

## LEVERAGING MEDICAID DOLLARS

# LEVERAGING PARTNERSHIPS TO MAXIMIZE THE MEDICAID DOLLAR

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Rising health care costs and the critical need to maximize health care dollars are key national concerns. The Department of Health and Human Services (HHS) administers two of the largest Government health care programs, Medicare and Medicaid, making those matters of paramount importance to the HHS Office of Inspector General (OIG). One major responsibility for the OIG is ensuring that Federal payments for Medicaid are accurate and appropriate.

Complexity is generally inherent in health care program administration, and Medicaid is no exception. Because it is structured as a Federal-state partnership, Medicaid presents special challenges for ensuring appropriate and effective use of funds. Accordingly, collaboration between a number of Federal and state partners is more than desirable—it is essential. We, therefore, place a premium on information sharing and strategic coordination across jurisdictional boundaries.

This article outlines the challenges of identifying and addressing improper payments and fraud in the Medicaid program. It also describes the roles of OIG and a number of our partners in contributing to a coordinated strategy for ensuring Medicaid integrity. Although the Medicaid program is unique in some administrative respects, we hope that by sharing how we rely on Federal-state partnerships to oversee Medicaid, useful insights may be gained for those responsible for other government program oversight activities where multiple authorities are involved.

### THE MEDICAID PROGRAM

Medicaid is the largest government health insurance program in the United States and provides a vital safety net for millions of low-income Americans. Jointly funded by the Federal Government and the states, the Federal share of Medicaid outlays in fiscal year (FY) 2004 exceeded \$176 billion and is expected to exceed \$192 billion in FY 2006. In FY 2004, Medicaid covered 43.7 million federally eligible children and adults, and the number of federally eligible enrollees is expected to exceed 46 million in FY 2006.<sup>1</sup>

At the Federal level, the Centers for Medicare and Medicaid Services (CMS) administer the Medicaid program. The Federal Government pays a share of each state's Medicaid program costs, known as the Federal Medical Assistance Percentage (FMAP). The FMAP ranges by state from 50 to 83 percent and is determined annually based on

<sup>1</sup> *Centers for Medicare and Medicaid Services FY2006 Budget in Brief.*

each state's average per capita income level. With certain exceptions, Federal payments to states for medical assistance have no set limit. Rather, the Federal Government matches (at FMAP rates) each state's outlay for covered items and services and also matches, at the appropriate administrative rate (typically 50 percent), the necessary and proper administrative costs.

Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis or may have managed care arrangements. Within federally imposed upper limits and specific restrictions, states have broad discretion in determining the payment methodology and payment rate for services.

## **IMPROPER PAYMENTS AND FRAUD IN MEDICAID**

Because Medicaid is a matching program, improper payments by states to providers cause corresponding improper Federal payments. However, the Federal Government does not routinely examine individual provider claims, and therefore inappropriate claims by states for a Federal share are not always easily identified. Controlling

the cost of Medicaid and maximizing the Medicaid dollar involves identifying and resolving improper and fraudulent payments and strengthening the integrity of the program through our audits, program evaluations, investigations, and use of statutory authorities to sanction providers who have engaged in fraud.

### ***TYPES OF IMPROPER PAYMENTS***

While some improper payments are fraudulent, our sense is that the majority of providers are honest in their billings for Medicaid reimbursement. However, improper payments may arise because of clerical errors, misinterpretations of rules, or poor record keeping. Improper payments include both overpayments and underpayments and are generally adjusted or collected administratively. Common categories of improper payments are detailed in Table 1.

### ***TYPES OF FRAUDULENT ACTIVITIES***

Some improper billings and related practices are also determined fraudulent. Fraudulent behavior may arise when enrollment procedures for providers

**Table 1. Types of Improper Payments**

Unsupported Services	Providers must maintain sufficient records to justify diagnoses, admissions, treatments, and continued care. When the records are insufficient or missing, claims reviewers cannot determine whether services billed were actually provided to beneficiaries, the extent of the services, or their medical necessity.
Medically Unnecessary Services	The medical record documentation leads an informed claims reviewer to conclude that the medical services or products received were not medically necessary.
Incorrect Coding	Standard coding systems are generally used to bill state Medicaid programs for services provided. In a coding review, medical reviewers determine whether the documentation submitted by providers supports a lower or higher reimbursement code than was actually submitted.
Noncovered Costs or Services	Some costs or services Medicaid will not reimburse because they do not meet the state's Medicaid reimbursement rules and regulations.
Third-Party Liability	Medicaid inappropriately pays claims, and is generally not reimbursed, for beneficiaries who have other sources of payment, such as private insurance.

**Table 2. Types of Fraudulent Activities**

Billing for Services Not Provided	One of the most common types of fraud. Examples include a provider who knowingly bills Medicaid for a treatment or procedure that was not actually performed, such as blood tests when no samples were drawn or x-rays that were not taken.
False Cost Reports	A nursing home owner or hospital administrator may intentionally include inappropriate expenses not related to patient care on cost reports submitted to Medicaid.
Illegal Remunerations (Kickbacks)	One health care provider may conspire with another to share in the monetary reimbursement the provider receives in exchange for the referral of patients. Kickbacks can include cash or other items of value. The practice results in encouraging performance of unnecessary tests and services designed to generate additional income to both the referring source and the provider.

are inadequate, internal controls are deficient, payment rates are excessive (inviting fraudulent and abusive behavior), or when especially vulnerable beneficiaries can be exploited easily. The types of fraudulent schemes we see in the Medicaid program in many ways mirror those in Medicare and are likely relevant to Federal health care programs in other Departments. Table 2 describes three categories of fraudulent activities.

### **ENSURING MEDICAID INTEGRITY: FEDERAL AND STATE PARTNERS**

The responsibility for detecting improper payments and investigating and prosecuting fraud and abuse in the Medicaid program is shared between the Federal and state governments. At the Federal level, OIG, CMS, and Federal law enforcement agencies (including the Department of Justice) collaborate to ensure Medicaid integrity and to investigate and prosecute fraud. Our state-level partners include state Medicaid agencies, state Medicaid Fraud Control Units, state auditors, and state attorneys general. Each of those Federal and state partners makes critical contributions toward protecting and maximizing the Medicaid dollar. Table 3 (on the next page) briefly describes some of the responsibilities of the partners and a few examples of their activities to ensure Medicaid integrity.

### **OFFICE OF INSPECTOR GENERAL**

The OIG conducts a variety of activities that promote the economy, efficiency, and effectiveness of Medicaid. Activities include investigations and litigation of fraud and wrongdoing, audits of Medicaid payments, evaluations of the management and effectiveness Medicaid programs, and provision of legal guidance. These activities result in criminal convictions, settlements, recovery of misspent funds, savings through funds put to better use, and improved program operations.

### **IDENTIFYING AND PURSUING IMPROPER PAYMENTS AND FRAUD**

One significant OIG role in Medicaid integrity is identifying and pursuing improper payments and fraud. Improper or fraudulent payments result in a substantial drain on state and Federal funds. Therefore, our office conducts a large number of Medicaid audits on our own initiative or at the request of CMS, the Department, or Congress. Intended to identify improper payments, these audits not only reveal questionable billings, but sometimes expose fraud, program management deficiencies, or weaknesses and loopholes in program rules. When we question Medicaid payments, we notify CMS of our findings. If CMS

**Table 3. Federal and state Partners in Ensuring Medicaid Integrity**

PARTNER	RESPONSIBILITIES	EXAMPLES OF RELATED ACTIVITIES
<b>Federal:</b>		
OIG	Promote economy, efficiency, and effectiveness of Medicaid through the elimination of fraud, waste, and abuse  Oversee Medicaid Fraud Control Units	<ul style="list-style-type: none"> <li>• Audit and evaluate Medicaid payments and administration</li> <li>• Investigate Medicaid fraud</li> <li>• Provide legal guidance</li> <li>• Refer and assist in Federal fraud cases</li> </ul>
CMS	Administer Medicaid (Federal level)  Oversee state Medicaid agencies	<ul style="list-style-type: none"> <li>• Oversee and assist states' program integrity efforts</li> <li>• Lead Medicaid Alliance for Program Safeguards</li> <li>• Develop Medicaid error rate</li> </ul>
DoJ	Enforce Federal laws (related to Medicaid fraud)	<ul style="list-style-type: none"> <li>• Investigate and prosecute Federal Medicaid fraud cases</li> </ul>
<b>State:</b>		
State Medicaid Agencies	Administer Medicaid (state level)	<ul style="list-style-type: none"> <li>• Conduct pre- and post-payment screens</li> <li>• Detect aberrant billing</li> <li>• Identify and refer potential fraud cases</li> </ul>
Medicaid Fraud Control Units	Investigate and prosecute Medicaid provider fraud, administration fraud, and patient abuse and neglect	<ul style="list-style-type: none"> <li>• Investigate fraud and abuse referrals</li> <li>• Prosecute identified fraud and patient abuse/neglect</li> <li>• Pursue civil litigation</li> </ul>
State Auditors	Ensure efficient and effective management of public funds (including Medicaid funds)	<ul style="list-style-type: none"> <li>• Audit internal controls and systems operations of state Medicaid programs</li> </ul>
State Attorneys General	Enforce state laws (related to Medicaid fraud)	<ul style="list-style-type: none"> <li>• Prosecute state Medicaid fraud cases</li> </ul>

agrees the questioned payments were improper, it recovers the Federal share from the states.

If we find possible fraud, our criminal investigators review the matter and determine whether to open an investigation. Our auditors may also assist in the ongoing criminal investigations being conducted by our office or other law enforcement agencies. OIG, along with the Department of Justice and other law enforcement agencies, has achieved major successes in using the False Claims Act, and in particular its *qui tam*<sup>2</sup> provisions, in pursuing fraud in both the Medicare

and Medicaid programs. Many of these cases have been brought against pharmaceutical companies and have resulted in unprecedented civil and criminal monetary penalties.

#### OVERSEEING THE STATE MEDICAID FRAUD CONTROL UNITS

Since 1979, OIG has been responsible for management and oversight of the state Medicaid Fraud Control Units (the units) grant program. The purpose of the Medicaid Fraud Control Units

<sup>2</sup> The *qui tam* provisions allow whistleblowers to bring suit under the False Claims Act seeking recoveries against defrauders of government programs. The False Claims Act imposes civil liability on any person or entity who submits a false or fraudulent claim for payment to the United States Government. The whistleblower, or relator, may share in any later recoveries, whether ordered by a court or as the result of a settlement.



is to investigate and prosecute Medicaid provider fraud, patient abuse or neglect, and fraud in the administration of the program. (The activities of the units are described in more detail later in this article.) OIG responsibilities include monitoring the units' overall performance and productivity and certifying the units, in accordance with performance standards developed jointly by OIG and the units themselves. We maintain ongoing communication with individual state units and the National Association of Medicaid Fraud Control units related to the interpretation of program regulations and other policy issues.

Oversight responsibilities afford OIG an opportunity to coordinate effectively with the units. Our office, the Medicaid Fraud Control Units, and other law enforcement agencies work closely on fraud cases and other activities, and these partnerships have greatly enhanced the OIG's ability for carrying out its mission. In FY 2004, the OIG conducted joint investigations with the units of 314 criminal cases and 91 civil cases and achieved 64 convictions.

## **CENTERS FOR MEDICARE AND MEDICAID SERVICES**

As the Federal administrator of Medicaid, CMS plays a crucial role in ensuring Medicaid program integrity. To that end, in 1996 the agency established a program integrity group specifically to address fraud and abuse issues within the Medicaid and Medicare programs. That group conducts and oversees many projects intended to reduce program fraud. CMS is also leading development of a methodology for measuring Medicaid program error rates. Another effort, called the Medi-Medi pilot, compares Medicare and Medicaid billing data to identify aberrant provider billings, such as situations in which both programs are billed for the same items and services.

CMS also leads the Medicaid Alliance for Program Safeguards, which is a national intergovernmental initiative for reducing Medicaid

fraud and abuse. Partners in that alliance include OIG, state Medicaid programs, state Program Integrity Units, state Medicaid Fraud Control Units, the Federal Bureau of Investigation, and the Department of Justice. Accomplishments include presenting intergovernmental executive seminars and issuing a comprehensive plan for program integrity, guidelines for addressing fraud and abuse in Medicaid managed care, and a resource guide of state fraud and abuse systems. Among other activities, the Alliance is conducting a series of program integrity reviews at state Medicaid agencies designed to help states strengthen their program integrity operations to prevent, identify, and resolve improper and fraudulent Medicaid payments.

## **STATE MEDICAID AGENCIES**

Each of the state Medicaid agencies is required to have a program integrity unit or other office that conducts preliminary investigations of suspected fraud and refers cases to the state's Medicaid Fraud Control Unit or other appropriate law enforcement officials for a full investigation. In addition, each of the state Medicaid agencies has a data system, called the Surveillance and Utilization Review Subsystem, which is a part of the state's Medicaid Management Information System. In smaller states, surveillance units may also operate the program integrity units, conducting preliminary reviews of Medicaid fraud or abuse and referring appropriate cases for a full investigation. In all states, the surveillance data system applies automated post-payment screens to Medicaid claims to identify aberrant billing patterns that may indicate fraud or provider abuse. When potential fraud cases are detected, the state agency refers the cases to the state's Medicaid Fraud Control Units.

## **STATE MEDICAID FRAUD CONTROL UNITS**

As discussed, OIG oversees the state Medicaid Fraud Control Units grant program, whose purpose

is to investigate and prosecute Medicaid fraud and patient abuse or neglect. The Units are part of the state attorney general's office or other state agency that is separate and distinct from the Medicaid state agency.

Over the years, the units' efforts resulted in hundreds of millions of dollars in recoveries and thousands of convictions. Recoveries include settlements or court-ordered restitution, fines, and penalties. In addition to financial fraud, the Units also investigate patient abuse and neglect in Medicaid-funded facilities. Those cases are critical to the provision of high quality and appropriate care, especially for our nation's frail elderly.

One area of increasing activity by the Medicaid Fraud Control Units is in civil litigation. Under a 1999 policy interpretation by our office, the Units are expected to investigate any potential criminal violations first and must then consider if there is a civil fraud case. The amount of civil recoveries by the Medicaid Fraud Control Units has been increasing since 1999, and at least two states have designated special sub-units to develop civil fraud cases. Civil fraud cases may be pursued under state laws, including false claims acts in those states that have such laws, or under the Federal Civil False Claims Act, which has been a longstanding and powerful tool in the fight against health care fraud and abuse. Under the False Claims Act, the Department of Justice may pursue False Claims Act penalties and damages. Under our own administrative sanction authorities, OIG may pursue civil monetary penalties and exclusion of providers for violations of health care laws.

Communication with numerous partners is critical to the mission of the Medicaid Fraud Control Units. In addition to referrals from state Medicaid agencies, the Units receive leads from other sources, including other state and Federal law enforcement agencies, whistleblowers, beneficiaries, concerned citizens, the press, and legislative bodies. If a matter that comes to the attention of a Medicaid Fraud Control Unit is determined to be an improper payment that does not warrant a fraud investigation, the matter is

referred to the state Medicaid agency to pursue recovery of the improperly paid amount.

## **STATE AUDITORS**

OIG has initiated a number of partnerships with state auditors. Several years ago, OIG began an initiative to work more closely with state auditors in reviewing the Medicaid program. A partnership plan was created to provide broader coverage of the Medicaid program by partnering with state auditors, state Medicaid agencies, and state internal audit groups. The level of involvement of each partner is flexible and can vary depending on specific situations and available resources. In one instance, the OIG role may entail the sharing of our methodology and experience in examining similar Medicare issues. In other cases, we may join together with state teams to audit suspected problems.

The partnership approach provides broader coverage of the Medicaid program and maximizes the impact of scarce audit resources by both the Federal and state audit sectors. To date, the joint efforts have been developed in 25 states. Completed reports identified \$263 million in Federal and state savings and included recommendations for improvement in internal controls and computer systems operations.

## **IMPROVING THE MEDICAID PROGRAM**

The shared goal of each partner is to bring about program improvements that help reduce the cost of providing necessary services to Medicaid beneficiaries to maximize the Medicaid dollar. In addition to identifying misspent funds, OIG also strives to find ways that will improve and strengthen the program. Many of our reviews determine whether the Medicaid program is managed properly and pays a fair price in the health care marketplace.

Over the years, in collaboration with our partners, our work has addressed numerous vulnerabilities in the Medicaid program. Below are two of the

most notable issues that we believe still merit attention and require corrective action that could significantly benefit the Medicaid program.

### **USE OF INTERGOVERNMENTAL TRANSFERS UNDER UPPER PAYMENT LIMIT RULES**

OIG audited enhanced payments made to local public hospitals and nursing facilities under upper payment limit rules in several states and found that billions of Medicaid dollars were, in effect, at risk of being diverted from their intended purpose. Enhanced payments are the difference between the state's reimbursement amount and the upper payment limit (that is, maximum amounts paid to certain providers under Medicare rules).

Medicaid funds are at risk when states use intergovernmental transfers to disproportionately shift the cost of Medicaid to the Federal Government, contrary to Federal and state cost-sharing principles. Intergovernmental transfers are transfers of non-Federal public funds between the state and/or local public Medicaid providers and the state Medicaid agency. States divert funds from an intended purpose by making an intergovernmental transfer after drawing down the Federal share of the benefit. Financial consequences include an inappropriate decline in the state share of Medicaid payments and corresponding increase in the Federal taxpayers' share. The increased Federal Medicaid funding derived from these transfers becomes commingled in general revenue accounts and can be used for purposes unrelated to Medicaid.

Of our Federal and state partners, CMS has been involved most in addressing such vulnerability. In accordance with our early work, CMS made regulatory improvements that would effectively reduce the funds that states can gain through these transfer mechanisms. To improve national consistency in Medicaid reimbursement policy, CMS also created the National Institutional Reimbursement Team, responsible for reviewing institutional reimbursement state plan amendments, providing technical assistance to the states, and developing Medicaid institutional

reimbursement regulations and policy. CMS worked with states to halt the inappropriate use of intergovernmental transfers. According to CMS, the agency identified 33 states using inappropriate intergovernmental transfers, and 26 of the 33 states have since halted the practice.

Additional changes are needed, however, to curb ongoing abuses. Recent OIG work at individual nursing facilities demonstrates that states still divert enhanced funding needed by poorly functioning facilities to other purposes, with negative implications for quality of care. OIG believes that CMS should continue to work with states on this issue. In addition, inappropriate financing mechanisms should be permanently eliminated by law or regulation.

### **PRESCRIPTION DRUG REIMBURSEMENT**

Nearly a decade of OIG work on Medicaid drug reimbursement leads to one conclusion—Medicaid pays too much for prescription drugs. The crux of the issue is that while states must reasonably reimburse pharmacies for prescription drugs, they often lack access to accurate pricing data that is necessary to do so. Because of that, states rely on published prices, such as average wholesale price, when determining Medicaid reimbursement. We have found that the published prices states use for estimating pharmacy acquisition costs are substantially higher than prices pharmacies actually pay for drugs.

The goal of our work is to ensure that Medicaid's prescription drug programs reimburse pharmacies at a fair price that reasonably reflects actual acquisition costs. We have offered a variety of options that would improve states' programs, which would lead to substantial savings. Those options include making more accurate pricing data available to states. Specifically, we recommended that Medicaid base reimbursement on prices calculated from actual sales transactions rather than the published prices currently being used.

In accordance with our findings, state Medicaid agencies made changes in their reimbursement

amounts and methods, but more improvements are needed. The Administration and Congress expressed interest in reforming Medicaid drug reimbursement and using sales-based prices.

In addition to our evaluations and audits, OIG partnered with the Department of Justice, Medicaid Fraud Control Units, and state attorneys general to pursue cases against drug manufacturers related to illegal pricing or fraudulent price reporting. For example, in 2004, Schering Plough Corporation agreed to pay almost \$345.5 million as part of a global settlement with the Government and entered a 5-year corporate integrity agreement with OIG. As part of the settlement, Schering-Plough agreed to pay almost \$293 million to resolve its civil and administrative liabilities in connection with illegal and fraudulent pricing under the Medicaid drug rebate program.

## **CONCLUSION**

Protecting the integrity of Medicaid is one of the top priorities for the OIG, and our success is

largely dependent on the ability to work effectively with a number of state and Federal partners. The HHS OIG will continue to devote its energies to auditing and evaluating the Medicaid program to identify payment issues and errors, recover improper payments, improve the program, and, when necessary, pursue appropriate law enforcement actions to recover funds paid to fraudulent providers.

We continually look for ways to build on our collaboration with CMS, state Medicaid agencies and auditors, the state Medicaid Fraud Control Units, the Department of Justice, as well as other intergovernmental enforcement agencies to identify and resolve fraud and abuse. Developing and leveraging such partnerships significantly increases our collective ability to maximize the Medicaid dollar, helping ensure the best possible deployment of the Nation's health care dollars are dedicated toward assisting those most vulnerable and in need.