Rx: Health Care FYI #27

Subject: *Strengthening Medicaid: Reducing Waste, Fraud and Abuse*

From: *Rep. Tim Murphy (PA-18)*

The problem: Waste, fraud and abuse in the Medicaid program takes away billions of valuable dollars from more than 50 million elderly, blind, disabled and low-income American individuals. With Medicaid spending set to reach more than ***$1.1 trillion*** over the next five years,[1] Congress must act to reform the Medicaid program to eliminate waste, fraud and abuse in order to strengthen and preserve the nation's health care safety net for those who need it most.

Examples of Medicaid Waste, Fraud and Abuse:

- In New York State, at least 10 percent of state Medicaid dollars were spent on fraudulent claims, while 20 - 30 percent more were siphoned off for abuse for over ***$18 billion*** a year.
- School officials around New York State have enrolled tens of thousands of low-income students in speech therapy without required evaluations, garnering more than ***$1 billion*** in questionable Medicaid payments for their districts. One Buffalo school official sent 4,434 students into speech therapy in a single day without talking to them or reviewing their records.
- In New York, a Brooklyn dentist claimed to have performed as many as 991 procedures a day on Medicaid patients for ***$1 million*** in fraud.
- Also in Brooklyn, a doctor prescribed ***$11.5 million*** worth of an expensive muscle-building drug intended for AIDS patients that was then diverted to bodybuilders in a criminal scheme.[2]
- A Medicaid fraud scheme in California involved more than 15 clinical laboratories that illegally billed over ***$20 million*** for tests that were never authorized by physicians.
- Owners of a California optical store used information from previous patients to defraud the Medicaid program of nearly ***$3 million*** by filing false claims for eyeglasses they said were replacements for Medicaid patients whose eyeglasses were lost, stolen, or destroyed.
- A Virginia transportation company purchased patient identity information from other transportation companies or assisted living homes and billed ***$1.6 million*** for Medicaid beneficiaries it never served.

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[1] House Report: 109-17. Concurrent Resolution on the Budget. Fiscal Year 2006 Report of the Committee on the Budget to accompany H. Con. Res. 95. The Committee on the Budget. U.S. House of Representatives. March 11, 2005.

[2] Levy, Clifford. New York Medicaid Fraud May Reach Into Billions. The New York Times. July 18, 2005.

- An Indiana pharmaceutical and Durable Medical Equipment company inflated the cost of the drugs provided to Medicaid beneficiaries and paid kickbacks to nurses for referring patients to the company for ***$2 million*** in fraud.
- In Florida, an audit of a hospital found that 99 percent of its nonemergency service claims were billed for services that did not qualify for Medicaid payments.
- A medical supply company with suppliers throughout the country agreed to repay states nearly ***$50 million*** because of fraudulent marketing practices for providing supposedly free feeding pumps used to directly feed patients who can not feed themselves to nursing homes.[3]

What the Federal Government is doing to eliminate waste:

- Federal oversight of state Medicaid administrative efforts is limited. However, the Centers for Medicare and Medicaid Services (CMS) has two programs:
  1) The Payment Accuracy Measurement program used to verify each state's Medicaid claims payments. CMS measures payment error rates for inpatient hospital services, long-term care services, independent physicians and clinics, prescription drugs, home and community-based services and primary care case management. Then, CMS sets to allowable error rate for claim reimbursement.
  2) The Medicare-Medicaid data match program identifies improper billing by matching Medicare and Medicaid claims information on providers and beneficiaries who try to get double reimbursements from both federal programs for the exact same services.

- CMS aims to review 8 states each year until all 50 states and the District of Columbia have been covered. From January 2000 through December 2003, CMS has conducted reviews of 29 states. At its current pace, CMS will not begin a second round of reviews before fiscal year 2007. This suggests that CMS's oversight of the states' Medicaid program integrity efforts are not sufficient for the size of patients covered under the program.

Recommendations:

- Increase congressional oversight of the federal-state Medicaid programs.
- Increase resources at CMS to ensure the integrity of state Medicaid programs.
- Restrict funding for providers and states that illegally engage in waste, fraud or abuse.
- Ensure a quick enforcement process for prosecuting providers or other individuals identified of engaging in Medicaid fraud.
- Fund pilot programs in the states that reward innovative methods and take advantage of health information technology to reduce waste, fraud and abuse in state Medicaid programs.

[3] Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments. Government Accountability Office. July 16, 2004