

Medicaid Fraud and Abuse

Overview

Fraud, abuse and waste in Medicaid cost states billions of dollars every year, diverting funds that could otherwise be used for legitimate health care services. Not only do fraudulent and abusive practices increase the cost of Medicaid without adding value – they increased risk and potential harm to patients who are exposed to unnecessary procedures. In 2015, improper payments alone—which include things like payment for non-covered services or for services that were billed but not provided—[totaled](#) more than \$29 billion according to the Government Accountability Office.

While Medicaid fraud involves knowingly misrepresenting the truth to obtain unauthorized benefit, abuse includes any practice that is inconsistent with acceptable fiscal, business or medical practices that unnecessarily increase costs. Waste encompasses overutilization of resources and inaccurate payments for services, such as unintentional duplicate payments. As states look for innovative ways to contain burgeoning Medicaid costs and promote the program's integrity, fighting fraud and abuse offers one approach that everyone can support.

Program Integrity Initiatives. The federal government and states have adopted a [variety](#) of steps to combat Medicaid fraud, waste and abuse and to ensure that public funds are used to promote Medicaid enrollees' health. According to the Medicaid and CHIP Payment Access Commission ([MACPAC](#)), these include data mining, audits, investigations, enforcement actions, technical assistance to help state agencies detect fraud and abuse, and provider and enrollee outreach and education. Well-designed program integrity initiatives ensure that:

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- Eligibility decisions are made correctly;
 - Prospective and enrolled providers meet federal and state participation requirements;
 - Delivered services are medically necessary and appropriate; and
 - Provider payments are made in the right amount and for appropriate services.

A 2013 Pew Charitable Trusts' report found that states utilized three types of Medicaid fraud prevention strategies, including: provider screening; prior authorization and pre-payment reviews; and post-payment review and recovery. While states have traditionally relied upon the latter, "pay and chase" model in which they pay Medicaid claims and then try to recover improper payments, they are increasingly focusing on preventing and detecting fraudulent activities early on. New York, for example has integrated targeted data mining and risk analysis into its fraud-fighting tool box. In Texas, a few simple process changes and new pattern analysis and recognition efforts moved the state closer to 'real-time analysis' and significantly

increased the amount of fraud identified. For more on what these states have done to fight Medicaid fraud and abuse, check out this [Webinar archive](#).

Federal Medicaid Integrity Provisions. The Affordable Care Act (ACA) introduced various requirements aimed at improving Medicaid program integrity. Foreexample, the law created a web-based portal, enabling states to compare information on providers that have been terminated (and whose billing privileges have been revoked). An overview of the law's provisions related to improving Medicaid program integrity is available [here](#).

Common Examples of Medicaid Fraud

PROVIDER FRAUD	PATIENT FRAUD	INSURER FRAUD
<ul style="list-style-type: none"> ▪ BILLING FOR SERVICES NOT PERFORMED ▪ BILLING DUPLICATE TIMES FOR ONE SERVICE ▪ FALSIFYING A DIAGNOSIS ▪ BILLING FOR A MORE COSTLY SERVICE THAN PERFORMED ▪ ACCEPTING KICKBACKS FOR PATIENT REFERRALS ▪ BILLING FOR A COVERED SERVICE WHEN A NONCOVERED SERVICE WAS PROVIDED ▪ ORDERING EXCESSIVE OR INAPPROPRIATE TESTS ▪ PRESCRIBING MEDICINES THAT ARE NOT ▪ MEDICALLY NECESSARY OR FOR USE BY PEOPLE OTHER THAN THE PATIENT 	<ul style="list-style-type: none"> ▪ FILING A CLAIM FOR SERVICES OR PRODUCTS NOT RECEIVED ▪ FORGING OR ALTERING RECEIPTS ▪ OBTAINING MEDICATIONS OR PRODUCTS THAT ARE NOT NEEDED AND SELLING THEM ON THE BLACK MARKET ▪ PROVIDING FALSE INFORMATION TO APPLY FOR SERVICES ▪ DOCTOR SHOPPING TO GET MULTIPLE ▪ PRESCRIPTIONS ▪ USING SOMEONE ELSE'S INSURANCE COVERAGE FOR SERVICES 	<ul style="list-style-type: none"> ▪ OVERSTATING THE INSURER'S COST IN ▪ PAYING CLAIMS ▪ MISLEADING ENROLLEES ABOUT HEALTH PLAN BENEFITS ▪ UNDERVALUING THE AMOUNT OWED BY THE INSURER TO A HEALTH CARE PROVIDER UNDER THE TERMS OF ITS CONTRACT ▪ DENYING VALID CLAIMS

Additional NCSL Resources

- [Fighting Medicaid Fraud](#), *State Legislatures*, April 2013
- [LegisBrief: Medicaid Program Integrity: Fighting Fraud, Waste and Abuse](#)[KG1]
- [Webinar Archive: Improving Medicaid Program Integrity: State Strategies to Combat Fraud and Abuse](#), January 2013
- [Confronting Costs & Medicaid Fraud Fighters](#), *State Legislatures*, June 2012

Other Recent Medicaid Program Integrity and Fraud Prevention Resources

- [Combating Fraud and Abuse](#), The Pew Charitable Trusts, March 2013
- [Directory of State Program Integrity Directors](#), National Association for Medicaid Program Integrity, Accessed June 2017
- [Fraud and Abuse](#), CMS, 2017
- [Health Care Fraud and Abuse Control Program Report](#), Office of Inspector General, Accessed June 2017
- [Key Legislative Milestones in Program Integrity](#), MACPAC, January 2016
- [Medicaid Anti-Fraud and Abuse Practices Database](#), The Pew Charitable Trusts, 2013
- [Medicaid: CMS Needs Better Data to Monitor the Provision of and Spending on Personal Care Services](#)
U.S. Government Accountability Office (GAO), January 2017
- [Medicaid Guidance Fraud Prevention](#), CMS, December 2014
- [Medicaid in an Era of Health & Delivery System Reform](#), Kaiser Family Foundation, October 2014

- [Medicaid Program Integrity: CMS Should Build on Current Oversight Efforts by Further Enhancing Collaboration with States](#)
- [Medicaid Program Integrity: Improved Guidance Needed to Better Support Efforts to Screen Managed Care Providers](#), GAO, May 2016
- [Program Integrity](#), CMS, Accessed June 2017
- [Program Integrity](#), Medicaid and CHIP Payment Access Commission (MACPAC), Accessed June 2017
- [The State's Efforts to Control Medicaid Fraud and Abuse](#), Florida Agency for Healthcare Administration