving Results

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Source: Pew analysis of CMS Program Integrity Review Reports 2008 – 2011. Practices are submitted by states to CMS staff who determine which practices are “noteworthy”.
### How States are Improving Results

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<th>NY: Cardswipe and Post &amp; Clear programs</th>
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Measuring Success

• Payment error rate down:
  – 8.1% overall error rate in 2011, down from 10.5% in 2008

• Return on investment
  – Over $8 on Medicaid Fraud Control Unit spending (HHS OIG)
  – About $5 for Medicaid program integrity units (State program integrity assessments)