Medicaid Cost Containment: Combatting Fraud & Abuse

What is fraud and abuse?

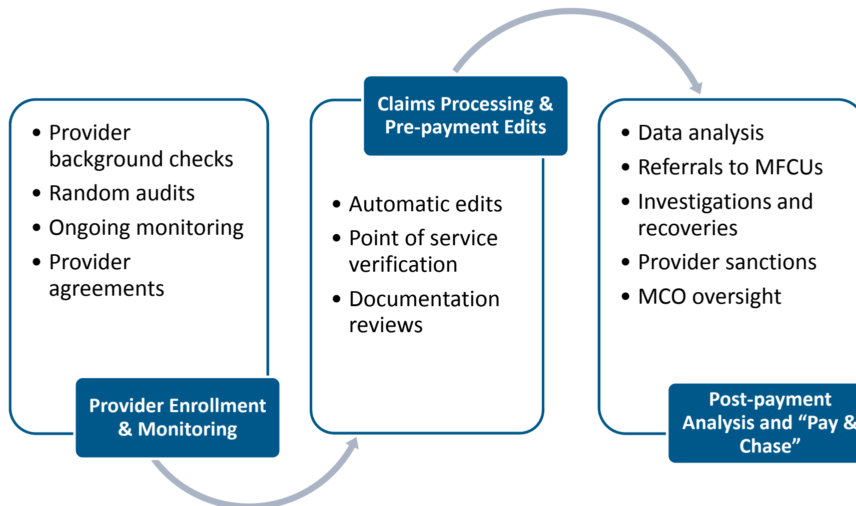
$22 Billion:
Medicaid improper payments FY2011

- **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

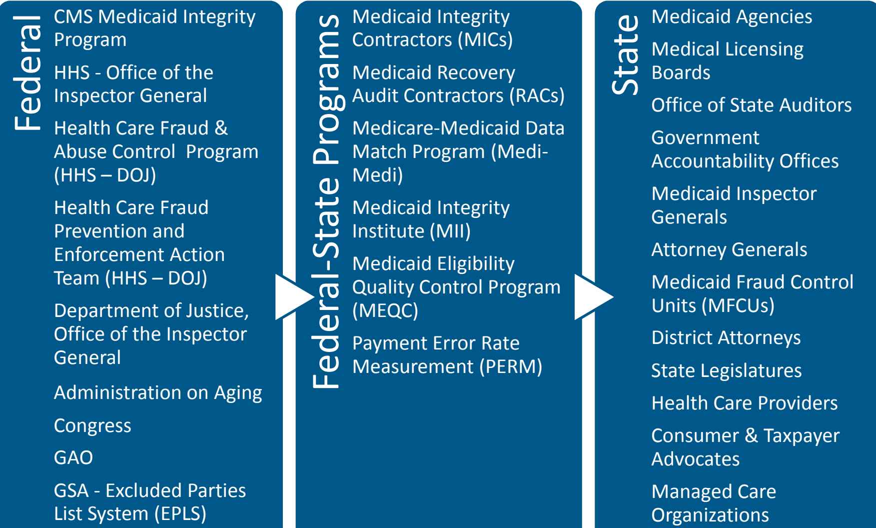
Legislative Milestones

Year	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



Key Players & Programs



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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

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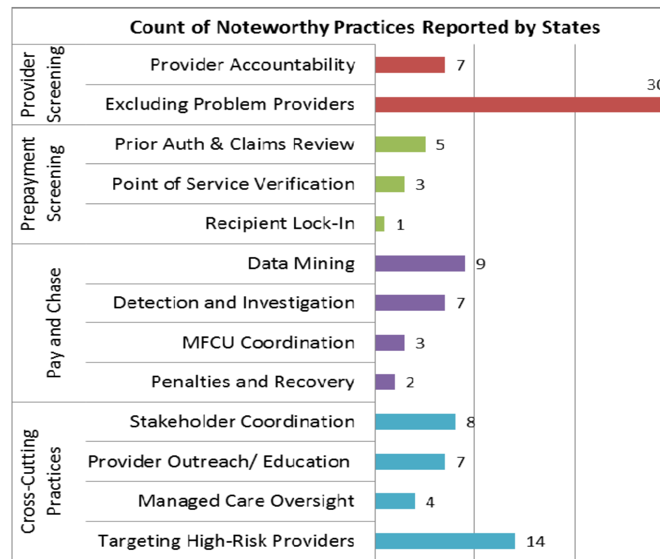
State Recommendations

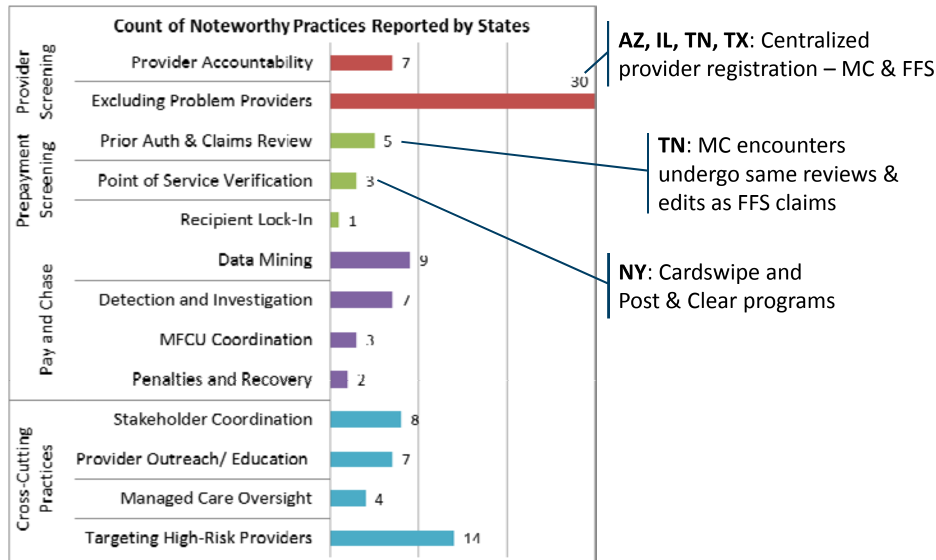
- Invest in staff, training and technology
- Increase provider accountability
- Coordinate with stakeholders (e.g., sister agencies, bordering states, MCOs, providers)
- Leverage federal resources
- Target initiatives to most vulnerable regions and sectors (e.g., DME, home health, ambulance)
- Move away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

How States are Improving Results



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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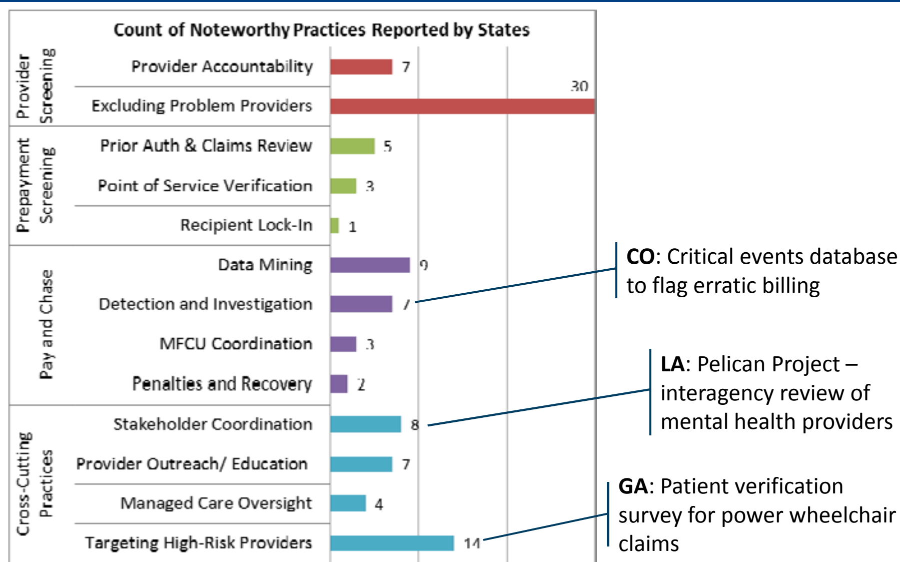
How States are Improving Results



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10

Medicaid Program Integrity Toolbox

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Pew – MacArthur Medicaid Program Integrity Toolbox

This first-of-its-kind database compiles and categorizes promising practices states employ to combat Medicaid fraud and abuse. These practices were cited by the Centers for Medicare & Medicaid Services (CMS) in the agency's state reviews.

Select a state

Illinois

Provider screening

Subcategory

Identify and Exclude Invalid and Fraudulent Providers

Provider Agreements and Accountability

Illinois

Provider screening

Identify and Exclude Invalid and Fraudulent Providers

NP: HFS exercises strong oversight of transportation and durable medical equipment (DME) providers

HFS engages in a number of laudatory practices in connection with its non-emergency medical transportation (NEMT) and DME providers. HFS conducts site visits on all NEMT providers, during which the State verifies the address and inspects licenses. New transportation providers are also subject to mandatory criminal background checks, and are placed on probation for 180 days, during which time HFS-OIG monitors their claims. All DME providers also receive onsite reviews, during which the State checks inventory to determine whether it is reasonably related to billings. Moreover, both NEMT and DME providers must reenroll in the Medicaid program on a periodic basis.

NP: HFS requires managed care providers to be enrolled with HFS

States that delegate delivery of some medical services to MCOs often lack sufficient oversight of the providers serving managed care enrollees, and sometimes do not even know the identity of their MCOs' providers. HFS requires that all MCO providers be enrolled with the Medicaid program. By requiring that all MCO providers be enrolled with HFS, the State is able to maintain centralized control over the screening and credentialing process, and better ensure the integrity of its programs.

EP: State Sanctions Database

Illinois is one of a growing number of States that maintains its own sanctions database. The system tracks providers who have been or are currently in the process of being sanctioned by HFS, and also includes HHS-OIG exclusions and reinstatements. The database is updated monthly. HFS uses the system to screen providers during initial enrollment, within 7 days after enrollment, and on a monthly basis.

Provider Agreements and Accountability

None

Measuring Success

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- 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)

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