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## **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.<sup>1</sup>

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.<sup>2</sup>

### **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.<sup>3</sup>

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<sup>1</sup> 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.

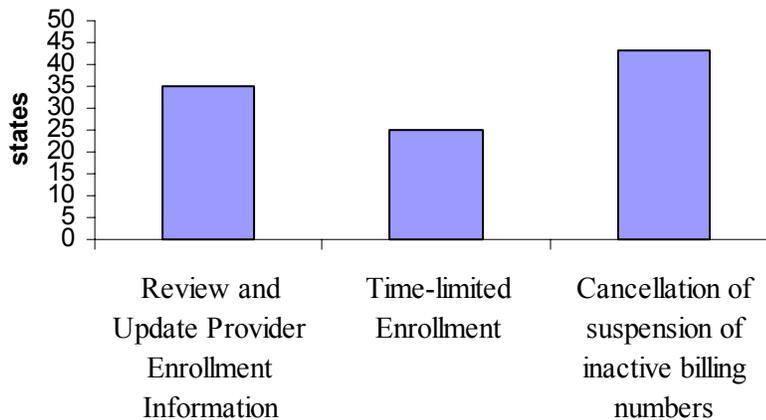
<sup>2</sup> Office of Attorney General: Attorney General Tom Corbett. "Protecting Pennsylvania Families." No date specified. <http://www.attorneygeneral.gov/cld/medicaid.cfm>. Accessed March 31, 2004.

<sup>3</sup> 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.



**Figure 1:** Number of states applying specific measures to all providers.

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**Review and update provider enrollment information:** Tighter enrollment controls allow for close scrutiny of providers at high risk of improper billing. This high control may also keep high-risk providers from enrolling or remaining in the state Medicaid program.

**Time-limited enrollment:** Twenty-five states require providers to reapply after a set amount of time in order to serve in the state Medicaid program. This practice allows states to verify licensing, ownership and credentials. California reports savings of an estimated \$200 million in 2003 by increasing scrutiny and implementing a provisional status for the first 12 to 18 months. Illinois also puts their non-emergency transportation services on a probation period for the first 180 days in order to evaluate billing patterns and conduct additional on-site inspections. Wisconsin and Nevada also have similar plans.<sup>4</sup>

**Cancellation or suspension of inactive billing information:** Out of date information increases the likelihood that the state will be billed for patients who are ineligible for the state Medicaid programs. New Jersey deactivates account number that has been inactive for twelve months.

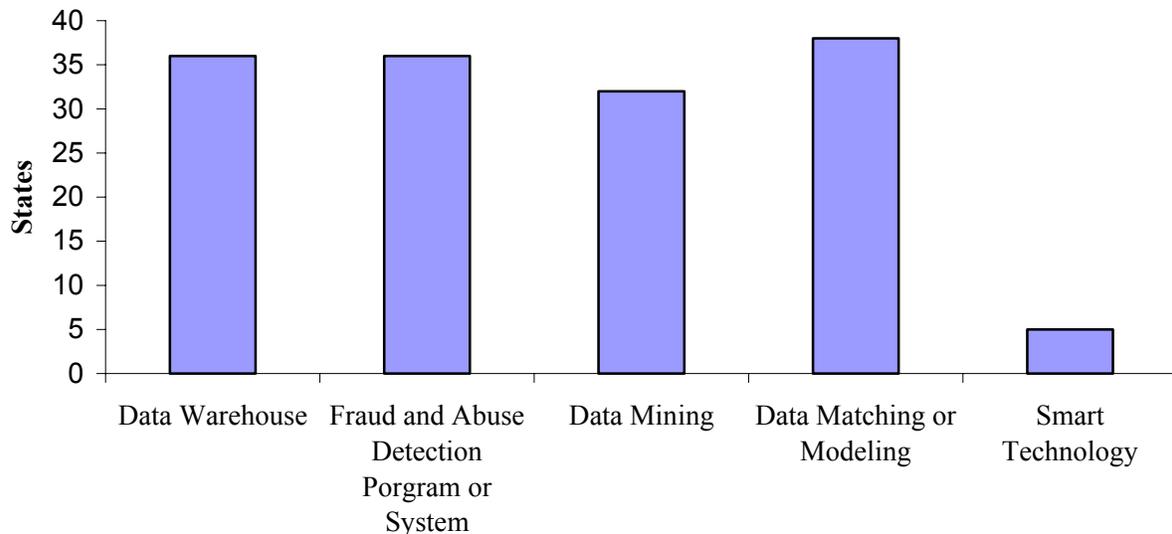
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<sup>4</sup> United States Government Accountability Office. “Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments.”

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.<sup>5</sup>

### 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.



**Figure 2:** Number of states taking different actions specifically targeted at high-risk providers.

**Surety bonds:** Also known as performance bonds this initiative protects states from financial losses if the terms of contract are not met. Florida and Washington require a \$50,000 bonding on many different provider agencies.

**On-site inspections:** These inspections are conducted before allowing providers to enroll or re-enroll into the Medicaid program. This process validates the provider’s existence and also allows for a greater depth of information its service capacity. Florida has not admitted 49 providers and has estimated that they saved one million dollars in unacceptable billings during 2001 and 2002. Since 2003 they have randomly inspected 10 percent of all new applicants.<sup>6</sup>

**Criminal background checks:** Thirteen states implement criminal background checks by verifying provider applications criminal background with law information agencies.

<sup>5</sup> United States Government Accountability Office. “Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments.”

<sup>6</sup> United States Government Accountability Office. “Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments.”

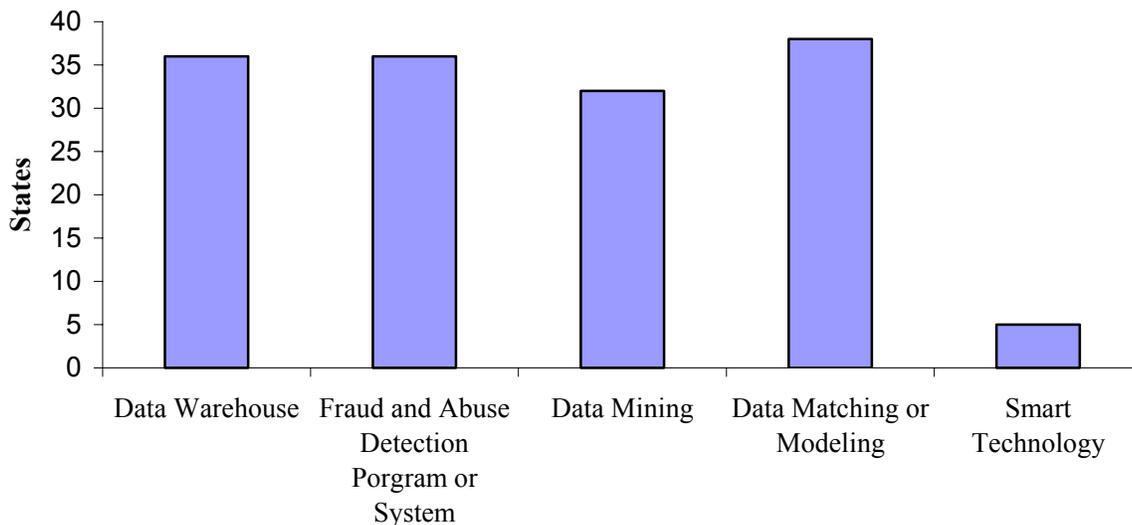
**Intensified claims review or auditing:** States verify the billings providers make and the services they provide during certain periods.

**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.<sup>7</sup>

**Time-limited enrollment:** see above<sup>8</sup>

### 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.



**Figure 3:** Number of states using specific technologies aimed at detecting fraud and abuse.

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**Data warehouse:** A data warehouse stores years of information on claims, providers, and beneficiaries in an integrated database

**Fraud and abuse detection program or system:** These systems use technology in order to pinpoint incorrect billing. Within one such program pharmacists must get an authorization number after answering a series of questions on the phone in order to fill prescriptions.

**Data mining:** Data mining is the analysis of large databases to identify unusual utilization patterns

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<sup>7</sup> United States Government Accountability Office. “Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments.”

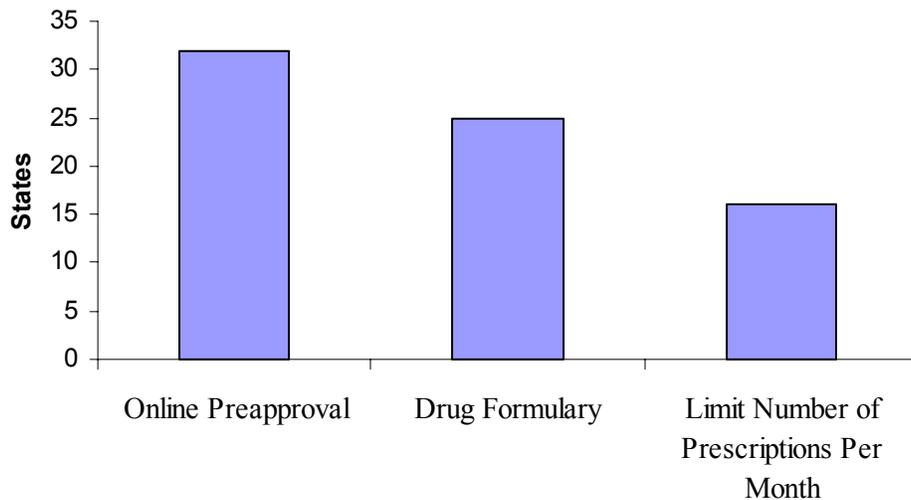
<sup>8</sup> United States Government Accountability Office. “Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments.”

**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<sup>9</sup>

### Prescription drug controls

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



**Figure 4:** Number of states using prescription drug controls to combat Medicaid fraud and abuse.

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**Online pre-approval:** The states require pharmacies to validate the customer’s enrollment before filling the prescription.

**Drug formulary:** A drug formulary is a list of prescription medications approved for coverage

**Limit on number of prescriptions per month<sup>10</sup>**

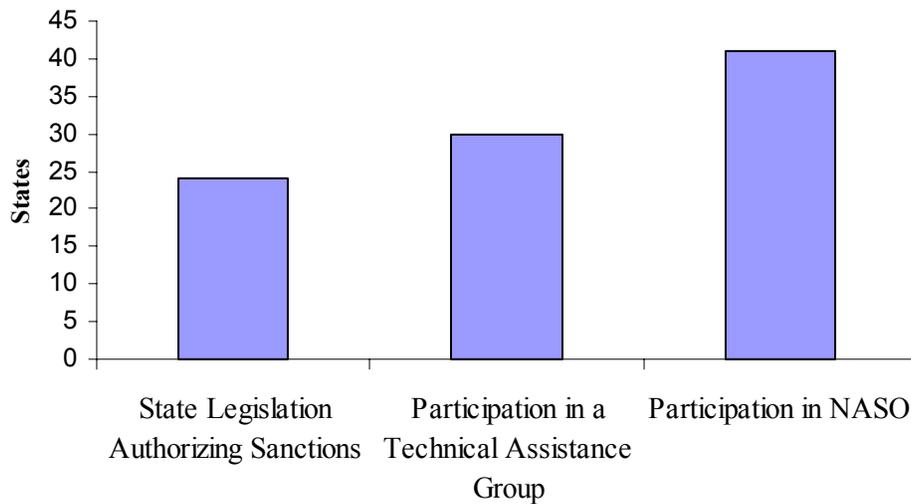
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<sup>9</sup> United States Government Accountability Office. “Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments.”

<sup>10</sup> United States Government Accountability Office. “Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments.”

## Other

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



**Figure 5:** Number of states taking miscellaneous actions to combat Medicaid fraud and abuse.

**State legislation authorizing sanctions:** Twenty-four states have reported mandating sanctions against fraudulent providers or beneficiaries. New Jersey has made it law that all licensed prescribers use non-reproducible and tamper proof prescription blanks as well as making prescription forgery a third degree felony. Texas has expanded its Medicaid fraud investigation branches as well as expanding the states ability to conduct claims reviews, issue subpoenas, impose prior requirements and surety bond requirements. They also have pushed exploration of biometric technology that would use fingerprinting in order to identify patients

**Participation in a technical assistance group:** see section on the Centers for Medicare and Medicaid services below.

**Participation in NASO:** The NASO is the National Association of Surveillance and Utilization Review Officials (<http://www.nasosurs.com>)<sup>11</sup>

<sup>11</sup> United States Government Accountability Office. “Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments.”

## 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 abuse in the mid-1990s. In 1997, the Southern Consortium, composed of the Atlanta and Dallas Regional Offices, came to the forefront of the effort through the creation of the National Medicaid Fraud and Abuse Initiative (known as the Medicaid Alliance for Program Safeguards after October of 2001.)<sup>12</sup>

The Alliance aims to assist states with fraud and abuse prevention in a number of ways, including: attempting to strengthen and expand the partnership between the State and Federal governments as related to Medicaid fraud and abuse prevention; providing for the communication of fraud and abuse information; providing technical assistance for states' fraud and abuse prevention efforts; and overseeing states' fraud and abuse prevention efforts.<sup>13</sup>

In order to facilitate the sharing of fraud and abuse prevention strategies and information between states, CMS created the Medicaid Fraud and Abuse Control Technical Advisory Group (TAG). The TAG is a national forum through which states share issues, solutions, resources, and experiences. It includes representatives from 19 states, one state Medicaid Fraud Unit, and three CMS staff members. Through a networking mechanism, the TAG informs all states on its activities.<sup>14</sup>

### Taxpayers Against Fraud

Taxpayers Against Fraud (TAF) is a nonprofit advocacy organization based in Washington D.C. that supports the federal False Claims Act (FCA) and the adoption of state level FCAs across the country. They are an information clearinghouse for the legislature, attorneys, whistleblowers, and the media. TAF provides small loans to *qui tam* (whistleblower) plaintiffs, as well.<sup>15</sup>

TAF also operates a 501(c)(3) nonprofit organization named the Taxpayers Against Fraud Education Fund (TAFEF).<sup>16</sup> A report compiled on behalf of the organization in June 2003 highlighted the importance of both the federal FCA and the adoption of state-level FCAs in each of the fifty states. According to the TAF website, currently, only twelve US states (CA, DE, FL, HI, IL, LA, MA, NM, NV, TN, TX, VA), the District of Columbia, and the city of Chicago have FCAs in place.<sup>17</sup>

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<sup>12</sup> Centers for Medicare and Medicaid. "Medicaid Alliance for Program Safeguards." September 16, 2004. <http://www.cms.hhs.gov/states/fraud/backgrnd.asp>. Accessed March 31, 2005.

<sup>13</sup> Centers for Medicare and Medicaid. "Medicaid Alliance for Program Safeguards."

<sup>14</sup> Centers for Medicare and Medicaid. "Medicaid Alliance for Program Safeguards."

<sup>15</sup> Taxpayers Against Fraud Education Fund. "Why Are TAF and the TAF Education Fund Needed?" No date specified. <http://www.taf.org/whytaf.htm>. Accessed March 31, 2005.

<sup>16</sup> Taxpayers Against Fraud Education Fund. "Why Are TAF and the TAF Education Fund Needed?"

<sup>17</sup> Taxpayers Against Fraud Education Fund, "State False Claims Acts." No date specified. <http://www.taf.org/statefca.htm>. Accessed March 31, 2005.

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.<sup>18</sup>

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.<sup>19</sup>

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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 Professor Anthony Gierzynski. The material contained in the reports does not reflect official policy of The University of Vermont.

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<sup>18</sup> Schneider, Andy. “Reducing Medicaid Fraud: The Potential of the False Claims Act.” Taxpayers Against Fraud Education Fund. June 2003. <http://www.taf.org/publications%5CPDF%5CReducingMedicaidFraud.pdf>. Accessed March 31, 2005.

<sup>19</sup> Schneider, Andy. “Reducing Medicaid Fraud: The Potential of the False Claims Act.”