Medicaid Program Integrity: Key Issues and Provisions of the Deficit Reduction Act

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Indicators of Need for Increased Attention to Program Integrity in Medicaid

- Perception that attention to Medicare program integrity has been far greater than that devoted to Medicaid program integrity
- GAO placed Medicaid on list of “high-risk” programs in 2003
- Increasing number of large cases and settlements against providers and drug manufacturers in both Medicare and Medicaid
- GAO June 2005 finding that federal resources devoted to helping states address program integrity were not commensurate with dollars at risk
- Media reports of significant fraud and abuse problems in some states
- Prominence in federal and state budgets of this $300 billion program
Federal Medicare and Medicaid Fraud Recoveries, FY 1997-FY 2004

Dollars in thousands

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>$665</td>
<td>$31</td>
</tr>
<tr>
<td>1998</td>
<td>$239</td>
<td>$9</td>
</tr>
<tr>
<td>1999</td>
<td>$369</td>
<td>$5</td>
</tr>
<tr>
<td>2000</td>
<td>$577</td>
<td>$27</td>
</tr>
<tr>
<td>2001</td>
<td>$1,000</td>
<td>$43</td>
</tr>
<tr>
<td>2002</td>
<td>$1,400</td>
<td>$59</td>
</tr>
<tr>
<td>2003</td>
<td>$723</td>
<td>$152</td>
</tr>
<tr>
<td>2004</td>
<td>$1,500</td>
<td>$99</td>
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Key Provisions of the New Medicaid Integrity Program

- Substantial new investment of federal resources in Medicaid program integrity
- Designed to put Medicaid program integrity efforts on a par with those of Medicare
- CMS must develop comprehensive Medicaid program integrity plan before October
- 100 new CMS employees will provide “support and assistance to states to combat provider fraud and abuse”
- Better coordinates Medicare and Medicaid program integrity efforts by sharing claims data across programs

SOURCE: Kaiser Commission on Medicaid and the Uninsured
What is Program Integrity?

- Setting policy and managing a program to ensure that health and long-term care services are provided as effectively and efficiently as possible
  - Preventing breaches of program integrity is at least as important as enforcing rules and prosecuting violations
- Program integrity should ensure that:
  - Eligible people are aware of Medicaid coverage and enrolling appropriately
  - Beneficiaries are receiving appropriate, high-quality services
  - Providers meet basic standards and receive appropriate payments for services they provide
  - Providers and beneficiaries receive clear guidance describing rules
  - Payments and services meet requirements of state and federal law
  - Quality health care and public funds are not being placed at risk by violations of the rules or abuses of the system

Some Key Issues in Medicaid Program Integrity

<table>
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<tr>
<th>Activity</th>
<th>Provider Type</th>
<th>Practices</th>
<th>Dollars at Risk</th>
</tr>
</thead>
</table>
| Drug Rebate “Gaming”          | Drug Manufacturer           | • Concealing best price  
                                  |                              | • Marketing the spread     | $$$$$          |
| Billing Fraud                 | Hospitals, physicians, DME suppliers, clinical labs, pharmacies, home health, transportation | • Billing for Services Not Provided  
                                  |                              | • Upcoding                 | $$$            |
| Drug Diversion                | Physician, pharmacy         | • Buying/selling diverted drugs  
                                  |                              | • Unnecessarily prescribing drugs in exchange for kickbacks | $$             |
| Quality of Care               | Long-term care              | • Patient abuse and neglect  
                                  |                              | • Services not provided as specified  
                                  | Acute care                  | • Falsified cost reports  
                                  |                              | • Providing unnecessary services  
                                  |                              | • Services provided by inappropriate or unlicensed provider | $              |
Federal Program Integrity Responsibilities

CMS responsibilities
• Interpreting federal requirements for states and providers
• Providing training and guidance to states
• Monitoring and enforcing state compliance with federal rules, including fraud and abuse rules
• Reviewing state agency performance through on site reviews
• Ensuring quality of institutional care through developing survey protocol and conducting “look behind” surveys
• Providing financial support for state activities through matching funds

OIG responsibilities
• Monitoring and enforcing compliance with federal fraud and abuse laws that apply to providers
• Audits, evaluations, and investigations
• Sanctions (civil monetary penalties, exclusions)
• Negotiating and enforcing corporate integrity agreements
• Administering grants to, oversight of, and certification of MFCUs

State Program Integrity Responsibilities

State Medicaid agency responsibilities:
• Beneficiary enrollment; income and eligibility verification
• Enrolling providers, setting rates and paying providers
• Monitoring quality of care
• Operating Medicaid Management Information Systems (MMIS), Surveillance and Utilization Review Subsystem (SURS), etc.
• Detecting improper payments and recovering overpayments
• Analyzing patterns in provider claims and payment (“data-mining”)
• Nursing facility survey and certification
• Preliminary investigation of fraud and abuse; referring fraud cases to the Medicaid fraud control unit (MFCU)

Responsibilities of other state agencies:
• Medicaid fraud control units investigate and prosecute provider fraud and patient abuse and neglect
• States also license providers and conduct audits
State Program Integrity Efforts: Provider Enrollment Policies

**Measures applied to all providers**

- Cancel/suspend inactive billing numbers: 47
- Intensified claims review or auditing: 34

**Measures applied to high-risk providers**

- Require Surety Bonds: 4
- Criminal Background Check: 13
- On site inspections: 29


DRA Provides New Fiscal Incentive for States to Enact False Claims Acts

- False claims act helps states prevent and pursue cases of significant fraud and abuse in all public programs
  - FCA allows a government or a whistleblower on behalf of the government to bring civil lawsuits against parties that defrauding government programs
  - Federal government and 16 states have false claims acts
- DRA provides new fiscal incentive through Medicaid
  - For states with false claims acts, the state share of any FCA recoveries related to Medicaid increases by 20-40 percent, depending on the state
  - In addition to increased share of recoveries, FCA deters potential cases of fraud and abuse
- False claims act also provides consumer protections and ensure quality of care