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**The New Medicaid Integrity Program:
Issues and Challenges in Ensuring Program Integrity in Medicaid**

Victoria Wachino
Wachino Health Policy Consulting

June 2007

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

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Executive Summary

In 2006, Congress created the Medicaid Integrity Program, a new federal effort within the Centers for Medicare and Medicaid Services (CMS) to ensure program integrity in the Medicaid program, which covers health and long-term care services to more than 50 million low-income children, parents, seniors and people with disabilities. The creation of this program offers an opportunity for the federal government to increase its commitment to promoting the efficiency, effectiveness, and integrity of Medicaid, which purchases about one-fifth of all health care services in the United States and is one of the largest programs in the budget of both the federal government and the states. However, there are few comprehensive analyses of the overall program integrity challenges that Medicaid faces. This paper is intended to provide such an analysis, and relies on reviews of the existing literature and perspectives provided by a group of experts in program integrity in Medicaid.

The paper finds:

The new Medicaid Integrity Program brings substantial new resources to bear on the issue of program integrity in Medicaid, including federal funding that will ultimately reach \$75 million a year, 100 additional staff at CMS dedicated to ensuring Medicaid program integrity, and new program integrity contractors who will perform many of the program's core functions. The Medicaid Integrity Program is modeled on the *Medicare* Integrity Program, which was created in 1996 but is much larger. The Medicaid Integrity Program was created in the Deficit Reduction Act of 2005 (DRA) as part of a set of Medicaid program integrity reforms.

Program integrity is central to program management and ensuring a program's effectiveness and efficiency. Program integrity is a critical component of program management and should help ensure public confidence that a government program is serving its target population effectively and fulfilling the purpose for which the program was created and is maximizing the return on taxpayers' investment in the program, with minimal waste. Program integrity should also help achieve key program goals. In Medicaid, program integrity requires setting policy and managing the Medicaid program so that health and long-term care services are provided to beneficiaries as effectively and efficiently as possible. It should ensure that quality health care to low-income people or state and federal tax dollars are not being put at risk through violations of the rules or abuses of the system. More specifically, program integrity should ensure appropriate amounts are being paid to legitimate providers for appropriate and reasonable services provided to eligible beneficiaries. Achieving these goals is a complex undertaking that involves all aspects of program management, from policy development to staffing to day to day operations.

Program integrity has traditionally been defined much more narrowly. A narrow focus that exclusively defines program integrity as issues related to “fraud and abuse” misses the much larger picture of managing a program to ensure that care is provided in an appropriate and efficient manner and in a way that prevents quality care and public funds from being placed at risk. In this larger picture, preventing violations of program integrity and avoiding inappropriate costs is at least as important as addressing cases of fraud and abuse, even if the monetary effects of these efforts are harder to quantify.

A holistic approach also helps legislators, program managers, and the public identify and evaluate tradeoffs between goals for the program that are important but at times compete with each other. For example, policy goals of preventing errors, waste or fraud may at times conflict with goals to improve quality and accessibility of services, or ensuring that eligible people enroll in the program. Having a holistic view of program integrity can promote operational success, ensuring that policies in different program areas are coordinated and work well together. Evaluating tradeoffs and coordinating different policies and management areas is especially important in a program that is as large and complex as Medicaid.

Program integrity is extremely difficult to measure. Supporting this holistic definition of program integrity would require robust analytic measurements across a range of program areas. Currently, a much more limited set of program integrity measures is reported. Existing program integrity metrics generally measure: recoveries of amounts in cases of fraud and abuse that are brought against organizations or individuals; payment errors; and costs that are avoided by implementing new policies and procedures. Each of these measures, while meaningful, has limitations and drawbacks as a measure of program integrity. Individually, none of these measure program integrity, even as that term is narrowly defined. Developing additional measures of program integrity would better help those who run the program at the federal and state levels set priorities, identify high-risk areas, and allocate limited resources.

For example, error rates have the potential to be a significant program integrity and management tool by focusing attention on preventing mistakes and targeting program integrity efforts to high-risk areas. CMS is currently implementing a payment error rate measurement system (PERM) for Medicaid and SCHIP. The implementation of this system, which is designed to meet the requirements of federal law governing measurement of improper payments in major federal programs, has raised significant concerns about burden and accuracy from states. From a programmatic perspective, PERM could put state policies designed to simplify eligibility at risk if measurements do not accurately reflect state policies and mistakenly classify accurate eligibility determinations as errors.

The program integrity challenges facing Medicaid mirror those facing the health insurance system nationwide. As one of the nation’s leading health insurers, Medicaid faces the same set of challenges to its integrity that other insurers do. The broadest challenge facing insurers is balancing the need to effectively address “fraud and abuse” with the need for covered individuals to get the services they need without needless delay

and ensuring that providers can participate in a transparent, efficient system in which they can provide high-quality care. Additional challenges involve Medicaid's and other insurers' role as third-party payers that pay others (such as managed care organizations) to provide services, as opposed to providing them directly. Having the actual provision of services removed from program administrators can make it difficult to prevent program integrity violations and promote quality. Another central challenge for administrators is to recognize that those who are intent on committing fraud change tactics at least as rapidly as insurers' efforts to thwart them do.

In addition, Medicaid faces a set of challenges that set it apart from other insurers: it finances half of the nation's long-term care, has a population that is more transient than the covered populations of other insurers, especially *Medicare*, and has payment rates that are lower than those of *Medicare* and private insurers, creating consistent concerns that program integrity efforts will discourage provider participation in the program. These concerns may be especially strong in light of some recent evidence that provider participation in the program seems to be diminishing. Finally, because Medicaid serves an extremely vulnerable low-income population, new policies and procedures that may impede eligible people from enrolling or obtaining services once they have enrolled can cause serious consequences.

Responsibility for ensuring Medicaid program integrity is shared between the federal government and the states. Medicaid's federal/state partnership, in which states operate the program within broad federal guidelines, makes ensuring program integrity a considerably more complex undertaking than it is for other insurers. States determine key elements of their programs within federal guidelines, deciding who is eligible, what benefits are offered, and how much providers are paid, so the Medicaid program can vary dramatically state to state. States also perform the day to day management of their programs, meaning that most operational program integrity responsibilities reside with the states. Recent budget proposals to reduce federal support for administrative activities would make it harder for states to invest in new or improved approaches to ensuring program integrity. It will be extremely difficult for the new federal Medicaid integrity program to guarantee compliance with the rules of 56 different states and territories. Moreover, it will be a challenge for the federal government to make sure that increased efforts work to complement the program integrity efforts that states already have underway. Extensive collaboration between the federal government and the states would promote the successful implementation of the Medicaid Integrity Program.

Quality of care is a significant program integrity issue. Ensuring that the health and long-term care services that Medicaid finances are provided in accordance with generally accepted medical practice can also be considered a program integrity issue. Although measuring and improving quality require broad approaches, a component of program integrity can help monitor care and ensure that beneficiaries are not receiving substandard care, or care that can be harmful to their health. In Medicaid, program integrity violations that have compromised quality of care have, for example, occurred with regard to providers who provide unnecessary or risky services, drug manufacturers who market drugs "off label" for unapproved use, and managed care and institutional care providers

who are paid for providing a set of services to beneficiaries but fail to do so. Because the area in Medicaid in which the closest examination of quality of care issues has been conducted is long-term care, this paper devotes attention to quality in this context, but quality of care issues arise in many other areas as well.

Targeting high-risk areas would help employ limited resources most effectively. Employing a holistic definition of program integrity would require that the program examine some of the broad challenges it faces. Even under a narrow definition of program integrity, limited resources will have to be matched to significant challenges. Resources are limited, and setting priorities will be critical. Targeting resources to where the risks are the highest would help maximize efficient use of funds and staff. Risks can be measured both in terms of financial risks and risks to the quality of care provided to beneficiaries. A review of the program integrity literature indicates that high-risk areas are (Figure 1):

Figure 1

Key risks in Medicaid Program Integrity

Provider Type	Risky Practice	Fiscal Risks	Quality of Care Risks
Drug Manufacturer (primarily)	Abuses related to Medicaid’s purchasing of prescription drugs	\$\$\$\$\$	**
Hospitals, physicians, DME suppliers, clinical labs, pharmacies, home health, transportation	<ul style="list-style-type: none"> ▪ Billing Fraud ▪ Providing Services that are not medically necessary or that compromise quality of care 	\$\$\$\$	****
Managed Care	<ul style="list-style-type: none"> ▪ Underproviding services ▪ Inappropriate beneficiary marketing and enrollment practices 	\$\$\$	***
Long-term Care	<ul style="list-style-type: none"> ▪ Patient abuse and neglect ▪ Services not provided as specified ▪ Falsified cost reports 	\$	*****

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Purchasing Prescription Drugs. Some drug manufacturers have fraudulently gamed the rebate structure Medicaid uses to purchase prescription drugs. Practices have included marketing the spread, concealing best price and relabeling drugs to evade inclusion of some sales in the calculation of the Medicaid drug rebate. A separate set of cases has involved manufacturers illegally marketing prescription drugs for uses that have not been approved by the Food and Drug Administration. There have also been issues raised with regard to some pharmacies’ repackaging prescription drugs. Drug diversion schemes have involved organizations, some pharmacies, and people who resell prescription drugs. Some of the recent cases involving drug manufacturers have been extremely large, and it has been estimated that total recoveries from Medicaid-related settlements and judgments

involving drug manufacturers totaled more than \$3.8 billion between 2000 and 2006, suggesting that the financial risks in this area are large.

Provider Billing Issues. Some providers have used the billing process to bill for services that were not provided, bill multiple times for services that were provided, falsify signatures and certifications, and “upcode” to obtain higher reimbursement than what would be paid for services that were provided. Some providers have also provided services that are not needed by patients. The frequency of cases involving these practices and the size of some of the settlements and judgments of these cases imply that the financial risks to the program in this area are significant.

Issues Related to Managed Care. The program integrity risks that arise from managed care are different in nature from those that exist in traditional fee-for-service arrangements. Capitated payments provide an incentive to underprovide care, whereas in fee-for-service payment arrangements incentives exist to overbill. Fraudulent practices engaged in by some managed care organizations include underproviding services, irregularities in marketing to and enrolling beneficiaries, and providing fraudulent information during the contracting process. At times some MCOs have been perpetrators of fraudulent or abusive schemes, while at others they have been victims of such schemes, because they, like other insurers, can be subject to fraudulent practices by the providers with whom they contract.

Quality issues in long-term care. Ensuring quality of care is an important program integrity issue throughout the Medicaid program. Over time, there has been an especially close examination of quality of care issues in long-term care. Medicaid is the nation’s largest purchaser of nursing home care, and there have been significant concerns raised by some analysts, particularly the Government Accountability Office, about quality of care and patient safety in some nursing homes. Serious deficiencies in some nursing home care, including instances where nursing homes caused harm or placed residents in danger, as well as cases of patient abuse, have been documented. There has been a concerted, multi-year federal effort focused on nursing home quality. These efforts appear to have helped reduce the rate at which these reported instances occur, but some significant problems persist. Risks to patient well-being can also arise in home and community based long-term care settings.

Other Program Integrity Issues. From the review of the program integrity literature, the risks arising from fraud by beneficiaries appear to be very low, and where such risks do exist, the program’s financial liability and threats to quality of care are slight. Recent Medicaid policy developments, including some changes in the DRA could pose new program integrity challenges. For example, the move toward consumer spending accounts (such as “self-directed” home and community based care and Health Opportunity Accounts) as well as new state options to vary cost-sharing and benefit packages across beneficiary groups and geographic areas in a state can also pose new challenges in monitoring program integrity. New citizenship documentation requirements could make it more difficult for eligible people to enroll in Medicaid, raising a different program integrity concern. Recent movements toward contracting out

some key state administrative functions can also raise program integrity concerns. Finally, New York State's most recent section 1115 Medicaid waiver restructuring the state's health system requires a state for the first time to increase its fraud and abuse recoveries. Encouraging states to do more to promote program integrity fits with Congress and CMS' increased emphasis in this area and sends a strong signal to providers that the state takes program integrity issues seriously. However, there are risks in using state recoveries including potentially fostering an overly aggressive approach to enforcement, making inappropriate determinations of what is fraudulent, or even discouraging prevention of fraud and abuse to facilitate meeting recovery targets.

Implications of the *Medicare* Integrity Program for Medicaid. The new Medicaid Integrity Program is modeled on the existing *Medicare* Integrity Program. Since the *Medicare* Integrity Program was created in 1996, some of its activities have generated a significant return on investment. In addition, since the 1996 inception of the Health Care Fraud and Abuse Control program, the enforcement and prosecution companion to the *Medicare* Integrity Program, recoveries from *Medicare* fraud and abuse cases have increased substantially. Few other measures of these program's successes and challenges are publicly available. One clear challenge to the early implementation of the *Medicare* Integrity Program was to carry out new program integrity efforts in such a way that rules were clear to and perceived as fair by providers. CMS recalibrated its efforts after significant concerns from the provider community were voiced, and Congress set some limits on how the integrity program could be carried out. CMS' efforts at working with the provider community appear to have paid off. Its collaborative work on program integrity with key provider groups has been credited with helping to reduce the *Medicare* payment error rate.

Although the *Medicare* Integrity Program may be a logical model for improving program integrity efforts in Medicaid, its applicability to Medicaid has some clear limitations. First among them is that *Medicare* is entirely federally run, but Medicaid is a state/federal partnership. The split of responsibilities between the federal government and the states – and the fact that states bear most of the responsibility for ensuring program integrity – will likely make it much more difficult to carry out the Medicaid integrity program than it was to increase program integrity efforts in *Medicare*. In addition, managed care has historically played a much larger role in serving Medicaid beneficiaries than it has in serving *Medicare* beneficiaries, and the kinds of program integrity cases faced in a managed care environment are different from those faced in a fee for service environment. Medicaid also serves a much broader population and plays a much larger role in paying for long-term care than *Medicare* does.

The Medicaid Integrity Program creates new opportunities to ensure sound and efficient management of the Medicaid program. Increasing program integrity efforts in Medicaid will likely require a careful and balanced approach, and ideally will be undertaken as a broad effort in which the overall effectiveness and efficiency of the program is maximized and progress is charted toward all of the program's many goals. Targeting efforts to focus on high-risk areas and minimizing efforts in low-risk areas could be critical. These efforts must be balanced with and integrated with program goals

of improving coverage, maintaining access to care, paying providers adequately, ensuring quality care, and enrolling eligible people. Given the variation across state Medicaid programs, collaboration between states and the federal government will be necessary to enhance program integrity efforts and to ensure that state and federal efforts complement, rather than conflict with, each other.

I. Introduction

The Deficit Reduction Act of 2005 launched a new federal program dedicated to improving program integrity in Medicaid. The Medicaid Integrity Program is a substantial new investment in program integrity and creates an opportunity to ensure that the Medicaid program is administered as efficiently as possible. The Centers for *Medicare* and Medicaid Services (CMS) of the Department of Health and Human Services is implementing the Medicaid Integrity Program, and released its first-ever comprehensive plan for ensuring Medicaid program integrity in July 2006.

The Medicaid Integrity Program is a substantial new investment in program integrity and creates an opportunity to ensure that the Medicaid program is administered as efficiently as possible.

Congress created the Medicaid Integrity Program in response to a perception that the program faces significant program integrity challenges. Although government agencies and outside experts have published many reports that identified discrete program management deficiencies or transgressions in the Medicaid program, there have been few systematic reviews of program integrity issues in Medicaid. Because understanding the issues that the program faces is central to developing policies to address them, this paper provides an overview of program integrity issues in Medicaid.

This paper begins by describing the program integrity provisions of the DRA. It then defines program integrity for Medicaid and reviews the measurements of program integrity in Medicaid and *Medicare* that are most commonly used. It reviews some of the challenges that all health insurers face in ensuring program integrity, and discusses some challenges that are unique to Medicaid. It also reviews the areas of Medicaid that are at high risk for fraudulent and abusive activity, suggesting that efforts to prevent fraud and abuse could be targeted to these areas, and identifies some emerging program integrity challenges. Finally, the paper reviews the experience of the *Medicare* Integrity Program, which is the model upon which the Medicaid Integrity Program is based, and discusses the implications of the *Medicare* Integrity Program experience for Medicaid, as well as the limits of applying the *Medicare* experience to Medicaid.¹

A. Methods

There are two primary sources of information employed in this analysis. The first is a large body of publicly available program integrity literature, largely from government sources like the Government Accountability Office (GAO), the Office of Inspector General of the Department of Health and Human Services, and CMS. This included a limited number of reports by outside experts of program integrity issues in health care and Medicaid that were available and pertinent, including the 1996 book on health care fraud by Malcolm Sparrow, *License to Steal: Why Fraud Plagues the American Health Care System*. This body of literature, although large, focuses on almost entirely on fraud and abuse, and within that topic tends to describe relatively discrete issues or individual cases of fraud and abuse. The literature also defines program integrity more narrowly

than the definition that is offered in this paper. Few syntheses that describe these issues in a larger context or present these issues together and assess their relative risks are available. Section III.C. of this paper attempts to do this, using the available literature. This research focused primarily on analyses performed at the federal level; state-specific program integrity reports were not reviewed.

The second primary source of information used in this paper is the expertise of a group of program integrity experts who gathered at a meeting to discuss the new Medicaid Integrity Program convened by the Kaiser Commission on Medicaid and the Uninsured on May 5, 2006, at the Kaiser Family Foundation office in Washington D.C. This group included people with experience managing the Medicaid program and working on program integrity issues at the state and federal levels, as well as outside experts. This invaluable discussion shaped the parameters and issues included in this paper. The definition of program integrity in this paper is the product of the May 5 discussion. Several meeting participants have been an ongoing source of expertise to the author as this paper was being written. All participants in this meeting were offered the opportunity to review and comment on this paper.

This paper does not focus on issues related to fiscal integrity, i.e., the appropriateness of federal payments to states. CMS has over the past several years increased the attention and resources the agency devotes to reviewing state financing arrangements, like those that involve upper payment limits or disproportionate share hospital payments, to ensure that the federal government is making appropriate payments to states. These issues have been reported on in some length in other reports.² Efforts related to Medicaid fiscal integrity have at times created an adversarial relationship between the federal government and states. Medicaid program integrity efforts, in contrast, require a collaborative relationship between the federal government and states.

B. Why Did Congress Create the Medicaid Integrity Program?

KEY POINTS:

In creating the Medicaid Integrity Program, Congress responded to:

- An interest in ensuring that a program of Medicaid's importance and size was operating efficiently and effectively;
- A disparity between the federal resources devoted to *Medicare* program integrity efforts and those dedicated to Medicaid program integrity efforts;
- Concerns raised by the Government Accountability Office that CMS's Medicaid program integrity resources were not appropriate to the size of the program integrity risks, and
- Media reports describing cases of fraud and abuse in some states.

Despite reports by GAO and others, there are still no reliable estimates of the extent of fraud and abuse in Medicaid.

Congress, the Administration, the states and the public have a strong interest in ensuring that publicly funded programs meet their goals and are effectively and efficiently managed. This interest applies to Medicaid, which plays a big role in the health care system by providing care to many of the most vulnerable members of our society. Medicaid provides health and long-term care to more than 50 million low-income people, purchases about one-fifth of all health care services in the United States, and is one of the largest programs in the budgets of the federal government and each state. For its beneficiaries, Medicaid fills in the gaps in the nation’s private, employer-based system of health insurance, serves as the central financing source of long term care, and covers services *Medicare* does not. Medicaid has helped offset recent erosion in employer-sponsored coverage, has been demonstrated to improve access to care for the people it serves, and has pioneered improvements in the health care system, such as home and community based care for seniors and people with disabilities.

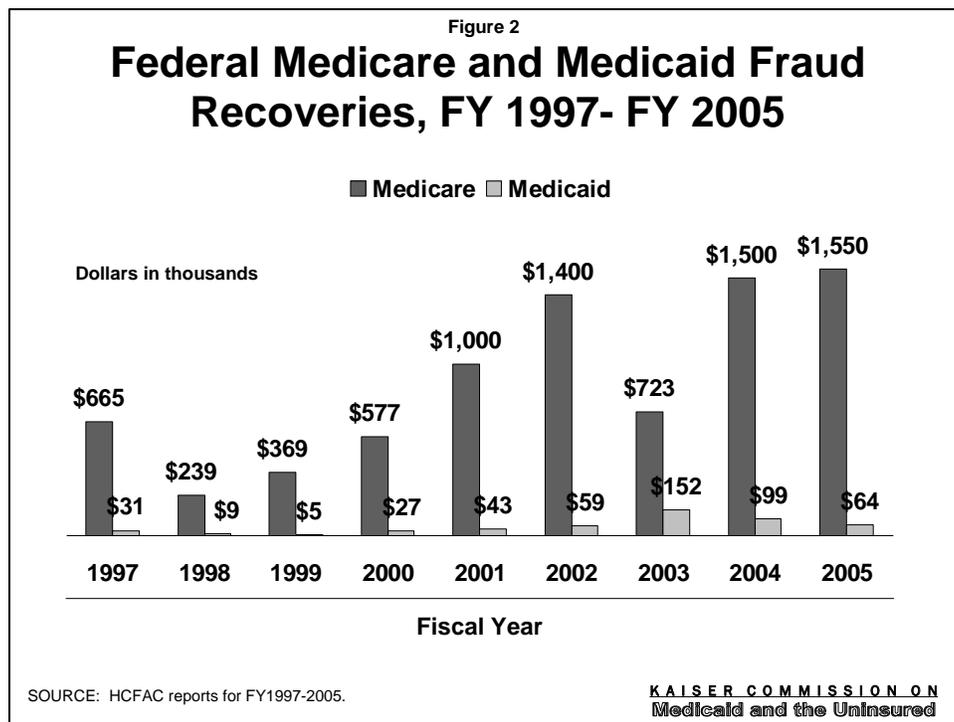
Over time, as the size and importance of public health care programs like Medicaid and *Medicare* have grown, increased attention has been spent on issues related to ensuring the integrity of these programs. In the 1990s, there were significant public allegations of fraud and abuse by some providers in the *Medicare* program. In response, Congress created the *Medicare* Integrity Program, which provided a dedicated funding stream to support the new program, run largely through contractors, to identify and prevent fraud and abuse in *Medicare*. No similar large-scale effort or funding source was developed with respect to Medicaid, although CMS, the HHS OIG, and states had ongoing programs, systems, and staff devoted to addressing fraud and abuse in Medicaid.³

Since then, there has been a significant disparity between the dedicated investment the federal government makes in the *Medicare* integrity program and comparable resources provided to Medicaid. Although there are existing program integrity efforts supported by CMS, like the Medicaid Fraud Control Units, as well as by states, which have their own program integrity programs, Medicaid has not had the type of dedicated investment in program integrity that *Medicare* has enjoyed. At the same time, increasing concerns were expressed by GAO and others that the federal government needed to dedicate more attention to issues of program integrity in Medicaid. There has also been a significant disparity in the amounts of fraud and abuse recoveries between *Medicare* and Medicaid (**Figure 2**). In 2003, GAO placed Medicaid on its list of “high risk” federal programs that have serious program weaknesses in areas that “involve substantial resources and offer critical services to the public”.⁴

GAO identified “inappropriate billing by providers serving program beneficiaries” as a key issue guiding Medicaid’s placement on the high-risk list, and described inappropriate billing as putting Medicaid at “risk of serious financial loss.”⁵

The Government Accountability Office has criticized the low level of federal resources devoted to program integrity as well as a lack of goals for Medicaid program integrity efforts.

Two years later, GAO concluded that “The resources CMS devotes to working with states to fight Medicaid fraud and abuse do not appear to be commensurate with the size of the program’s financial risk.”⁶ In particular, GAO noted that CMS employed only eight full-time equivalent personnel to help states with program integrity in Medicaid and that on-site federal reviews of state program integrity efforts occurred only once every seven years at best. The report criticized the low level of federal resources devoted to program integrity and a lack of goals for Medicaid program integrity efforts.



At the same time, the number of high-profile cases of fraud and abuse in both *Medicare* and Medicaid appear to have grown over time, with large health care providers and drug manufacturers settling allegations of defrauding one or both of these public programs. The dollar amounts of these settlements are substantial, with settlement figures in the millions, tens of millions, and at times hundreds of millions of dollars. In 2005, some media reports described significant cases of fraud and abuse in the Medicaid program in New York State, the nation’s largest state Medicaid program.

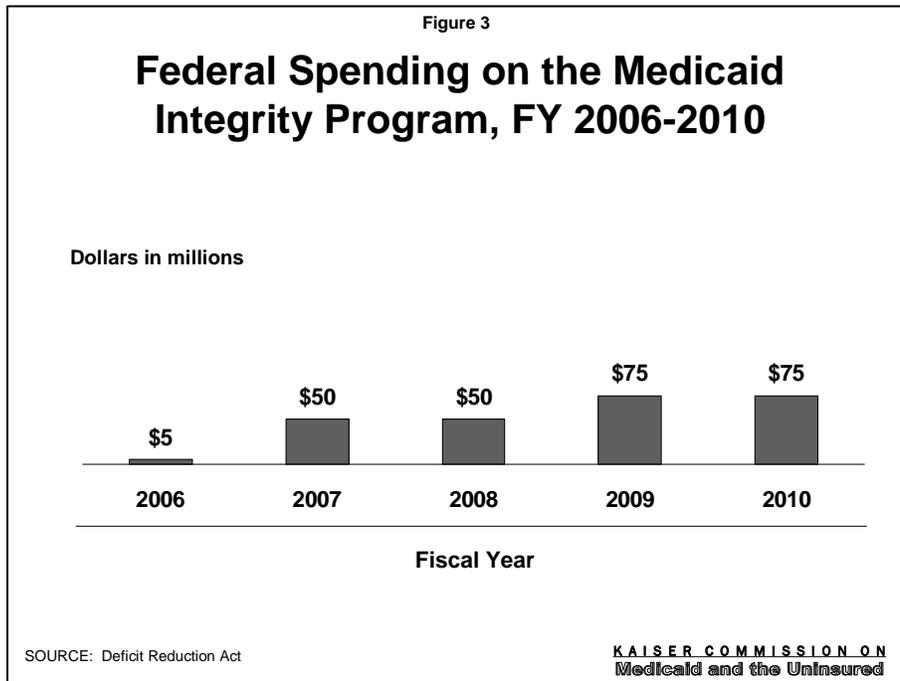
But beyond these individual cases, there is little information available that estimates the size or nature of program integrity issues in Medicaid. There are no reliable estimates of the amount of federal or state dollars that are lost as a result of program integrity challenges. There have been few analyses that identify what underlying program management issues or weaknesses lead to cases of fraud and abuse. Few if any analyses have identified whether program integrity challenges vary state to state or vary significantly between *Medicare* and Medicaid. These estimates and analysis are difficult to perform, in large part because fraud and abuse is difficult to measure. The lack of information about the extent of program integrity problems in Medicaid or what leads to

program integrity problems challenge the development of policy solutions that will prevent or address these problems.

C. The Medicaid Program Integrity Provisions of the Deficit Reduction Act

The Deficit Reduction Act included a package of reforms that were designed to improve the ability of both states and the federal government to tackle issues related to provider fraud and abuse in the Medicaid program. The largest component of these reforms is the Medicaid Integrity Program (MIP), which substantially increases funding, staffing, and contract resources at CMS to help control fraud and abuse. The MIP is modeled on the *Medicare* Integrity Program, which was created in 1996. The DRA does not define what Congress considers “program integrity,” but the language of the MIP provisions of the DRA focus on issues related to provider fraud and abuse.

The Medicaid Integrity Program. The Medicaid Integrity Program provides \$255 million in mandatory funds (meaning that they are not subject to annual appropriations) over five years for new CMS Medicaid program integrity efforts; an additional \$25 million each year is provided to the HHS Office of Inspector General. At the end of five years, funding for the MIP would be set at \$75 million annually (**Figure 3**).



The MIP is to be carried out through two mechanisms. First, it requires CMS to hire 100 new employees to help protect Medicaid program integrity by providing “effective support and assistance to states to combat provider fraud and abuse.” It also gives CMS authority to enter into contracts with entities that will help deal with issues related to fraud and abuse in Medicaid. Contractors can review actions of Medicaid providers to determine whether fraud waste or abuse has occurred. The contractors are authorized to conduct audits, identify overpayments, and provide education for providers and

beneficiaries about program integrity and quality of care (a more detailed description of the program integrity provisions of the DRA is in Appendix A). The DRA also requires CMS to develop a comprehensive Medicaid program integrity plan every five years and to report annually on the effectiveness of the MIP. CMS released its first Medicaid program integrity plan in July 2006.⁷

In addition to the Medicaid Integrity Program, the DRA includes a number of other significant provisions that are designed to improve program integrity:

National expansion of the Medi-Medi Data Matching Project. The law creates a national program coordinating *Medicare* and Medicaid program integrity efforts by matching claims data between the Medicaid and *Medicare* programs. This will enable states, the federal government, and program integrity contractors to analyze billing trends across the two programs to identify patterns of fraudulent activity that are taking place in both programs. This program, the “Medi-Medi Data Matching Project,” expands an existing pilot data matching project that began in California and now operates in ten states. This project has been credited with successfully identifying cases of fraud and abuse that would not have been apparent if only the claims from either Medicaid or *Medicare* were analyzed in isolation. Between 2001 and 2005, the Medi-Medi project generated 335 investigations and \$182 million in potential overpayments.⁸ Forty-two cases resulted in referrals to law enforcement and \$4.7 million in overpayments were potentially recoverable.

The Medi-Medi Data Matching Project has been credited with successfully identifying cases of fraud and abuse that would not have been apparent if only Medicare or Medicaid claims were analyzed alone.

Federal and state officials who have worked in some of the ten pilot states have noted the ability of the Medi-Medi project to help them see the “whole picture” of billing patterns by providers across both programs, build a stronger case against fraudulent providers, better target fraud prevention efforts to high-risk areas, and reduce duplication of program integrity efforts across both programs.⁹ CMS recently noted that “Medi-Medi has provided State and Federal law enforcement and program integrity units with dramatic insights into the overall practices of providers who are exploiting both programs.”¹⁰ The DRA provides mandatory funding for this project of \$180 million over five years, beginning at \$12 million in FY 2006 and increasing to \$60 million in FY 2011.

Fiscal incentive to enact state false claims acts. The DRA also provides a significant new fiscal incentive for states to establish their own false claims acts. The federal government and sixteen states currently have false claims acts, which allow whistleblowers to bring suits in the name of the government against a party who has committed fraud in any government program.¹¹ The federal false claims act is viewed as having been

Since the DRA became law, a number of states have enacted false claims acts with provisions that meet the DRA’s requirements.

successful in fighting fraud and abuse in federal programs and is estimated to have returned more than sixteen billion dollars to the federal government since 1986. The federal false claims act has been used to take on issues of program integrity in federal health care programs, especially the *Medicare* program, where it has recently been estimated that for every dollar spent prosecuting fraud and abuse, the government achieves a return of \$15 in recoveries.¹² The DRA encourages states to enact false claims acts by allowing states to keep a larger share of the recoveries from any false claims cases than states will retain if they do not have a false claims act.¹³ States with false claims acts will receive the state share of any false claims act awards related to Medicaid cases increased by ten percentage points. Since the DRA became law, a number of states have enacted false claims acts with provisions that meet the DRA's requirements.

Grants to states for program integrity and efficient management. The DRA also funds new "Medicaid transformation grants" that can be used to undertake activities, including program integrity changes, that improve the "efficiency and effectiveness" of state Medicaid programs. The activities that these grants can fund include "methods for reducing waste, fraud and abuse under Medicaid" as well as increasing use of generic drugs, improving use of electronic health records to reduce patient error rates, and medication risk-management programs.¹⁴ Total funding for these grants is \$75 million in each of FY 2007 and FY 2008; the first set of grant awards was announced in January 2007.

The DRA also includes program integrity provisions aimed at improving enforcement of third party liability requirements and prohibiting double billing for the ingredient cost of outpatient prescription drugs.

The new Medicaid Integrity Program gives the federal government an opportunity to set priorities for ensuring program integrity in Medicaid, target significant new resources appropriately, and hire and deploy staff to high priority areas. As the Government Accountability Office, which has been critical of the lack of attention and resources dedicated to Medicaid program integrity, noted shortly after the enactment of the DRA, "Planning for, and implementing, the DRA provisions provide CMS with a unique opportunity to strengthen its leadership of state and federal efforts to control fraud and abuse in the Medicaid program."¹⁵

In July 2006, CMS released its comprehensive Medicaid Integrity Plan for fiscal years 2006 to 2010.¹⁶ The plan notes that the Medicaid Integrity Program "represents CMS' first national strategy to detect and prevent Medicaid fraud and abuse in the program's history." In the plan CMS articulated four key principles for carrying out the Medicaid Integrity Program: 1) national leadership; 2) accountability for the program integrity activities of CMS and its contractors; 3) collaboration with internal and external partners and stakeholders; 4) flexibility to deal with the changing nature of Medicaid fraud. In a statement that accompanied the release of the plan, then-CMS Administrator Mark McClellan said that he expected CMS' new efforts at improving program integrity to "yield significant savings to help sustain the program."¹⁷

II. What is program integrity?

KEY POINTS:

- Program integrity is a critical component of program management and should help support key program goals.
- Program integrity in Medicaid means setting policy and managing the Medicaid program to ensure that health and long-term care services are provided to beneficiaries as effectively and efficiently as possible. Program integrity should ensure that quality health care to low-income people or state and federal tax dollars are not being put at risk through violations of the rules or abuses of the system. It should specifically ensure that the correct payments are paid to legitimate providers for appropriate and reasonable services provided to eligible beneficiaries.
- All elements of policy design and program management are important to ensuring program integrity.
- The program integrity literature employs a definition of program integrity that is much more narrow than this definition. This more narrow definition tends to focus exclusively on “fraud and abuse” and emphasize enforcement and prosecution.
- Narrow definitions of program integrity risks emphasizing enforcement rather than prevention.
- Narrow definitions of program integrity also isolate program integrity from other program management functions, which makes coordination and recognition of tradeoffs among competing goals more difficult.

A. Defining Program Integrity

Program integrity is a critical component of program management. Program integrity efforts should operate within a holistic approach to program management. Ideally, program management’s goal is ensuring that the public can have confidence that a government program is serving its target population effectively, fulfilling the purpose for which the program was created and is maximizing the return on taxpayers’ investment in the program, with minimal waste. In Medicaid, program integrity efforts could support this approach by helping the program achieve some key goals, helping to guarantee that:

- Beneficiaries are receiving high quality care, and health and long-term care services provided under Medicaid are appropriate and meet beneficiaries’ needs;
- Providers are receiving appropriate payment for providing care to Medicaid beneficiaries;
- Providers who provide care to Medicaid beneficiaries meet basic participation standards established by the state;

- Providers and beneficiaries receive clear guidance describing program rules and requirements;
- People who are eligible for Medicaid are enrolling in the program and doing so appropriately;
- Payments and services meet the requirements that are established in state and federal law.

Defining program integrity. This paper defines program integrity in Medicaid as setting policy and managing the Medicaid program so that health and long-term care services are provided to beneficiaries as effectively and efficiently as possible. Program integrity should ensure quality health care to low-income people and prevent state and federal tax dollars from being put at risk through violations of the rules or abuses of the system. More specifically, program integrity should ensure the correct payments are paid to legitimate providers for appropriate and reasonable services provided to eligible beneficiaries. Program integrity should also help ensure that the quality of the care that Medicaid finances is provided in accordance with generally accepted medical practices, promotes the health and well-being of Medicaid beneficiaries, and is safe. Program integrity should also minimize errors, whether they are mistakes that result in inappropriate provision of services or inappropriate denial of services. Errors are far more common than activities that are specifically fraudulent or abusive.

Achieving this definition is a complex undertaking that involves all aspects of program management, from policy development to day to day operations. Nearly everything a program does has an impact on program integrity, and all policies and activities can either increase or decrease vulnerabilities to waste, fraud and abuse. This includes claims processing, coordination of benefits, provider enrollment, provider education and guidance systems, provider payment, quality assurance and clinical management, as well as audits, identification and investigation of aberrant behavior and referral of suspected cases of fraud and abuse to appropriate enforcement and prosecution agencies. Program integrity requires having all available and appropriate policies in place so that the overall program is operating effectively and efficiently, including but not limited to preventing fraud and abuse from occurring in the first place and going after it when it does take place.

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This program integrity definition is broader than the definition that is typically employed. Frequently, program integrity is defined much more narrowly. Some define program integrity solely as activities whose purpose is to address fraud and abuse. Others defined program integrity even more narrowly, focusing almost exclusively on cases of fraud and abuse and civil and criminal misconduct that result in large recoveries or settlements for the government. In this definition, program integrity is equated solely as

enforcement of laws and rules and prosecution of those who have allegedly violated these rules. Although this is an important component of program integrity, it is not program integrity per se.

But focusing solely on enforcement of the rules and prosecution of cases in which program rules have been violated misses the much larger picture of managing a program so that care is provided in an appropriate and efficient manner and in a way that prevents quality care and public funds from being placed at risk. In this larger picture, preventing violations of program integrity and avoiding inappropriate costs is at least as important as enforcement of cases of fraud and abuse, even if the monetary effects of these efforts are harder to quantify.

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The Deficit Reduction Act does not define program integrity, but the resources it assigns to HHS are focused on reviewing actions of and auditing providers to identify waste, fraud and abuse, identifying overpayments and educating providers and beneficiaries about payment integrity and quality of care. The DRA also provides resources to help CMS support states' efforts at combating provider fraud and abuse.

This paper employs the broad definition of program integrity offered above. However, since the definitions of program integrity that are commonly used are much more narrow, parts of this paper that reflect the research literature on program integrity reflect that narrow definition. Sections II B and III of this paper, especially, reflect a definition that is more narrowly focused on "fraud and abuse" because they rely on existing products that employ this definition.

Viewing program integrity narrowly, as either "addressing fraud and abuse" or "enforcing and prosecuting fraud and abuse" segregates these goals from other program management goals with which preventing and prosecuting fraud and abuse competes. This segregation can make effective program management much more difficult, because policies can be put in place that are exclusively designed to protect against fraud and abuse but undermine other important program goals like access to and quality of needed care. Conversely, policies designed to improve other areas of the program need to take into account the need to protect the program from fraud and abuse.

Coordinating policies and making tradeoffs among them is an important overall goal of program management, particularly for a program as large and complex as Medicaid. Tensions exist between program officials and fraud control officials. The former tend to value effectiveness and efficiency, while the latter emphasize avoiding problems and risks.¹⁸ In health insurance, efficiency and speed compete with the need to prevent the occurrence of bad actors, and with the need to weed out those bad actors when they appear. The best way to resolve this tension may be to do it explicitly, with program managers openly considering and resolving differences between these competing goals.

Although the focus of traditional “fraud and abuse” activities is frequently on reducing costs and generating savings, ensuring overall “program integrity” can involve either increasing or decreasing spending in order to meet program goals. Although program integrity emphasizes cost efficiency and value to the public and taxpayers, and reducing costs can be a means to that end, improving program integrity may at times require increased spending.

Narrow definitions of program integrity overemphasize enforcement and diminish prevention. Even within a universe that defines program integrity solely as combating fraud and abuse, overemphasizing enforcement and prosecution has significant risks. It is at least as important to prevent fraud and abuse from occurring in the first place as it is to prosecute those who commit it. Preventing abuse is significantly more cost-effective than prosecuting it, because prosecution only recovers a fraction of the losses in most fraud cases. More critically, prosecution does nothing to address losses due to fraud that go undetected, or that are detected but cannot be documented to the extent that is necessary to bring a court case.

Preventing losses is far more effective than trying to chase down dollars once they have been lost.¹⁹ Successful prosecution depends on the probability of a perpetrator being apprehended committing fraud, establishing intent, the probability of being prosecuted and convicted, and the likelihood of a serious punishment once convicted. The strained capacity of the criminal justice system, the time and the effort involved in preparing a case as well as the size, scope and complexity of the cases mean that many fraud cases never get prosecuted.²⁰ GAO in 1999 noted, “Our observations on coordination difficulties demonstrate that efforts to detect and prosecute wrongdoing are important but are typically expensive and labor intensive, sometimes with little financial recovery to show for the effort.”²¹

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-- Government Accountability Office

One leading practitioner of identifying and prosecuting cases of fraud, Patrick O’Connell, chief of the Texas Attorney General’s Office of Civil Medicaid Fraud, made a similar point in testimony before Congress on the successful false claims, or *qui tam*, suits the state has recently brought against some drug manufacturers who have been alleged to have engaged in fraudulent practices. “While Texas is pleased to have recovered significant sums of money in these *qui tam* cases, litigation is not the most efficient way to run this system,” according to O’Connell. “The program could have used our hard earned tax dollars to provide more and better services if [state staff] were not tied up in litigation caused by manufacturers who game the system.”²²

A system that focuses exclusively on preventing fraud and neglects enforcement will also suffer. There need to be consequences for violating rules, and prosecution can be an extremely effective deterrent to abusive behavior. The need for a balanced approach to preventing fraudulent practices is one reason experts like Sparrow argue for a problem-solving approach to fraud control, in which cross-cutting teams work not on just individual fraud cases but on identifying priority problems and developing strategies to solve them.

B. How Is Program Integrity Currently Measured?

KEY POINTS:

- Measurements of program integrity are essential to setting priorities and charting progress. But few comprehensive measurements of program integrity exist; more are needed. Existing program integrity measurements tend to focus exclusively on addressing fraud and abuse.
- Currently, program integrity in Medicaid is most commonly measured through the number of cases prosecuted and dollars recovered from fraud and abuse cases. This is a very limited measure.
- Measuring improper payments is a potentially broader measure that could reflect a more holistic definition of program integrity. However, measuring improper payments in Medicaid is significantly more challenging than measuring improper payments in other programs, and concerns have been raised with regard to the implementation of PERM, CMS’s payment error rate measurement program for Medicaid.
- Measures of cost avoidance, while less common, could also be helpful measures.
- Process measures and benchmarks of state activities in key program integrity areas could help CMS and states chart progress. These measures should reflect a broad definition of program integrity, not a narrow one.

The previous section of this paper defined program integrity broadly, stating that it should support holistic efforts of program management and help ensure that health and long-term care services are provided to beneficiaries as effectively and efficiently as possible. It also said that Medicaid program integrity should pay the right amount to the right provider for appropriate and reasonable services provided to beneficiaries, and ensure that quality health care to low-income people or state and federal tax dollars are not being put at risk through violations of the rules or abuses of the system. But program integrity is frequently defined much more narrowly, and existing measures of “program integrity” reflect that narrow definition.

This section of the paper examines existing measurements of program integrity efforts. Measurements are essential to developing appropriate policies and effective administration. To determine appropriate allocation of resources, it is important to know the size of the problem.²³ This section of the paper discusses the benefits and drawbacks of these measurements that are currently being used. There are generally three types of current measures of fraud and abuse: measuring prosecution of cases, measuring program errors, and measuring cost avoidance. In addition, some organizations have employed benchmarks or performance measures of program integrity activities.

Measuring “fraud and abuse” is extremely difficult, and may be impossible. Fraud is by its nature covert, and any measurements report only what has been detected. Furthermore, to measure what is truly “fraud,” without including mistaken allegations of fraud, one must document not the broad universe of fraud cases, but cases that have been successfully prosecuted, because it is only individuals or entities that have been convicted that one can report as having engaged in fraud.²⁴ This frustrates the development of fraud measures and also makes interpreting existing measurements challenging. According to Sparrow, “Nearly every available statistic in a fraud-control environment is ambiguous—at best, ambiguous; at worst, perverse and misleading.” Some activities or outcomes that are easy to measure may in fact be peripheral to program integrity, and too much focus on things that are easy to measure risks missing activities that are critical to ensuring program integrity but whose outcomes are harder to measure.

Sparrow also describes the challenges in interpreting any measurement of the amount or degree of fraud: “If the amount of detected fraud increases, that can mean one of two things: Either the detection apparatus improved, or the underlying incidence of fraud increased. Few organizations can tell for sure which, or how much of each, is happening.”²⁵

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-- Program integrity expert Malcolm Sparrow

Measures of prosecution of fraud and abuse cases and related dollar recoveries.

The most prominent measure of fraud and abuse is to report either the number of fraud and abuse cases that have been brought to court, or the dollar recoveries that have been received once these cases are prosecuted or reach settlement, or both. Some government agencies report this as the primary measure of the success of their program integrity efforts. For example, in their annual report on the Health Care Fraud and Abuse Control program, which funds the *Medicare* Integrity Program and some other program integrity efforts, HHS and the Department of Justice report the number of cases and the amount of judgments and settlements obtained from these cases. In fiscal year 2005, the federal government “won or negotiated approximately \$1.47 billion in judgments and settlements, and it attained additional administrative impositions in health care fraud cases and proceedings,” according to a recent annual report, which also reported that U.S.

Attorneys' Offices opened 935 new criminal health care fraud investigations involving 1,597 potential defendants, and convicted 525 defendants.²⁶

One variation on reporting dollars recovered is measuring the “return on investment” that is generated from fraud and abuse prosecution efforts. Typically, this divides total dollar recoveries from prosecution of fraud and abuse cases by the cost to the government of investigating and prosecuting all cases in a set time period. This measure is employed by the Health Care Fraud and Abuse Control program, Office of Inspector General, and some outside analysts. The DRA requires CMS to develop and report on the return on investment that is obtained through the new Medicaid Integrity Program.

Such statistics, while helpful, are of limited use in measuring program integrity. First, these statistics are aimed at measuring only prosecution of fraud and abuse. They do not capture efforts related to prevention and deterrence of fraud and abuse. In any program that had outstanding program integrity, the number of cases prosecuted, and any recoveries or return on investment would be extremely small. Second, recovery statistics do not describe how much money has been lost to fraud and abuse, but rather how much has been recovered from cases that the government has successfully prosecuted. Finally, it seems impossible to know whether an increase in cases in recovery means that the underlying rate of fraud in a program has increased or whether prosecution efforts have increased in intensity or efficiency.

Even as a measure of the success of enforcement efforts, simply reporting the number of cases brought, convictions, or recoveries falls short. To better measure enforcement efforts, one would want to know the success rate of government efforts at bringing cases (how many cases were successfully prosecuted), how many mistaken cases of fraud and abuse were brought in error, and how effective the government was at obtaining the recoveries to which it is entitled.

Measuring payment errors. Another approach to measuring program integrity is to measure the amount of payment errors, or “improper payments” a program makes. Estimating improper payments can be a useful program integrity tool and is a significantly broader measurement than measuring recoveries or prosecutions. In the past, GAO has advocated that Medicaid begin measuring improper payments as part of its efforts to improve program integrity. “Identifying the dollar amount of improper payments is a critical step in determining where the greatest problems exist and the most cost beneficial approach to addressing the problems,” GAO stated in 2002.²⁷ Similarly, in 2000, a CMS program integrity official testified that “Error rates are essential for accurately determining the extent of improper payments and assessing any improvement in preventing them.”²⁸

Some issues related to requiring a state to increase fraud and abuse dollar recoveries: The recent New York Medicaid waiver

Last year, New York State and CMS agreed to a “Federal-State Health Reform Partnership” Medicaid Section 1115 waiver of federal Medicaid law. The waiver restructures the state’s health care delivery system, in part by reducing excess hospital capacity and moving from institutional to community based care. The waiver includes several milestones that the state must meet. One of these milestones is increasing the amount of dollar recoveries that the state receives related to cases of Medicaid fraud and abuse. The waiver requires that New York increase Medicaid fraud recoveries over the next five years to “at least 1.5 percent of its total Medicaid expenditures for FFY2005,” according to an HHS document. HHS describes current fraud and abuse recoveries in New York as being “less than one percent.” There are specific dollar targets for recoveries that the state is required to meet beginning in fiscal year 2008. If the state does not meet them, the state will be responsible for paying the federal government the difference between the amount the state recovered and the target set under the waiver, within some limits. These targets will reach \$644 million in the fifth year of the waiver. The requirement for the state to increase its Medicaid fraud and abuse recoveries and repay the federal government if it does not meet amounts set out in the waiver is unprecedented.

For the past two years, program integrity issues in New York’s Medicaid program have been the subject of intense media scrutiny. As a result, the state legislature has engaged in extensive debate on how to address program integrity issues in the state’s Medicaid program. The waiver’s recovery requirement of the waiver appears to have helped focus attention on the need for additional program integrity efforts in New York. For example, since the waiver was approved, the state has enacted a false claims act. Moreover, setting state recovery targets will likely lead to a substantial increase in recovery efforts, which will be central to helping New York obtain any significant unrecovered funds that have been lost to fraud and abuse in the state. Increasing recovery efforts also sends a strong signal to providers in the state that the state is serious about addressing program integrity.

However, as a measure to ensure program integrity, there are risks in setting a hard dollar target for expected recoveries. As described earlier in this paper, enforcement is only one piece of a broader program that ensures program integrity, and recoveries are a limited measure of the effectiveness of such a program. Second, the recovery target creates an extremely strong incentive to increase recoveries, one that could encourage investigators to identify as fraud cases that may in fact be questionable. An overly aggressive approach to enforcement could make participating in the Medicaid program more difficult for providers, a concern that was raised by providers during the early implementation of the *Medicare* Integrity Program. The strong emphasis on obtaining recoveries could also discourage or de-emphasize prevention of fraud, because effective prevention discourages fraud and makes recoveries less likely. This would actually undermine program integrity rather than promote it.

CMS is beginning to measure improper payments in the Medicaid program. The new CMS program, the Payment Error Rate Measurement project, will estimate the number of payment errors (both overpayments and underpayments) that are made in Medicaid, based on samples of payments made in a set of states on a rolling three-year basis. PERM was developed at the end of a pilot project in which many states began measuring error rates in Medicaid. Estimating improper payments in federal programs that are

determined to be at high risk of improper payments is required by a federal law, the Improper Payments Information Act of 2002.²⁹ CMS has for many years estimated the improper payment rate in *Medicare* through the Comprehensive Error Rate Testing Program; these rates are discussed later in this paper.

There are several key issues to consider with respect to measuring improper payments:

Improper payments are a significant program integrity issue. Although there are no hard data, it is highly likely that improper payments are more common than activities that are fraudulent or abusive, and that the financial risks from improper payments exceed the financial risks of fraud and abuse. GAO recently observed that “Our work over the past several years has demonstrated that improper payments are a long-standing, widespread, and significant problem in the federal government.”³⁰

Measuring improper payments supports a broad definition of program integrity. Measuring improper payments would help measure progress toward meeting the definition of program integrity that was offered in the previous section of this paper, in contrast with measuring recoveries, which would not. Moreover, improper payment rates measure both underpayments and overpayments, which means that they will identify practices that result in underprovision or underpayment as well as practices that result in overpayment. Claims that were inappropriately denied, providers that were paid too little, and people who were wrongly denied eligibility should be as much of a focus as claims that were inappropriately paid, providers that were paid too much, and people who were incorrectly determined eligible.

Measuring improper payments can be an important program management tool. Reporting error rates can help focus a program manager’s attention at avoiding program integrity risks, because minimizing an error rate requires up-front efforts to prevent fraud and abuse, and is not helped by after-the-fact efforts to recover losses from fraud and abuse. Measuring error rates can help identify high risk areas and target efforts at ensuring program integrity to areas where the errors are highest, helping to steward limited resources. Measuring error rates can also be useful to identify inefficient or ineffective practices, and to track trends over time.

Measuring improper payments is likely to be significantly more difficult for Medicaid than it has been for Medicare. Medicaid’s state-federal structure makes it significantly more difficult to measure improper payments. Calculating error rates depends on the difficult task of correctly interpreting the payment, benefit coverage and eligibility policies of 56 different states and territories. Aggregating error rates across states to estimate a national error rate can also be challenging. Obtaining a sample size that is adequate to estimate improper payments precisely within any one state will be difficult, especially for smaller states.

In addition, as a means-tested program, Medicaid’s eligibility requirements, which are determined by states within federal standards, are significantly more complex than are

Medicare's. Estimates of improper payment rates in *Medicare* do not include measurements of eligibility errors.

Some of the challenges in measuring errors in Medicaid are reflected in the new PERM program. Some of these issues have been raised in the context of the implementation of PERM, which will develop state and national error rates for Medicaid and SCHIP each year. CMS and states will develop improper payment rates for fee-for-service claims, managed care payments, and eligibility. States have argued that PERM will be burdensome to states, will not accurately interpret state policies, and could overstate actual error rates. States have also voiced concerns about issues related to communication and coordination between states, CMS, and PERM contractors.³¹

What constitutes an “error” in PERM or any error measurement program must be defined precisely and in accordance with policies and their underlying goals, or key policy goals could be undermined. Reporting error rates can have a powerful impact not just on how the Medicaid program is administered, but also on what policies the program adopts. Policies that may achieve program goals but risk generating errors are unlikely to be adopted. Defining and measuring errors could, for example, put some policies that are designed to simplify and streamline the Medicaid eligibility process at risk. States have recently expressed concern that “PERM is forcing some states with presumptive eligibility policies to reconsider such policies which already have been found to streamline Medicaid eligibility and enrollment.”³² For that reason, what constitutes an “error” and any measurement of such an error must be as closely aligned as possible with program policies and support those policies’ underlying goals.

Measurements of improper payments are often mistakenly interpreted as measurements of “fraud and abuse.” Measuring errors is not the same undertaking as measuring fraud and abuse, although it is often mistakenly interpreted as such. Errors include instances of clerical

mistakes, incomplete documentation, mistaken coding, incorrect dates of services, and other errors that are inadvertent or administrative in nature. An

Measuring errors is not the same undertaking as measuring “fraud and abuse,” although it is often mistakenly interpreted as such.

estimated error rate may include some activities that are fraudulent or abusive, but is by no means limited to that. As one CMS program integrity official stated in 2000 during Congressional testimony on error rates, “It is essential to stress that these measurements are of payment errors, most of which are honest mistakes by well-intentioned providers. These are not measurements of fraud.”³³ At the same time, error rates do not capture all instances of fraud and abuse, nor are they intended to. Error rates focus primarily on ensuring that documentation exists and supports the claim that was paid. In cases in which documentation is falsified so systematically that all of the pieces of documentation (claims, medical records, cost reports), support each other, that fraud could remain completely undetected in an error rate estimate.

Measures of cost avoidance. Another approach to measuring program integrity is to measure how policy changes and administrative efforts have helped avoid unnecessary costs. Estimating cost avoidance is a broader and more comprehensive measure of program integrity efforts than is measuring recoveries.

The most prominent example of measurements of avoided costs, although it is not specific to Medicaid, is a semiannual report by the HHS Office of Inspector General. The OIG makes recommendations for changes in policy and management practice to avoid risks and deficiencies that OIG identifies during its investigations and audits. OIG estimates the dollar savings that the recommendations it has made that have been implemented have produced. (The OIG includes both policy changes that are made in legislation and those that are made administratively in its estimates.)

For fiscal year 2006, OIG estimates that the total savings from its recommendations was just under \$36 billion for *all* the programs in its purview, which includes *Medicare*, Medicaid, public health agencies such as FDA and NIH and other parts of HHS such as the Administration for Children and Families. These funds, according to OIG, are “funds that will be available for better use as a result of documented actions taken, including reductions in budget outlays, deobligations of funds, reductions in costs incurred, preaward grant reductions, and reductions and/or withdrawal of the Federal portion of interest subsidy costs of loans or loan guarantees, insurance, or bonds.”³⁴ These avoided costs account for the vast majority of savings that OIG claimed in FY 2006, which according to OIG was a record year.³⁵ Of OIG’s FY 2006 estimate of its savings and recoveries of \$38.2 billion, \$35.8 billion was from savings generated from OIG recommendations. Of the remaining \$2.4 billion, \$1.6 billion was from “investigative receivables” and \$789.4 was from “audit receivables”. OIG also estimates the amount of savings that could be produced if recommendations it has made that have not yet been fully implemented were to be fully implemented.³⁶ Some states estimate the dollar savings from cost avoidance as a result of their inspector general functions.³⁷

Measuring cost avoidance is the only available measure that quantifies the impact of efforts to prevent program integrity risks rather focusing on losses after the fact. Measuring avoided costs can be an extremely useful tool to improve program integrity and focus attention on areas that need improvement. It also helps maintain a management focus on preventive

Measuring cost avoidance is the only available measure that quantifies the impact of efforts to prevent program integrity risks instead of focusing on losses that have already taken place.

efforts, which are more cost effective than are recovery efforts. It can, however be difficult to accurately estimate costs that are avoided. Cost avoidance measurement requires making more complex assumptions and projections than are necessary to report costs that have been actually incurred. In addition, in any such measures, it is essential to make sure that only appropriately avoided costs are measured. It the adoption of new

policies and procedures is resulting in the avoidance of necessary and appropriate costs, these should be reported as well.

Benchmarking program integrity activities. Another approach to measuring program integrity is to measure the activities or processes that an organization or organizations have in place to address program integrity. Although benchmarking activities would provide information only on the process and not on the outcome of different program integrity efforts, it would better measure the level of program integrity effort. This could be especially useful for better understanding states' approaches to ensuring program integrity. The Government Accountability Office in 2004 reported on the number of states that employed some selected program integrity approaches; this is the latest available information on states' program integrity policies. CMS' comprehensive program integrity plan states that CMS will hire a state program integrity assessment contractor that will report on states program integrity efforts by establishing baselines of state activities and "recommending performance metrics and standards against which States' performance may be measured in the future."³⁸ Benchmarking states' program integrity efforts would be especially useful in combination with other program integrity measures that focus on outcomes and measure progress toward program integrity goals.

III. Challenges in approaching program integrity in health insurance, including Medicaid

KEY POINTS:

- Errors are the inadvertent product of mistakes and confusion. Fraud involves an intentional act of deception. Abuse is actions that are inconsistent with acceptable business and medical practice. Of the three, errors are the most common.
- Fraud in health insurance is difficult to detect. This is equally true in Medicaid, Medicare, and private health insurance.
- Fraudulent practices change rapidly, and mutate in response to fraud prevention and enforcement efforts, which makes addressing it challenging.
- Medicaid faces some unique challenges in developing new program integrity measures. These include low provider payment rates, low rates of provider participation and a vulnerable population that has significant health care needs.
- In a time of rising health care costs, effective program integrity measures can be an alternative to other policies to reduce costs, such as reducing benefits or eligibility.

A. Program integrity challenges cut across health insurers

This section of the paper begins by defining fraud, abuse, and error, and describes the challenges in addressing fraudulent and abusive activity that exist across health insurance

programs. It also identifies some unique challenges Medicaid faces that other insurers do not.

Defining fraud, abuse, and error. In examining program integrity issues, GAO distinguishes between fraud, abuse, and error. According to GAO, errors are inadvertent and are generally due to administrative mistakes or misunderstanding of program rules. Fraud is “an intentional act of deception to benefit the provider or another person,” and abuse “typically involves actions that are inconsistent with acceptable business and medical practices.”³⁹ For GAO, all three areas is important.

Most program integrity challenges are shared by all health insurers. Defining, preventing, and dealing with fraud and abuse in the health insurance system is difficult. This is as true for the Medicaid program as it is for other insurers, including *Medicare* and private insurance. Although the GAO definition above is helpful in understanding different types of problems, there can be overlap or gray areas between these problems, and an activity that one person defines as “fraud” can conceivably be described by the person engaging in that activity as “error.” Moreover, program rules and requirements are not always clear or clearly understood, and this can lead to instances of violations that are unintentional but appear fraudulent to program administrators. At times, some questionable practices do not receive appropriate attention from program administrators. This can be interpreted as acceptance by those who engage or are considering engaging in such practices. Gray areas, lack of clarity, and the risks of inattention put the onus on administrators, investigators, and prosecutors to employ program integrity approaches that are transparent, targeted, and allow for the possibility of error.

Health care fraud, like most white collar fraud, is very difficult to detect. At times it is not apparent to patients or insurers that they are being defrauded. This is different in nature from other types of crimes, when victims are aware of a violation and report it so that it can be identified and investigated.⁴⁰ Health care fraud is dynamic and mutates in response to changing efforts to control it. This means that fraud controls can become obsolete quickly. In an environment where approaches to fraud are mutable, it is extremely difficult for states and the federal government to not just keep up but anticipate which approaches to fraud prevention will be most effective at addressing ever-changing fraud. Those seeking to commit fraud also frequently design the fraud so that it eludes the first-level controls that are designed to screen for fraudulent activities. Brian Flood, Inspector General of the Texas Health and Human Services Commission, said: “With the hard-core offenders, it's a constant game of cat and mouse. They study what we catch. They're determined, so they switch over to something else. We learn their technique. They change their behavior. Then we change our technique again.”⁴¹

In addition, all health insurers rely heavily on claims processing systems, which are designed to pay claims quickly and at low cost.⁴² These systems are not set up to detect fraud. Even as such systems increase in sophistication, they will be a limited fraud detection tool, and the need for human analysts to review activity and identify and analyze trends will persist.

Medicaid also faces a few unique challenges. These program integrity challenges face all health insurers, including Medicaid. In addition, GAO has noted that some characteristics of Medicaid make preventing fraudulent and abusive practices difficult. First, as a third-party payer, Medicaid, like other insurers, pays for services that are provided by others and cannot police each claim that is submitted for payment. It is a large program, and though it should be to the maximum extent possible ensuring that it does not pay fraudulent claims, this will always be a challenge. Second, the transience of the Medicaid population, where beneficiaries' eligibility status changes frequently and causes individuals to go off and on the program, makes Medicaid a potential target for fraud and abuse schemes in which providers bill for services that are provided to ineligible individuals.

Third, Medicaid provider rates are generally lower, and in some cases much lower, than those of *Medicare* or other insurers, which has made some program administrators reluctant to impose additional program integrity requirements that could be perceived as unduly burdensome out of fear of depressing provider participation.⁴³ With some recent evidence indicating that provider participation in Medicaid is diminishing and access to care is being compromised, this concern may be especially strong right now.⁴⁴ Finally, the population of low income children, parents, seniors, and people with disabilities that Medicaid serves is vulnerable, and as a result policies that are intended to tackle program integrity issues that also make enrolling in the program or obtaining needed services more difficult can have serious ramifications for the people the program is designed to serve.

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Effective program integrity measures may help avoid harmful cost-cutting measures. In health care, effective program integrity measures can help avoid harmful reductions in benefits, eligibility, and provider payment rates, particularly in a time of rising health care costs. According to Sparrow:

“In practice, these less discriminating methods hit the honest and the genuinely needy much harder than the dishonest. Restricting eligibility or reducing benefits has a negligible effect on fraud, because fraud perpetrators can easily adjust their billing patterns and patient lists to fit the new rules. And when reimbursement rates drop, it is the honest providers who take the pay cut, not the crooks. In the major public programs such as Medicare and Medicaid, cuts in reimbursement rates drive away honest providers, who can no longer afford to participate. But dishonest providers compensate by increasing their billing volume.”

Sparrow concludes: “Across the board cuts therefore will have a perverse effect. Genuinely needy patients will be denied services, and honest providers will be driven out of the system...”⁴⁵

B. Who helps ensure program integrity in Medicaid?

KEY POINT:

- In Medicaid, program integrity responsibilities are divided among the federal government and the states. States have most day to day operational responsibilities for ensuring program integrity. The federal role generally focuses on enforcement, prosecution, and oversight.

The Medicaid program is a federal/state partnership in which the states operate the program within broad federal guidelines. Within a set of broad federal parameters, states determine the key elements of their programs. States set the policies that carry out their Medicaid programs (for example, deciding who is eligible, what benefits are offered, and how much providers are paid). States also perform all of the day to day management of their programs, in accordance with the state plan for their Medicaid programs that they submit to CMS and CMS approves.

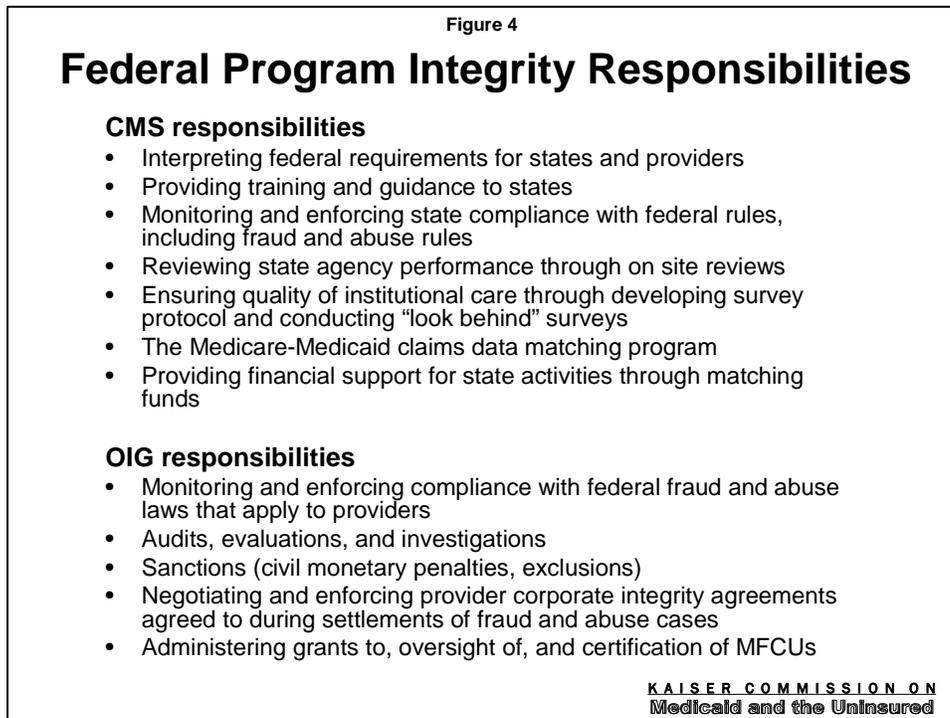
While the federal government has clear responsibilities related to promoting the integrity of the Medicaid program, most of the daily operational program integrity responsibilities reside with the states.⁴⁶

While the federal government has clear responsibilities for helping to ensure the integrity of the Medicaid program, most of the daily operational program integrity responsibilities reside with the states.

Federal program integrity responsibilities. At the federal level, program integrity is the responsibility not only of CMS but of two enforcement agencies, the HHS Office of Inspector General (OIG) and the U.S. Department of Justice (DOJ). CMS's role in ensuring program integrity has historically been one of establishing federal rules for states, interpreting those rules, and providing support and oversight of state program integrity activities. CMS supports state program integrity efforts in its role in the fraud and abuse technical assistance group, a coordinating body CMS sponsors in which states discuss fraud and abuse issues. Although CMS runs the Medi-Medi program, it possesses very few other direct programmatic responsibilities for ensuring program integrity (**Figure 4**). (One prominent exception to this is CMS' role in ensuring the quality of institutional care provided under Medicaid and *Medicare*.) Under the new Medicaid Integrity Program, many of the federal responsibilities will be carried out by contractors.

The HHS OIG and DOJ also have responsibility for monitoring and enforcing federal fraud and abuse laws and prosecuting violations of these laws. The OIG carries out these responsibilities by performing audits, evaluations and investigations, imposing penalties on providers who have violated federal law (these penalties include monetary penalties and excluding providers from participating in the program), and negotiating settlements with providers who are settling allegations of fraud and abuse and wish to continue

participating in government programs. The conditions that govern this continued participation are called “corporate integrity agreements.” The OIG certifies that state Medicaid fraud control units (MFCUs) meet federal regulatory requirements and are eligible to receive federal matching funds, and also oversees MFCU’s activities.⁴⁷



State program integrity responsibilities. States bear most of the responsibility for ensuring Medicaid program integrity on a day to day basis (**Figure 5**). State Medicaid agencies manage nearly all of the processes and systems related to program integrity. States enroll both beneficiaries and providers into the program. They set rates and pay providers. They manage computer systems that are responsible for paying claims as well as other complex data systems, like Medicaid management information systems. States are also responsible for audits and identifying and investigating overpayments or aberrant patterns of behavior by providers. State Medicaid agencies also conduct preliminary fraud and abuse investigations, after which they refer cases to the Medicaid Fraud Control Unit, which are separate units run by the state, usually organizationally part of state Attorneys General offices, that investigate and prosecute cases of provider fraud as well as patient abuse and neglect.⁴⁸ State agencies also license providers, conduct audits, and conduct surveys and certification of nursing facilities. Many states contract out some of these management functions.

Investing in program integrity at the state level can be difficult, as the costs of administering a program well compete with the costs of achieving other goals. A 1999 report on seminars CMS conducted with senior state program integrity officials noted that the discussions that took place “suggest that the nature and magnitude of the Medicaid fraud problem is, in many states, still not properly understood; or, if understood, is not treated as a serious or central issue in program administration.”⁴⁹ In recent years, state

spending on administering the Medicaid program has been cut, and hiring freezes, early retirements, and staff reductions have been imposed in many states.

Figure 5

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”)
- 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
- Nursing facility survey and certification
- States also license providers and conduct audits

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In its budget request for Fiscal Year 2008, the Bush Administration proposed to reduce to 50 percent the matching rate that the federal government pays to states for all administrative activities in Medicaid. Currently, although the federal government pays 50 percent of the costs of most Medicaid administrative activities, it pays a higher 75 percent match rate for some administrative activities, including several related to ensuring program integrity: ongoing costs of operating a state fraud and abuse control unit, performing utilization and quality reviews of hospitals and managed care plans, and performing surveys and certifications of nursing homes. The budget would reduce the matching rate for these and some other administrative functions to 50 percent. If enacted, this would make it harder for states to invest in new or improved program integrity activities.

What program integrity policies do states have underway?

CMS intends as part of implementing the new Medicaid Integrity Program to assess and benchmark states' program integrity activities. There is some limited information already available about state's program integrity efforts. It makes clear that the specific approaches states use to ensure program integrity and address issues of provider fraud and the level of effort that states appear to be devoting to these approaches vary.

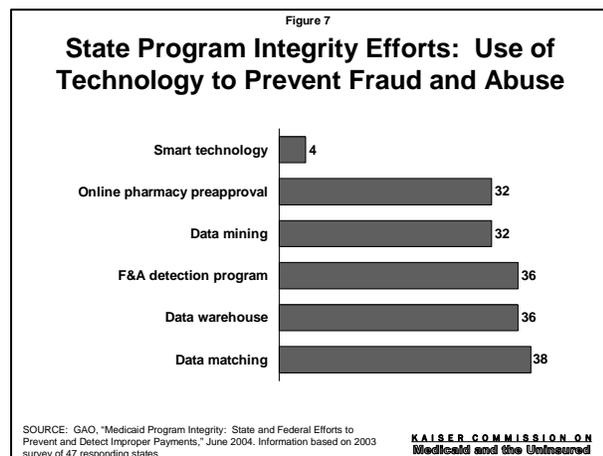
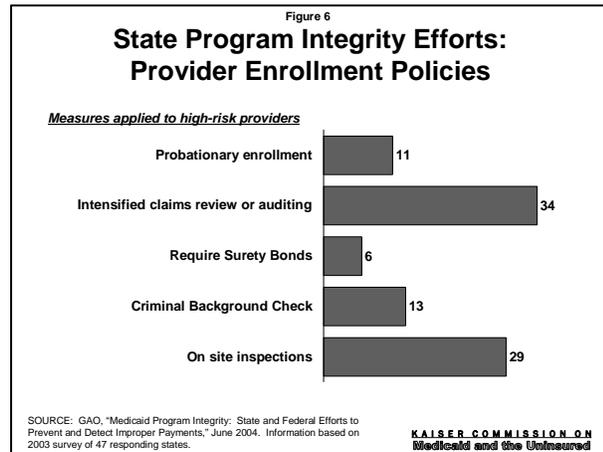
In 2004, the Government Accountability Office surveyed states about program integrity efforts related to appropriate provider billing.¹ All of the 47 states who responded reported that they had one or more policy in place designed to control provider enrollment to prevent unscrupulous providers from participating in Medicaid (**Figure 6**). Those policies ranged from cancelling or suspending inactive provider billing numbers to establishing time-limited enrollment.

GAO also reported that of the 47 states that responded to the survey, 34, or nearly three-quarters, had one or more measures in place to control enrollment of "high-risk" providers.

These measures ranged from on-site inspections of a provider's facility to criminal background checks. However, few states reported that they employed some of the methods of controlling provider enrollment that were likely to be successful. For example, thirteen states reported that they performed criminal background checks on some types of providers that are considered "high-risk" and only six states required surety bonds of some kinds of providers.¹

Moreover, all states except one reported using technology to compile and analyze Medicaid claims and other data to identify fraud and abuse issues (**Figure 7**). Thirty-four states also reported that they conduct claims reviews to try to identify unusual patterns of billing that might indicate fraud or abuse on the part of high-risk providers. Twenty-four states, or about half of the states responding to the survey, reported having legislation mandating sanctions against those who commit fraud.

In addition, a 2003 survey by the American Public Human Services Association to which 33 states responded found that most responding states have processes in place, through audit measures or other systems, to ensure payment and eligibility accuracy.¹ Almost ninety percent of responding states reported that they measure the accuracy of Medicaid fee for service payments, and about half of those states include in their examinations claims for which no payment was made. States also examine medical necessity, third party liability and perform medical record reviews. Most of the states who responded to the survey also measure the accuracy of Medicaid managed care capitation payments, typically involving verification that a beneficiary for whom a capitation payment is made is eligible. Most states also reported that they measure the accuracy of their eligibility determinations through Medicaid eligibility quality control (MEQC) systems.



C. Implications of the Division of Responsibilities Between the Federal Government and the States

KEY POINTS:

- Because so much program integrity responsibility resides with the states, collaboration between the new federal Medicaid Integrity Program and the states will be essential. Collaboration should also include other program stakeholders, including providers.
- Medicaid policy varies dramatically by state. Federal efforts at ensuring program integrity will have to monitor compliance with each state's rules and policies regarding covered benefits, provider payment, and eligibility. An extremely high level of federal-state coordination will be necessary to accomplish this.
- Flexibility will be important so states can tailor program integrity approaches to their individual needs.

The division of responsibilities between the federal government and the states has two broad implications for the implementation of the Medicaid Integrity Program:

Collaboration between the states and the federal government will be essential to the success of the Medicaid Integrity Program. The DRA provided new resources and authorities to the federal government to carry out the MIP. Because the states have the lead responsibility for program integrity, states need to play an extremely active role in any efforts to improve program integrity in Medicaid. Collaboration between the federal government and the states on all aspects of the MIP will likely be critical to efforts to improve program integrity. That collaboration could span the range of activities involved in implementing the MIP, including identifying target program integrity goals for the new program, developing the scope of work and performance standards for the MIP contractors, articulating what states' needs for program integrity support are and how to meet them, and ensuring that federal efforts complement and strengthen the program integrity efforts that states already have underway, rather than conflicting or interfering with these efforts. The CMS comprehensive Medicaid integrity plan discusses the need for collaboration and coordination between the federal government and the states.

Different states have different program integrity support needs. Congress intended the new Medicaid Integrity Program to support states' program integrity efforts, so the program will have to offer flexibility to accommodate program integrity needs that differ substantially across states. Some states may find that the most useful tool they lack in improving program integrity is designing and procuring a new information technology system that helps them identify aberrant billing patterns. Other states may need more investigative tools. Still others will need or want to improve enforcement efforts. Some states may assign priority to educating providers or improving efforts to make sure that providers are properly credentialed. A one-size fits all approach to the Medicaid Integrity

Program would not allow for flexibility in meeting states' different needs. In past comments on program integrity efforts in Medicaid, GAO has noted that "striking a balance between the stewardship of Medicaid and the need for flexible approaches in dealing with 50-plus Medicaid programs is difficult."⁵⁰ One of the federal roles envisioned by the DRA is to provide support for states' efforts to prevent provider fraud and abuse; states should be actively involved in identifying their needs and ways of meeting them as well as ensuring that the new federal support being provided is sufficiently flexible to meet states' varied needs.

To maximize collaboration between the states and the federal government, the program integrity efforts the new Medicaid Integrity Program undertakes need to be separate and apart from efforts related to the appropriateness of federal payments to states. CMS has over the past several years increased the attention and resources the agency devotes to reviewing state financing arrangements to ensure that the federal government is making appropriate payments to states.⁵¹ While these efforts have focused on ensuring the program's *fiscal* integrity, the new Medicaid Integrity Program has as its focus ensuring *program* integrity. As the Government Accountability Office noted, "Financial management and program integrity, while related functions, are not interchangeable.

Financial management focuses on the propriety of states' claims for federal reimbursement... In contrast, program integrity... addresses federal and state efforts to ensure the propriety of claims made by providers."⁵²

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Efforts to address Medicaid fiscal integrity have at times created an adversarial relationship between the federal government and states as they struggle over which party bears financial responsibility for some transactions and services, and as the federal government ensures that the matching funds it provides are obtained transparently and spent appropriately by the states.⁵³ Medicaid program integrity efforts, in contrast, require a collaborative relationship between the federal government and states. This relationship should reflect that responsibility for ensuring program integrity is shared between the federal government and the states, with the states maintaining the lion's share of the day to day program integrity responsibilities. It should also reflect the states' and the federal government's shared interests in maintaining program standards, encouraging appropriate, high quality care, and minimizing financial risks to state and federal treasuries.

Cooperation among federal agencies and communication with stakeholders will also be critical to the successful implementation of the Medicaid Integrity Program. In addition to having a close collaboration among the federal government and the states, it is important that close coordination occur among the different federal players with a role in

assuring program integrity. The Centers for *Medicare & Medicaid Services* (CMS), HHS Office of Inspector General, and Department of Justice (DOJ) all share responsibility at the federal level for ensuring program integrity in health programs, as does the Government Accountability Office (GAO). Under the Medicaid program integrity provisions of the Deficit Reduction Act, consultations among these agencies are required, but consultations alone may be insufficient to ensure the success of the Medicaid Integrity Program. When CMS implemented the *Medicare* Integrity Program, OIG, GAO and DOJ partnered in CMS' implementation efforts, with the active engagement and support of high-level CMS leadership. Having these agencies work together also helped overcome some differences in approach and organizational culture between agencies that focus primarily on providing services and those that focus primarily on law enforcement. Coordination challenges will increase with the hiring of the new Medicaid program integrity contractors, whose work on audits and measuring state program integrity efforts will be separate from but overseen by CMS. Coordination between various federal entities and the new contractors will necessary as well.

The collaboration between federal program agencies and law enforcement agencies should be mirrored at the state level in collaborations between state Medicaid agencies, state Attorneys General Offices, and state Inspectors General, in those states that have them. GAO has documented the extensive challenges that agencies face in carrying out program integrity responsibilities, including staffing levels that are not commensurate with the labor intensive nature of bringing a fraud case, establishing communication across agencies so that criminal prosecutions can be carried out in a timely manner, and reluctance on the part of some state agencies to classify a case as a fraud case. GAO also noted that a federal requirement that agencies repay the federal government its share of any overpayments within 60 days of discovering the overpayment serves as a barrier to interagency coordination.⁵⁴ States support repealing this requirement and instead favor allowing states to repay the federal share of any recovery in the same quarter of the fiscal year in which the recovery is made.⁵⁵

At the state and federal levels, communication and consultation with contractors, provider and consumer groups should take place early in the process of developing new program integrity efforts, so that these stakeholders are aware of and have an opportunity to provide input about new policies and procedures. Provider groups in particular may seek an opportunity to identify concerns about the manner in which proposed program integrity procedures could affect their practices and their ability to provide high-quality care, and to suggest approaches that would minimize administrative burden.

D. What are the challenges in Medicaid program integrity that the program could address?

KEY POINTS:

- To steward limited resources, the Medicaid Integrity Program should allocate resources based on relative risk.
- Financial risks to the program have been highest in the areas of provider billing practices and from risks that arise from Medicaid’s purchasing of prescription drugs, according to a review of the program integrity literature.
- Risks exist to the program in other areas as well, including managed care.
- In addition, there have been significant quality of care issues related to long-term care, particularly nursing home care.
- Program integrity risks from inappropriate or fraudulent activities by beneficiaries are extremely small.
- Programmatic changes such as giving individuals the ability to purchase services with a set allocation of funds and relaxing federal standards for benefits and cost sharing can make it more difficult to ensure program integrity.

One central challenge CMS faces as it implements the Medicaid Integrity Program is to determine which program integrity issues to focus on. This determination could help guide the allocation of limited resources. The Deficit Reduction Act does not list a set of issues that the program is intended to focus on, though it does assign priority to provider fraud.

Targeting high risk areas would help guide effective allocation of limited MIP resources. One approach CMS may consider is to target areas in which the risks are the highest. Targeting potential high-yield areas would be consistent with a suggestion by the Government Accountability Office last year. GAO stated that “In developing its plan, CMS will need to focus on how it intends to allocate resources among activities to reduce program risk to the greatest extent possible...”⁵⁶ Emphasizing high-risk areas and deemphasizing low-risk areas is

consistent with approaches advocated by financial management experts.⁵⁷ It is also consistent with the states’ approaches to deciding how to

GAO stated that “In developing its plan, CMS will need to focus on how it intends to allocate resources among activities to reduce program risk to the greatest extent possible...”

carry out their program integrity efforts. According to an earlier report by GAO: “In general, states target their program integrity procedures to those providers that pose the greatest financial risk to their Medicaid programs.”⁵⁸

However, determining where the risks are highest will be difficult. There has been no comprehensive review to date of the program integrity issues that Medicaid faces, although CMS has engaged a contractor to conduct a program integrity literature review.⁵⁹ The best source for information that describes the program integrity issues that face Medicaid is reports by the HHS Office of Inspector General and the Government Accountability Office. These reports generally describe relatively discrete issues or individual cases of fraud and abuse, rather than estimating the size of the risk that these issues pose to the program as a whole, or assigning priority to focus on particular issues. Additional information is available about settlements and judgments of individual cases that have been brought at either the federal or state level in which people or entities have violated program rules. But, this information is episodic in nature, describing only individual cases without aggregating these cases into clear patterns or themes. Many states track program integrity issues, but vary in the degree to which they report this information publicly. This paper has reviewed many of the above information sources in an attempt to identify where the risks to Medicaid’s program integrity have been highest.⁶⁰

Program integrity risks can be measured both in terms of fiscal risks and in terms of risks to quality of care. Because in most cases fraudulent or abusive practices are not unique to one program or insurer, the review included some relevant program integrity issues in *Medicare* and other insurance programs in addition to Medicaid-specific cases. This review has attempted to develop categories of program integrity risks to Medicaid and presents these categories in rough order of where the risks are high, although a comprehensive review that counted and categorized each case was beyond the scope of this report (**Figure 8**). These risks are measured in two ways:

- In terms of dollar risks, where the fiscal impact of the practices is greatest.
- In terms of quality of care risks to beneficiaries. Some of the significant risks to the program are in areas that are related to quality of care and patient safety. Risks to quality are at least as important as financial risks, though they are harder to measure.

Program integrity can help ensure quality of care. Ensuring that the health and long-term care services that Medicaid finances are provided in accordance with generally accepted medical practice is a significant program integrity issue. Although measuring and improving quality require broad approaches that transcend traditional program integrity

responsibilities, program integrity can monitor care and help ensure that beneficiaries are not receiving substandard care, or care that can be harmful to their health

In Medicaid, program integrity violations that have compromised quality of care have, for example, occurred with regard to providers who provide unnecessary or risky services, drug manufacturers who market drugs “off label” for unapproved use, putting some patients at risk, and managed care and institutional care providers who are paid for providing a set of services to beneficiaries but fail to do so.

or well-being. In Medicaid, program integrity violations that have compromised quality of care have, for example, occurred with regard to providers who provide unnecessary or risky services, drug manufacturers who market drugs “off label” for unapproved use, putting some patients at risk, and managed care and institutional care providers who are paid for providing a set of services to beneficiaries but fail to do so. Because the area in Medicaid in which the closest examination of quality of care issues has been conducted is long-term care, this paper devotes attention to quality in this context, but quality of care issues arise in many other areas as well.

Figure 8

Key risks in Medicaid Program Integrity

Provider Type	Risky Practice	Fiscal Risks	Quality of Care Risks
Drug Manufacturer (primarily)	Abuses related to Medicaid’s purchasing of prescription drugs	\$\$\$\$\$	**
Hospitals, physicians, DME suppliers, clinical labs, pharmacies, home health, transportation	<ul style="list-style-type: none"> ▪ Billing Fraud ▪ Providing Services that are not medically necessary or that compromise quality of care 	\$\$\$\$	****
Managed Care	<ul style="list-style-type: none"> ▪ Underproviding services ▪ Inappropriate beneficiary marketing and enrollment practices 	\$\$\$	***
Long-term Care	<ul style="list-style-type: none"> ▪ Patient abuse and neglect ▪ Services not provided as specified ▪ Falsified cost reports 	\$	*****

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Finally, the descriptions of the risks in this section are largely based on individual cases of fraud that have been described in the program integrity literature. The practices and cases described in this section are significant and employed by a subset of providers but not necessarily widespread. While the nature of fraud makes it difficult to know the extent to which particular fraudulent practices are occurring, it is clear that not all providers are engaging in the types of practices described here.

1. Program Integrity Issues Related to Provider Billing Issues

Fraudulent billing practices. Many of the program integrity cases that have been brought under Medicaid and *Medicare* involve issues related to fraudulent billing by some providers. According to the HHS Office of the Inspector General, “One of the most common types of fraud perpetrated against *Medicare*, Medicaid and other Federal health care programs involves false claims for reimbursement.”⁶¹ Referring specifically to Medicaid, GAO noted that “State Medicaid programs have experienced a wide range of abusive and fraudulent practices by providers.”⁶²

These practices include:

- 1) Billing for services that were not provided, including adding services that were not provided onto a claim for legitimate services that were provided;
- 2) Billing multiple times for services that were provided;
- 3) Billing for procedures for which reimbursement is higher than it is for the services that were provided to the patient (which is referred to as “upcoding”);
- 4) Billing for services provided by unlicensed or untrained personnel;
- 5) Providing false certifications and information in the process of claiming reimbursement, including forged signatures on documents like certificates of medical necessity and forged beneficiary signatures on forms.⁶³

Fraudulent billing schemes cut across types of providers. Some hospitals, physicians, therapists, nursing homes, durable medical equipment providers, pharmacists, laboratories, transportation companies, and other types of providers have all been described in cases and reports as having engaged in one of the above practices with respect to Medicaid, *Medicare*, or both programs. These cases put a significant amount of public funds at risk, and undermine public confidence in health care programs.

Fraudulent billing schemes can be extremely complex and can involve manipulating beneficiaries or creating fictitious beneficiaries. One variation on billing for services not provided is the “rent a patient” scheme, in which recruiters identify and organize individual beneficiaries to visit a provider, which may be a phantom provider organized by a criminal. Alternatively, the recruiter will persuade or pay a beneficiary to provide their insurance identification number. The beneficiaries may or may not receive any services from that provider, but the provider generally bills for more services than were actually provided. The recruiters receive payment for each beneficiary they bring in to the provider, and sometimes pass part of this payment on to the participating beneficiary. At times, licensed providers will be paid to falsely attest that services described in a patient’s chart were provided.⁶⁴

Providing services that are not medically necessary or that compromise quality of care. Providers that violate program integrity standards around billing issues also frequently violate basic quality standards and can pose significant risks to patients’ health well-being. Some program integrity cases have involved instances where some providers systematically provide and bill for services, therapies, equipment, laboratory tests, etc. that are not needed by the patient, or provide more treatment than is necessary or appropriate for a patient’s particular diagnosis. In some cases, doctors or dentists have billed for large numbers of services that were not medically necessary, at times providing beneficiaries or their family members with money or gifts when the beneficiary receives services. Some transportation companies have billed *Medicare* and Medicaid for

transportation services that were not medically necessary. Some providers of durable medical equipment have been found guilty or been charged with submitting claims for services like wheelchairs, prosthetic and orthotic devices, hospital beds, and other equipment that were never received by beneficiaries. Some cases have involved falsifying physician signatures certifying that the equipment was medically necessary. In such cases, the health of beneficiaries as well as the quality of care provided to beneficiaries is placed at risk through the provision of these medically unnecessary services. In Medicaid, quality of care issues in long-term care settings has been closely examined, and the evidence in this area is discussed later in this section of the paper.

While the exact amount is unknowable, it seems likely that the amount of federal and state funds that are placed at risk through fraudulent provider billing practices, payment for unnecessary care, and inappropriate financial arrangements is large. There have been a number of large settlements involving providers who have fraudulently billed *Medicare*, Medicaid, or both programs. For example, the single largest settlement of health care billing allegations arising from false claims act involves Tenet Healthcare Corporation, which last year agreed to pay more than \$900 million to the federal government to resolve allegations that it submitted *Medicare* claims that were falsified, as well as allegations of upcoding, kickbacks, and inflating its charges beyond the cost of patient care.⁶⁵ This is an unusually large case. While some provider billing cases are small, many are not, and involve millions, tens of millions, and in some cases hundreds of millions of dollars.

2. Program integrity issues related to prescription drug purchasing

Since 2000, there has been a large and growing focus on program integrity issues related to purchases of prescription drugs by Medicaid and *Medicare*. The number of cases and scope of the cases, and the size of the settlements, in cases brought against some drug manufacturers is large.

Many of the Medicaid-related cases against some drug manufacturers involve the structure of how Medicaid buys prescription drugs. A 1990 law established the Medicaid drug rebate program, under which drug manufacturers pay rebates to states as a condition of Medicaid covering the manufacturer's FDA-approved drugs. The rebates for brand name drugs are generally calculated using two prices that participating manufacturers must report to the federal government, the "best price" and the "average manufacturer price" (rebates for generic drugs are based on average manufacturer price alone). CMS administers the drug rebate program and calculates rebates based on AMP and best price data. The drug rebate program governs the payment relationship between Medicaid and the drug manufacturers; pharmacies that fill prescriptions for Medicaid beneficiaries are paid using a different formula.⁶⁶

The types of cases involving Medicaid's purchases of prescription drugs include⁶⁷:

Many of the Medicaid-related cases against some drug manufacturers involve the structure of how Medicaid buys prescription drugs.

Marketing the spread. Some drug manufacturers have been alleged to have sold drugs at discounted rates to pharmacists or physicians. These discounts bring the price paid to these doctors or pharmacies substantially below what Medicaid pays for the drug. The pharmacist or doctor keeps the difference between the discounted price at which it purchased the medication from the manufacturer and what Medicaid pays. The discount is designed to increase sales of the drug.

Concealing best price. The “best price” component of the drug rebate structure is intended to guarantee that Medicaid is receiving the best price available to other purchasers in the United States. Some manufacturers have been alleged to have concealed the accurate reporting of “best price” to Medicaid by excluding discounts that the manufacturers have provided to some other purchasers.

“Lick and stick”/“Private labeling”. This practice involves some manufacturers giving discounts on brand name drugs that they provide to large customers, like health plans or other insurers, then labeling the drug packages such that the labels carry the name or the national drug code number of the purchaser of the drug, not the manufacturer of the drug. This labeling is designed to exclude the drugs from the calculation of the Medicaid rebate.

Illegal marketing. Some manufacturers have settled cases related to illegally marketing prescription drugs for unapproved uses. The Food and Drug Administration approves drugs for specific uses. However, manufacturers are prohibited from marketing or promoting their products for uses other than the uses for which the FDA has approved the drug. This is referred to as “off label” marketing.

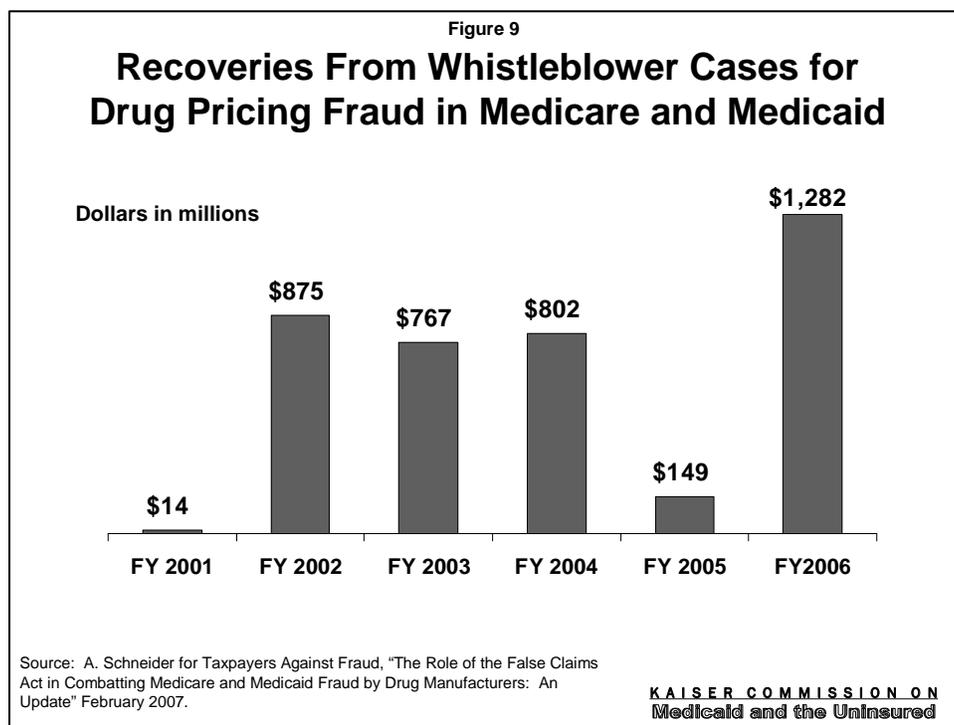
Repackaging schemes. Some pharmacists have illegally resold prescription drug samples after repackaging them. There have also been allegations of some pharmacists importing counterfeit drugs illegally and reselling them. This can compromise quality of care for beneficiaries by providing them with prescription drugs that are out of date or ineffective.

Drug diversion. In drug diversion schemes, beneficiaries are sometimes recruited as participants. Some pharmacists bill insurers, including Medicaid, for prescriptions filled for beneficiaries, but the beneficiaries sell the prescribed drugs to middlemen. The drugs are either resold by the middleman or returned to the pharmacies, where they are later resold at low prices. Those same drugs may ultimately be sold to legitimate patients, despite the possibility that the drugs may have expired, not been stored properly, or lost potency. At times, pharmacists have added medications to beneficiaries’ orders and kept the extra medications or providers have given beneficiaries prescriptions for drugs in exchange for their Medicaid number to bill for prescriptions.

In addition, there is an emerging program integrity issue in the drug purchasing arena regarding Medicaid and other health insurers related to pharmacy benefit managers. PBMs manage prescription drug benefits and negotiate prices for insurers and other third party payers, and some PBMs operate mail-order pharmacies. There have been

allegations that some PBMs have received kickbacks from drug manufacturers have systematically and improperly obtained Medicaid payment for prescription drugs for individuals whose drug costs were intended to be covered by the PBM itself.⁶⁸

Some of the nation's largest manufacturers of prescription drugs, including Pfizer, GlaxoSmithKline, Bayer, Schering-Plough, and AstraZeneca, have settled allegations of violating laws that govern how Medicaid purchases prescription drugs. Settlements related to Medicaid and *Medicare* have ranged from tens of millions to hundreds of millions of dollars, with the largest settlement, in a 2001 case against TAP Pharmaceuticals, of \$875 million.⁶⁹ This case involved both civil and criminal fines, resolving changes that TAP provided free samples of a cancer drug to doctors for which the doctors billed *Medicare* as well as allegations of marketing the spread and not reporting discounted prices given to physicians to the Medicaid drug rebate program.⁷⁰ Between 2000 and 2006, the total recoveries from settlements in federal Medicaid and *Medicare* cases against drug manufacturers was more than \$3.8 billion (**Figure 9**).⁷¹ Additional settlements are likely; it has been estimated that 180 whistleblower cases involving drug manufacturers are currently under seal at the Justice Department.⁷²



3. Program integrity issues related to providing services through managed care

The program integrity risks that are posed by providing care to beneficiaries through full-risk, capitated managed care are different in nature from those that are present when services are provided on a fee-for-service basis. Generally, in fee-for-service arrangements, program integrity risks arise from incentives to overbill to claim more payment. In managed care arrangements, where the managed care organization is paid a

fixed capitation payment by the state Medicaid agency for services that the MCO contracts with the state to manage and provide to beneficiaries, program integrity risks arise from incentives for plans to provide less care than is needed in order to save money. As the GAO has observed, "...Receiving a lump sum payment in advance for each enrollee can encourage dishonest providers to enhance their profits by stinting on patient care."⁷³

At the same time, like other insurers, MCOs are potentially subject to abusive schemes by those who provide services to the beneficiaries the MCO covers. These schemes are similar to those that take place under fee-for-service insurance, such as overbilling, billing for services not provided, kickbacks, etc. In this way, MCOs can be either a victim of fraud and abuse or a perpetrator of fraud and abuse.

Historically, since enrollment of Medicaid beneficiaries in managed care began in the 1990s, some have viewed it as reducing state fraud control responsibilities, arguing that the ability to manage the care of beneficiaries had effectively been delegated to the MCO, and the MCO has financial incentives to control fraud and abuse among the providers with which it contracts.⁷⁴ However, while under managed care the plan, not the state, is responsible for ensuring the integrity of the services of the providers with which it contracts, it does not relieve the state or the federal government of any program integrity responsibilities. Program integrity expert Malcolm Sparrow addressed this point:

"The erroneous belief that managed care provides a structural solution to the fraud problem threatens to strip away existing control resources, even though the new forms of fraud pose significant threats to human health... For payers to assume that managed-care plans themselves will take care of fraud control is utter folly. After all, it is plans themselves that have the greatest opportunities to commit fraud."

In the past, HHS has taken a similar view. In managed care program integrity guidelines for states that CMS issued in 2000, the agency stated,

"Until recently, the risk for fraud and abuse in managed care was thought to be small, as the responsibility for prevention and detection was implicitly transferred to the managed care entity. Purchasers thought that managed care organizations (MCOs) would absorb abusive or fraudulent payments through capitation payments and that strong contract language would prevent the provision of too little service.... Experience contradicts these assumptions."⁷⁵

CMS' guidelines on Medicaid managed care program integrity issues identified several categories of program integrity risks posed by managed care (not all of which are unique to managed care). To paraphrase, the risks CMS identified are:

- 1) *Risks involved in the managed care contracting process.* This includes falsification of information provided in the process of obtaining a Medicaid managed care contract and/or subcontracting for services, including information regarding provider credentials, provider availability, and financial solvency.
- 2) *Risks related to MCO marketing to and enrollment of beneficiaries.* This includes misrepresenting information in marketing to and enrolling Medicaid beneficiaries,

such as enrolling ineligible individuals and claiming Medicaid payment for services provided to them. It also includes selecting healthier beneficiaries and/or avoiding sicker beneficiaries (commonly referred to as “cherry picking”) as well as irregularities in the enrollment process;

- 3) *Risks related to underproviding services.* These risks generally entail failure by an MCO to furnish medically necessary services in accordance with its Medicaid contract, including not providing services or not offering access to services in a timely manner. There are also risks that the MCO will overcharge beneficiaries for any cost sharing or coinsurance obligations or “balance bill” beneficiaries for amounts above Medicaid payment levels;
- 4) *Risks arising from relationships between MCOs and their providers.* This includes the risk that the MCO may withhold or unnecessarily delay payments to providers, as well as risks arising from any financial arrangements that create incentives to underprovide services, direct referrals to certain providers or products, or provide poor quality of care. At the same time, as a payer of providers for services, MCOs are at risk of some of the same types of improper billing schemes that take place under fee-for-service arrangements by the providers with whom they contract.
- 5) *Risks of embezzlement or theft,* including diversion of capitation funds for excessive compensation or excessive administrative costs.⁷⁶

In the late 1990s, fraud cases involving managed care included cases where Medicaid beneficiaries have been charged enrollment fees by individuals purporting to represent an MCO, MCOs have enrolled fictitious people in Medicaid, and individual employees have illegally diverted funds from the MCO.⁷⁷ In the review of program integrity documents undertaken for this paper, few reported court cases or settlements of allegations of MCO fraud were identified after the 1990s, but in October 2006, a jury found the large Medicaid HMO Amerigroup guilty of “cherry picking” – systematically avoiding enrolling high risk Medicaid beneficiaries like pregnant women in favor of healthier clients, and awarded damages of \$144 million, which is the largest false claims act jury award. According to press reports, Amerigroup plans to appeal this verdict.⁷⁸

4. Program integrity issues related to long-term care

Many of the program integrity challenges described in the previous sections either directly involve quality of care, such as providers providing medically unnecessary services, or describe arrangements, like financial incentives for referrals or reselling prescription drugs that have lost their potency, that could potentially lower quality of care.⁷⁹ The risks to

quality of care appear to be considerable: during fiscal year 2003, the most recent year for which such data has

A review of the program integrity literature shows that over time some of the most serious quality of care risks to Medicaid beneficiaries have been documented in long-term care settings, particularly nursing homes.

been reported, the Medicaid Fraud Control Units opened more than 5,000 cases involving patient abuse and neglect.⁸⁰ A review of the program integrity literature shows that over time some of the most serious quality of care risks to Medicaid beneficiaries have been documented in long-term care settings, particularly nursing homes.

Nursing home care is paid for by different insurers, including Medicare, Medicaid, the Department of Veterans Affairs, private insurance and individuals who pay out of pocket. However, Medicaid is the single largest long-term care insurer in the nation and covers about two thirds of all nursing home residents. CMS and the states share responsibility for nursing home oversight, with the federal government playing a larger role in ensuring the quality of institutional care than they do for most other Medicaid providers. This is in response to a history of quality of care issues related to long-term institutional care, as well as the large role that Medicaid and, to a much lesser extent, *Medicare*, play in financing institutional care.⁸¹

For many years, the Government Accountability Office has devoted significant attention to quality of care in nursing homes. Over time, GAO has identified serious deficiencies in nursing home care, including cases where nursing homes caused harm to nursing home residents or placed residents at risk of death or serious injury and delays in investigating serious complaints by residents or their family members.⁸² In several reports, GAO described cases of physical and sexual abuse of nursing home residents.⁸³ There have been several cases in recent years in which nursing homes have settled allegations under the false claims acts relating to patient abuse and neglect.⁸⁴ GAO has on several occasions concluded that there were significant weaknesses in the state and federal inspection and oversight process.

Since the late 1990s, there has been a substantial federal and state effort to improve oversight of nursing home quality. Recently, GAO has noted some progress as a result of these efforts, documenting “a significant decrease in the proportion of nursing homes with serious quality problems, from about 29 percent in 1999 to about 16 percent by January 2005.” However, GAO also noted that state nursing home surveyors still understated serious deficiencies in nursing homes and that a large degree of variation exists between states in the proportion of homes that were found to have serious deficiencies.⁸⁵

There have also, though to a significantly lesser extent, been quality concerns raised with respect to provision of home and community based long term care services under Medicaid. In 2003, GAO reviewed state and federal oversight of quality of care issues in Medicaid home and community based services (HCBS), which until recently were provided by and administered under waivers.⁸⁶ GAO found that CMS provided little guidance to states on HCBS quality assurance approaches and that many state waiver applications contained little information on quality assurance procedures. GAO noted that although CMS “identified few if any specific cases of harm to waiver beneficiaries, the reviews for the majority of waivers serving the elderly with available relevant detail had one or more problems related to quality of care.” These problems included failure to provide necessary services, inadequate assessment of beneficiaries’ needs for care, and

inadequate case management. Despite these concerns, beneficiary satisfaction with home and community-based care has been high. Since the GAO last reported on this issue, CMS has increased its efforts to monitor and promote quality in home and community based services.

The Deficit Reduction Act of 2006 allows states to substantially expand home and community-based services to Medicaid beneficiaries who need long term care.⁸⁷ States can elect to, among other changes, provide home and community-based services to beneficiaries with incomes up to 150 percent of the poverty level as a state option without going through the waiver process.⁸⁸ The DRA also allows states to offer “cash and counseling” programs, under which beneficiaries can use an individual budget to “self-direct” or purchase personal care services as a state option without the state obtaining a waiver. In addition, the DRA created a “money follows the person” demonstration under which states can transition individuals from institution to community-based care. Given this substantial increase in the availability of home and community-based long-term care, it will be essential that the federal government and the states perform adequate quality assurance activities to ensure patient protections.

Beneficiary behavior poses little risk to Medicaid program integrity. The review of the program integrity literature undertaken for this paper identified relatively few program integrity issues related to beneficiary fraud. Fraudulent practices by beneficiaries are not well documented and, when they occur they tend to be small in scale. The risks to federal and state dollars and quality of care from beneficiary fraud are very small relative to the financial and quality risks of fraudulent practices, as documented by recent cases and the program integrity literature, posed by some providers and manufacturers. In explaining why his work has focused on fraud committed by providers, not by beneficiaries, program integrity expert Malcolm Sparrow said: “... providers steal millions of dollars, whereas patients generally only have the opportunity to steal thousands.”⁸⁹

One program integrity risk area in which there appears to be a potentially more significant beneficiary role has been in drug diversion schemes, where prescription drugs are obtained by individuals, including some Medicaid beneficiaries, and then resold to others. Some of these beneficiaries have been actively recruited by organizations and individuals who are working on a larger scale to divert prescription drugs, implying that preventing these schemes would most effectively be accomplished by focusing on dealing with those who organize them. A similar dynamic exists with regard to “rent-a-patient” schemes described in this paper. In contrast, there is little evidence of beneficiary fraud in the area of eligibility. There have been some reports by the HHS Office of Inspector General that document errors or lack of documentation has occurred related to eligibility and the OIG has made some suggestions of improvements in this area.⁹⁰ The issues raised in such reports are not related to enrollment streamlining and simplification, and a recent review of experiences of states that have adopted one simplification approach, self-declaration of income, documents that those states have low error rates, while at the same time increasing enrollment and worker productivity.⁹¹

New challenges are emerging to ensuring Medicaid program integrity. The Medicaid program is evolving rapidly, and at the same time that CMS responds to challenges to program integrity that have existed for some time, it must also ensure that program integrity risks are minimized in areas where the program is growing and changing, and as more discretion is delegated from the federal government to the states. At the same time that CMS is increasing its efforts at ensuring program integrity, a number of new threats to program integrity are arising.

Ensuring program integrity for “self-directed” care and areas in which federal standards are diminished. As mentioned above, Medicaid faces program integrity challenges as states have contracted with managed care organizations for the delivery of health care that is provided to the majority of Medicaid enrollees. In these delivery systems, the state has an indirect relationship with providers in a network. Some new policy changes that further remove the state from a direct contracting role will also pose program integrity challenges.

For example, the DRA allows states to create Health Opportunity Accounts (HOAs) to give individuals the ability to purchase health services under Medicaid with a set allocation of funds. This raises risks regarding maintaining Medicaid benefits standards, ensuring quality of care, and whether the funds that are allocated will be adequate to pay for the services required to meet a beneficiary’s health needs.

In addition, the DRA allows states to implement increased self-direction of personal assistance services without needing a “cash and counseling” waiver. A recent report on cash and counseling services for seniors noted that under cash and counseling programs the locus of responsibility for ensuring quality shifts to the patient. Although states have ultimate responsibility for monitoring quality under this relatively new method of obtaining care, the authors noted, “by choosing to participate, beneficiaries assume some of the risk and responsibility, formerly borne by agency providers, for the quality and adequacy of their care.”⁹² While the cash and counseling program includes some safeguards, it will be much harder to track how individuals make these expenditures and ensure that funds are being spent appropriately, and it will also be challenging to assess if individuals are receiving budgets that are adequate to meet their needs.⁹³

In addition, the DRA allows for variation in benefits and cost sharing rules across beneficiary groups and geographic areas of the state. This move away from a more uniform approach to the Medicaid program within a state will make it more difficult to monitor quality of care, provision of appropriate services, and program integrity. At the same time, the DRA’s citizenship documentation requirement will likely make it more difficult for eligible people to enroll in Medicaid.

Other states have been pursuing statewide demonstration waivers that allow them to receive federal matching funds without following all federal Medicaid rules. The waiver that is being implemented in two counties in Florida moves away from a defined benefits approach to a defined contribution approach. Under the plan, the state would allot each beneficiary a risk-adjusted premium amount and then allow them to choose a health plan

from a group of plans selected by the state. The health plans would have more flexibility to determine what benefits to provide.⁹⁴ This waiver is another example of how states are moving away from directly contracting for patient services and toward increased variation across beneficiaries and areas of the state. Ensuring program integrity in this new arena will be very challenging.

Ensuring program integrity when key state functions are delegated to contractors. Most, if not all, states contract out parts of the administration of their Medicaid programs, particularly for services like claims processing. Recently, some states have started to move toward contracting out key parts of the process of determining beneficiaries' eligibility for Medicaid. In 2005 Texas contracted out much of the process of enrolling and determining eligibility for public benefits, including Medicaid, SCHIP, food stamps, and Temporary Assistance for Needy Families (TANF), at the same time that it made policy changes like making the SCHIP enrollment process more stringent.

After the contract was implemented and these policy changes were made, between 2005 and 2006, approximately 100,000 children lost health insurance coverage in Texas. In some areas, application processing times grew and error rates for some programs increased.⁹⁵ A review by the Texas Comptroller of Public Accounts in late 2006 found that the contract was significantly over budget, fell well short of performance requirements, and caused eligible people to lose public health coverage. The Comptroller's analysis identified significant failures in the state's planning process, contract design, and contract management.⁹⁶ It also found fault with the contractor, Accenture. Earlier this year, the contract was cancelled. Other states are currently considering contracting out their eligibility determination process to private organizations. If they do so, both those states and the federal government will be challenged to make sure that the contract achieves program goals like enrolling eligible people while providing value for the government

IV. The *Medicare* Integrity Program Experience and Its Lessons for Medicaid

The existing *Medicare* Integrity Program is the model on which the newly-created Medicaid Integrity Program is based. This section of the paper describes this program, reviews its successes and challenges to date, discusses the implications of the experience of the *Medicare* Integrity Program for implementation of the Medicaid Integrity Program, and identifies limitations of applying the model of the *Medicare* Integrity Program to Medicaid.

A. What is the *Medicare* Integrity Program?

KEY POINT:

- The *Medicare* Integrity Program, which is ten years old, is the model Congress used in creating the new Medicaid Integrity Program.

In the 1996 Health Insurance Portability and Accountability Act, Congress created the *Medicare* Integrity Program, substantially increasing the resources HHS dedicates to ensuring program integrity in *Medicare*. The *Medicare* Integrity Program required HHS to contract with program integrity organizations to review providers' activities, conduct audits, and educate providers and beneficiaries about fraud and abuse issues.⁹⁷ HIPAA also created the Health Care Fraud and Abuse Control program (HCFAC), which is focused on enforcement and prosecution of health care fraud and abuse cases, and is jointly run by the Attorney General and the Secretary of the Department of Health and Human Services. HCFAC also coordinates federal, state, and local law enforcement activities with regard to health care fraud and abuse.⁹⁸

The *Medicare* Integrity Program and HCFAC are funded directly from the *Medicare* Hospital Insurance Trust Fund. Prior to HIPAA, *Medicare* program integrity activities had been funded from annual discretionary appropriations, where they competed for funding with other administrative activities of the Health Care Financing Administration. The dedication of a set amount of mandatory funds provided a single, stable source of funding for program integrity efforts in *Medicare*. Since 1997, HIPAA has increased funding for antifraud and abuse activities by about 80 percent. Under the law, funds that are obtained from criminal fines, civil money penalties, and other penalties and damages in health care cases are required to be returned to the *Medicare* Hospital Insurance Trust Fund.

HHS describes the purpose of the *Medicare* Integrity Program to “ensure the *Medicare* program pays the right amount to legitimate providers for covered, reasonable and necessary services that are provided to eligible beneficiaries,” according to HHS' annual performance plan for fiscal year 2007.⁹⁹ The program's goals are to identify, eliminate, and prevent *Medicare* fraud and abuse; decrease the submission of abusive and fraudulent claims, and take appropriate administrative action to ensure that appropriate and accurate payments for *Medicare* services are made.¹⁰⁰

B. What have been the *Medicare* Integrity Program’s successes and challenges?

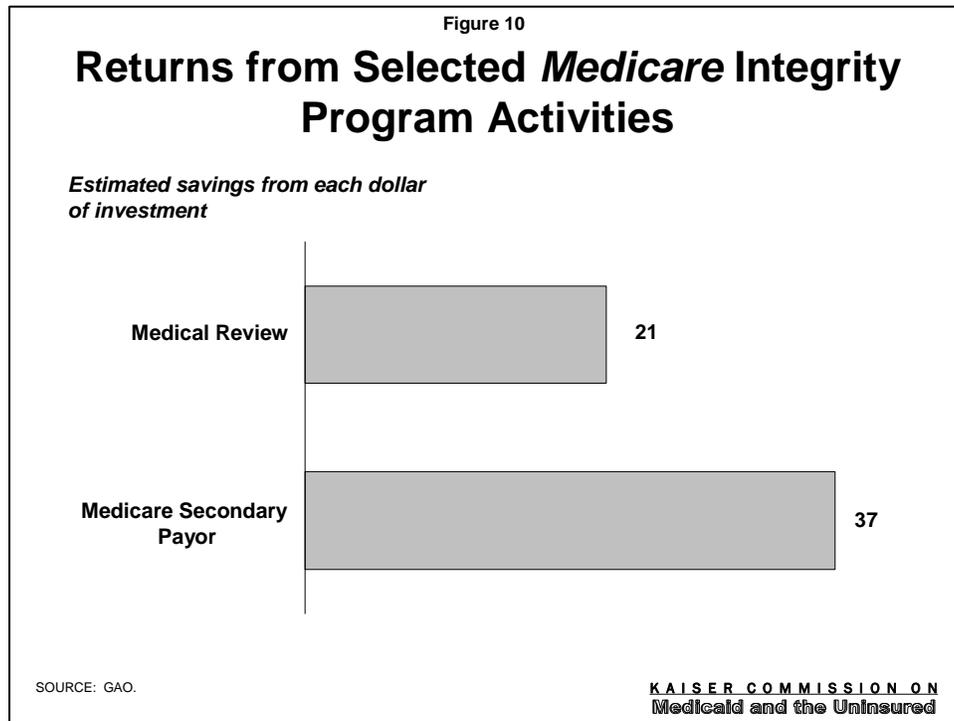
KEY POINTS:

- Since the Health Care Fraud and Abuse Program was created ten years ago, *Medicare* fraud and abuse recoveries have increased dramatically.
- There is also some evidence that the *Medicare* Integrity Program’s medical review and secondary payer activities are generating savings. Since the *Medicare* Integrity Program was created, there has been an increased emphasis on reducing *Medicare* error rates, but measuring trends in error rates is challenged by methodological changes that make comparisons over time difficult.
- The initial implementation of the *Medicare* Integrity Program was challenged by significant concerns from providers about unclear program rules and burdensome requirements.

Since the creation of the *Medicare* Integrity Program, there have been few public reviews of its successes and challenges. Although Congress requires an annual report on the funding and activities of HCFAC, this requirement does not apply to the *Medicare* Integrity Program. To evaluate the successes and challenges of the *Medicare* Integrity Program, this paper reviewed publicly available reports by the Government Accountability Office, testimony by HHS and GAO officials, and some external analysis.

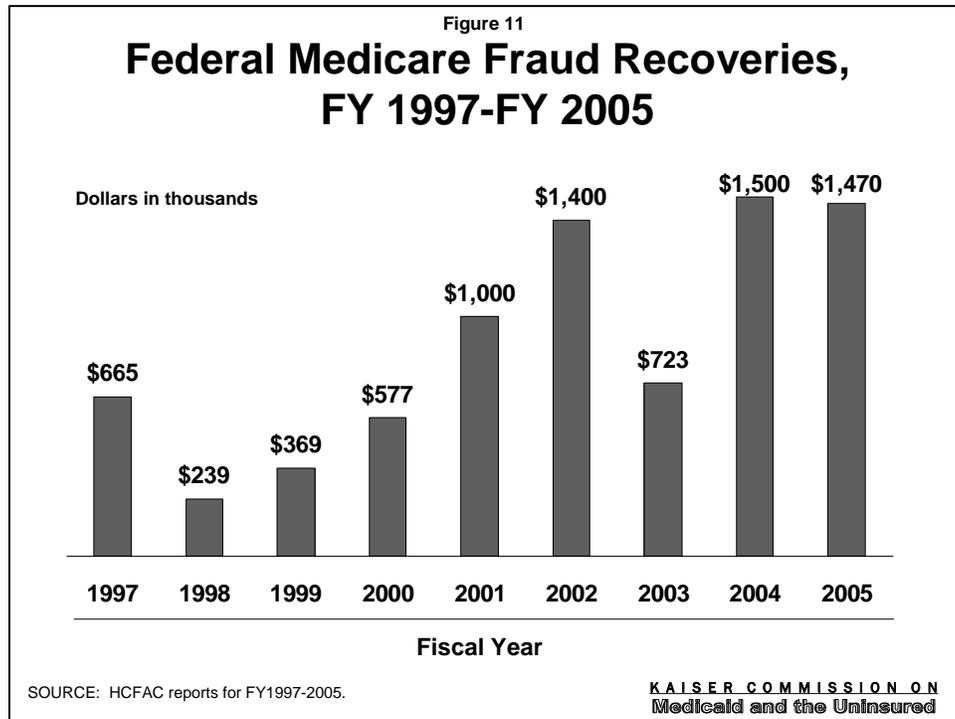
Successes of the *Medicare* Integrity Program. From a review of the available literature, the *Medicare* Integrity Program appears to have increased policymakers’ and public attention on reducing *Medicare* payment errors, or “improper payments.” However, it is difficult to determine whether the *Medicare* error rate has been reduced because of changes that have been made in the error rate methodology. CMS’ recent reports on payment errors shows a significant decline in the *Medicare* improper payments rate, but methodological changes have taken place over time, including a movement of the responsibility for calculating the improper payment rate from OIG to CMS in 2002 and subsequent changes in measurement approach.¹⁰¹ GAO has suggested that the recent decline in the *Medicare* error rate is the result of methodological changes, rather than improved payment controls.¹⁰²

Some MIP activities appear to be generating savings for *Medicare*. CMS has estimated that MIP’s “*Medicare* Secondary Payor” activities account for one-fifth of MIP spending. The *Medicare* Secondary Payor efforts and ensures that parties, like employer or retiree insurers, that have primary responsibility for paying for health care services for *Medicare* beneficiaries, pay claims instead of *Medicare*. This program generated \$37 in savings for every dollar spent. CMS also estimated that MIP’s medical review activities, which analyze and identify billing errors and accounts for slightly over another fifth of MIP spending, generate \$21 for every dollar spent (**Figure 10**). Similar return on investment estimates are not available for the remaining three primary MIP activities, which account for more than half of MIP spending.¹⁰³



Successes of HCFAC. The Department of Justice’s and HHS’ annual report to Congress on the Health Care Fraud and Abuse Control Program is the most significant regular source of public information on any federal activity related to program integrity in federal health care programs.¹⁰⁴ However, because these annual reports cover only the HCFAC program, its findings are relevant only to the government’s enforcement activities, not to the activities of the *Medicare* Integrity Program. These annual reports document the annual amounts returned to the *Medicare* Hospital Insurance Trust Fund from cases the federal government won or negotiated.¹⁰⁵

Returns to the *Medicare* trust fund from health care cases have been steadily increasing, although dollar recoveries in individual years vary (**Figure 11**).¹⁰⁶ The most recent HCFAC report states that as a result of federal enforcement and prosecution of health care cases, more than \$8.8 billion has been returned to the *Medicare* trust fund since 1997.¹⁰⁷ Recent reports by independent analysts have estimated that the returns to the *Medicare* trust fund exceed the amount the HCFAC account spends on civil enforcement costs at HHS and OIG by a ratio of \$15 in recoveries for every \$1 spent on enforcement.¹⁰⁸



Challenges of the Medicare Integrity Program and HCFAC. One of the most significant challenges the Medicare Integrity Program has faced is balancing the need for improved program integrity efforts with the concerns of health care providers. After the implementation of the Medicare Integrity Program, and new program integrity requirements designed to reduce Medicare spending under the Balanced Budget Act of 1997, HHS faced significant concerns from doctors and other providers that the intensified program integrity efforts undertaken by HHS and its contractors made participating in Medicare more difficult. Providers complained that some contractors required more documentation from providers than was required by CMS, that repayment amounts were estimated incorrectly, the appeals process for denied claims was too lengthy, and that the enforcement agencies were generally overzealous in their prosecution of suspected cases of fraud and abuse. Providers also described the information provided by CMS contractors about Medicare billing and coverage rules as unclear and said that it was not provided in a timely manner, making it difficult for providers to comply.¹⁰⁹ These concerns prompted Congress to hold a number of oversight hearings of CMS' program integrity efforts in the late 1990s.

In the late 1990s, HHS faced significant concerns from doctors and other providers that the intensified program integrity efforts undertaken by HHS and its contractors made participating in Medicare more difficult.

In response to these concerns, HHS implemented policies designed to simplify program guidelines and minimize burden, promote fairness and consistency and educate providers to help them better understand program integrity policies. The philosophy behind this approach was described by HHS officials as "Pay it right," referring to the goal of paying

the correct amount on legitimate claims quickly, ensuring program integrity while minimizing administrative burdens on providers. These policies included compliance guidance, development of

In its work improving *Medicare* program integrity, HHS adopted a “Pay it right” philosophy. The goal of this effort was to pay the correct amount on legitimate claims quickly, ensuring program integrity while minimizing administrative burdens on providers.

correct coding policy, and education on how to bill correctly. HHS clarified and simplified rules so that they were easily understood by providers and required contractors to have toll free numbers to respond to questions.¹¹⁰ HHS also began efforts to measure errors at the contractor level, which helps identify variation in contractor efforts and policies. Since then, HHS efforts to provide education have increased substantially. Between 1997 and 2005, MIP funding for provider education increased from \$10 million to \$70 million, and now accounts for about 10 percent of all MIP funding.¹¹¹

In addition, Congress responded to providers’ concerns about the *Medicare* Integrity Program by establishing additional rules by which the activities of the program take place. In the *Medicare* Modernization Act of 2003, Congress consolidated the number of *Medicare* contractors and changed the process by which they are hired. In addition, the MMA restricted the manner in which CMS and its contractors can implement some *Medicare* program integrity activities, including prohibiting retroactive application of new *Medicare* policies, delaying the effective date of new policies, and banning penalties in cases where providers had taken action based on written advice from contractors. The MMA also limited the circumstances under which program integrity contractors may conduct random prepayment reviews of *Medicare* providers or extrapolate from a sample of claims in order to determine repayment amounts and defined hardship requirements and repayment plans for providers who are required to repay a *Medicare* overpayment.¹¹²

In addition, it is clear that as CMS began the *Medicare* Integrity Program, it faced challenges in trying to develop a strategy that would identify priorities for the work of the new contractors who were to carry out the program, the program safeguards contractors, as well as in trying to develop adequate measures of these contractors’ performance. In 2001, the Government Accountability Office said that CMS had been issuing contractor task orders in an “ad hoc” fashion and noted that it took three years for CMS to issue its first program safeguard contractor task order. GAO also noted that CMS lacked “clear, quantifiable performance measures and standards that are linked to defined outcomes.”¹¹³ More recently, an OIG report found that the performance evaluation reports for CMS’ program safeguard contractors contained only limited information measuring contractor’s fraud and abuse achievements, and recommended that CMS include information on the results of contractors’ activities as well as what activities were performed and how effectively.¹¹⁴

C. Implications of the experience of the *Medicare* Integrity Program for the new *Medicaid* Integrity Program

KEY POINT:

- Although the *Medicare* Integrity Program may be a logical model for the new *Medicaid* Integrity Program, and has had some successes, there are limits in applying the *Medicare* model to *Medicaid*. This is due to the different natures of the programs. *Medicaid* differs from *Medicare* in that it is a state-federal partnership, covers different populations, and offers different services, including long-term care. *Medicaid*, unlike *Medicare*, also enrolls most of its beneficiaries in managed care.

In structure and approach, the new *Medicaid* Integrity Program closely resembles the *Medicare* Integrity Program on which it was based. And some of the lessons of the *Medicare* experience clearly carry over to *Medicaid*. At the same time, there are some large differences in the way *Medicare* and *Medicaid* are administered, in the populations the two programs serve, and in the ways beneficiaries enroll in each program and receive health care that need to be taken into account in applying the model of the *Medicare* Integrity Program to *Medicaid*.

1. Lessons from implementation of the *Medicare* Integrity Program

The public record on the *Medicare* Integrity Program's success in achieving savings and reducing errors is not clear. There have been few public reviews of whether the *Medicare* Integrity program has achieved savings for the program. It is clear that the enforcement efforts of HHS, OIG, and DOJ have resulted in recoveries from settlements and judgments that have been returned to the *Medicare* trust fund. Some of these cases also reflect the efforts of the CMS program integrity staff and *Medicare* contractors that have referred cases for investigation. However, this primarily measures the efforts of the Health Care Fraud and Abuse Control Program, which focuses on enforcement and is separate from those of the *Medicare* Integrity Program. No broader reviews have estimated what savings, from recoveries or cost avoidance, have been achieved since the implementation of the *Medicare* Integrity Program. Creating the *Medicare* Integrity program likely deterred some organizations from engaging in program integrity violations, but estimating the extent to which this has occurred is difficult if not impossible. CMS has estimated return on investment from medical review and *Medicare* secondary payor activities, and these results indicate that these two activities can produce significant savings, but quantitative estimates of savings or returns from the other activities are not available. In addition, although CMS has reported that the *Medicare* error rate has fallen over time, GAO has raised questions about whether it is possible to determine whether the rate has declined in light of recent changes in the error rate methodology.

Increased program integrity efforts can generate significant concerns for providers. After the *Medicare* Integrity Program was implemented, providers expressed strong concern that the new efforts were at times making the program more burdensome to participate in and unfairly denying appropriate payments. This raises some potential concerns for the new increased federal program integrity efforts for Medicaid. CMS and states will be challenged to balance intensified efforts to better promote program integrity and combat fraud and abuse with the need to ensure that participating in the Medicaid program does not become difficult for providers or make it more difficult for them to care for Medicaid beneficiaries. The need to maintain the ease of the program for providers is underscored by increasing concerns about the number of physicians who are not accepting Medicaid patients. The rate at which physicians decline to see Medicaid patients is several times higher than it is for *Medicare* or private insurance. In addition, recent data indicate that the number of physicians who do not see Medicaid patients has grown slightly.¹¹⁵

CMS had difficulty striking this balance at the outset of the *Medicare* Integrity Program, although the agency and Congress subsequently reacted to provider concerns by engaging in extensive consultation with provider groups and then making significant modifications to program integrity efforts including provider education, compliance guidance, and efforts to minimizing administrative burdens for providers. Carrying over the *Medicare* work that CMS undertook in response to provider concerns could help ease the implementation of the Medicaid integrity program. In addition, extensively consulting with provider groups as the Medicaid Integrity Program is implemented could be key. In *Medicare*, consultations with providers appear to have both eased provider concerns and helped carry out the Medicaid integrity program effectively. In 2003 the Office of Inspector General credited CMS' work with and the contribution of some provider associations to clarify payment rules and ensure appropriate documentation of claims with contributing to the substantial reduction in the *Medicare* fee for service improper payments rate.¹¹⁶

In 2003 the Office of Inspector General credited CMS' work with and the contribution of some provider associations to clarify payment rules and ensure appropriate documentation of claims with contributing to the substantial reduction in the Medicare fee for service improper payments rate.

2. Limitations in applying the *Medicare* Integrity Program model to Medicaid

It is also important to keep in mind the many limitations inherent in applying the model of the *Medicare* Integrity Program to Medicaid. In one sense, the implementation of the Medicaid Integrity Program will benefit from *Medicare*'s experience: as a result of ten year's experience with implementing the Medicaid Integrity Program, HHS likely has a stronger sense of what significant program integrity issues have arisen in health care, and this experience could help target funds to the highest-yield activities. However, there are large differences between *Medicare* and Medicaid that make the approach used to improve program integrity in *Medicare* difficult to apply to *Medicaid*. These differences include:

Medicaid is largely administered by the states, not the federal government. But *Medicare* is run entirely by the federal government, with assistance from contractors that provide a limited degree of regional variation. The design of the Medicaid Integrity Program will have to fit the federal/state structure of Medicaid, and make sure that the resources it provides both support states in their efforts to promote program integrity and accommodate the diversity of state program rules and requirements. The Medicaid Integrity Program will have to monitor and improve compliance with the policy, rules and procedures of the Medicaid programs that are operated by each of the 56 different states and territories. This will be a major implementation challenge for the Medicaid Integrity Program. It will be extremely difficult for the federal government or its contractors to be knowledgeable about, review, and help enforce the rules of each of these 56 different programs. In addition, the federal government will be challenged not to duplicate state-level efforts. In some areas, particularly in the audit area, states have long had lead responsibility for carrying out Medicaid provider audits. With the federal government possessing significant new audit resources, states and the federal government will need to coordinate audit efforts to make sure that they are not subjecting some providers to multiple audits unnecessarily, which could pose an administrative burden.

Most Medicaid beneficiaries are enrolled in managed care, but relatively few Medicare beneficiaries are. Moreover, nearly all states have contracted out provision of health care services for a significant share of their Medicaid populations to managed care organizations. Just over sixty percent of the total Medicaid population was enrolled in managed care as of 2004, according to CMS.¹¹⁷ (The overwhelming majority of these enrollees are children and non-disabled adults, although some states are increasingly enrolling seniors and people with disabilities in managed care. Although a majority of Medicaid beneficiaries are enrolled in managed care, Medicaid spending is not heavily concentrated in managed care, because children and non-disabled adults tend to be less expensive to care for on a per enrollee basis than are seniors and people with disabilities.) This statistic includes beneficiaries who are enrolled in primary care case management programs, in which the state pays a primary care doctor a “gatekeeping” fee for providing primary care and managing beneficiaries’ access to specialty and hospital care, as well as beneficiaries who are enrolled in managed care organizations.

In managed care delivery systems, the state pays a capitated amount to a managed care organization which then employs or contracts with providers in a network. So, unlike a fee-for-service environment, the managed care entity rather than the state has a direct relationship with the providers. This creates overlapping program integrity responsibilities. The state bears responsibility for ensuring that MCO benefits are accessible and meet quality standards, and that coverage determinations are consistent with the state’s requirements. Over time, managed care has posed challenges to states in terms of monitoring service use and quality of care provided to beneficiaries who are served through MCO arrangements.¹¹⁸ The MCO is responsible for ensuring the integrity of the care provided by providers with whom the MCO contracts. In contrast, managed care currently serves less than 20 percent of *Medicare* enrollees, though the proportion of *Medicare* beneficiaries enrolled in managed care has recently been increasing.¹¹⁹ The

Medicare Integrity Program has therefore only to a very limited focus on issues related to managed care organizations. However, as enrollment of *Medicare* beneficiaries in MCOs increases, CMS is expanding its emphasis and developing new approaches to ensuring program integrity in a managed care context. New Medicaid program integrity efforts will also need an increased emphasis and more sophisticated approaches in this area.

Differences in populations served and services offered. Relative to Medicaid, *Medicare* serves a more limited population and offers a more limited range of services. People age 65 and over and people with significant disabilities are eligible for *Medicare*, but Medicaid, a means tested program, serves seniors, people with disabilities, children, parents, and some adults. In addition, while *Medicare* focuses primarily on acute care services, Medicaid offers a more comprehensive benefit package, and in particular is the nation's primary source of long-term care coverage. The techniques that have been used to improve program integrity in *Medicare* may need to be modified to apply to the different set of services offered and providers who participate in Medicaid. One major area of difference includes Medicaid's extensive home and community-based care programs, which have operated under many individual waivers and therefore differ significantly not just state to state but even within states. Moreover, Medicaid has increasingly offered "money follows the person" options for states, under which beneficiaries are given a set amount of funds with which to choose providers and services. Developing program integrity approaches, including ensuring consumer protections, is challenging with respect to these programs.

Conclusion

The new Medicaid Integrity Program is an unprecedented opportunity for the federal government to promote program integrity in Medicaid by supplying significant new financial and organizational resources to CMS for the sole purpose of addressing program integrity issues. This paper defines program integrity as ensuring that health and long-term care services are provided to beneficiaries effectively and efficiently, with a goal of ensuring that quality care and tax dollars are not being put at risk through violations of the rules or abuses of the system. A critical component of this is ensuring that the right payments are being made to legitimate providers for appropriate and reasonable services that are provided to beneficiaries. Program integrity is a critical part of program management, which should ensure that the public can have confidence that a government program is fulfilling its purpose and maximizing the return on the taxpayers' investment in the program. Program integrity can also help achieve key program goals.

Meeting the goals set in the definition of program integrity is a complex undertaking that involves all aspects of program management, from policy development to staffing to day-to-day operations. The definition of program integrity that is traditionally employed by government and experts is considerably more narrow than this holistic definition, and tends to focus exclusively on issues related to "fraud and abuse." Using this more narrow definition and focusing solely on fraud and abuse without taking into account the larger aspects of managing a program makes it much more difficult for legislators and program managers to develop effective policy that takes into account tradeoffs among competing program goals or effective coordination of policies in different program areas. Evaluating tradeoffs and coordinating different policies and management areas is especially important in a program as large and complex as Medicaid.

There are few measurements of program integrity, and those measurements that do exist are not based on the more holistic definition of program integrity offered in this paper. Existing measurements focus much more narrowly on issues defined as "fraud and abuse," but even these measures are limited in measuring progress toward preventing and controlling fraud and abuse.

The challenges the Medicaid program faces in ensuring program integrity reflects program integrity challenges common to all health insurers. Insurers work to provide needed health services to people they cover with maximum effectiveness and efficiency, and eliminating fraud and abuse is just one piece of this puzzle. At times anti-fraud efforts compete or conflict with efforts to enroll people efficiently, pay claims quickly, and have services available as people need them. Third party payers grapple with ensuring quality and eliminating fraud in services that they do not provide themselves and instead pay others to carry out. Moreover, fraud is mutable and fraud tactics morph in response to efforts to prevent them.

In addition to the challenges in ensuring program integrity that cut across insurers,

Medicaid faces some unique challenges. Both because Medicaid is means-tested and the population it serves tends to be transient, Medicaid beneficiaries go on and off of eligibility rolls more frequently than a privately insured population does. The Medicaid population is extremely vulnerable, so policies and procedures that create obstacles to enrolling and obtaining care can have unusually serious consequences for beneficiaries. In addition, Medicaid covers services that other insurers do not, like long-term care. Perhaps most critically, Medicaid provider payments have historically been much lower than those of other insurers, which means that program integrity efforts that impose significant additional administrative burdens could discourage provider participation in the program.

In addition, administering the Medicaid program through its state-federal partnership is complex, and program integrity responsibilities are divided between the two partners with most of the day to day management and program integrity responsibilities residing with the states. This complicates efforts at improving program integrity and makes it critical that state and federal efforts be closely coordinated. Recent budget proposals to reduce the federal matching rate for some state administrative activities, including activities related to program integrity, would make it more difficult for states to improve or upgrade their program integrity activities. In addition, because each state Medicaid program is different from all other programs, with different eligibility rules, benefit packages and provider payment rates, federal efforts at ensuring rules are followed will have to accommodate the very different rules of all 50 states, the District of Columbia, and the five territories.

To maximize the effectiveness of limited resources, many program integrity experts advocate that program integrity efforts focus on high risk areas. The literature reviewed for this paper identifies significant fiscal risks to the Medicaid program in provider billing and financial arrangements, Medicaid's purchasing of prescription drugs, and risks arising related to managed care. In addition, significant quality of care risks exist in long-term care settings, particularly in nursing homes related to beneficiaries not receiving necessary care. Quality of care risks also exist in other settings outside of long-term care and there is some risk related to the provision of unnecessary services to beneficiaries. Few risks were identified with regard to the behavior of beneficiaries, and where such risks do exist the financial exposure of the Medicaid program is low.

The Medicaid Integrity Program is modeled on the *Medicare* Integrity Program, which was created in 1996, along with the Health Care Fraud and Abuse Control Program. One early challenge CMS faced in implementing these programs was reaction from the provider community, which felt that the manner in which CMS and its contractors were implementing new program integrity requirements was burdensome, confusing, and unfair. CMS recalibrated its approach after these concerns were voiced, and in 2003 Congress set restrictions on some *Medicare* program integrity activities. Provider concerns about the potential burden of program integrity assurance efforts in Medicaid could be even stronger, given Medicaid's lower payment rates and more complex administrative structure. In addition, lessons from the *Medicare* Integrity Program should be applied to Medicaid cautiously, given the large differences between these two

programs. Key differences include that Medicaid is largely administered by the states within federal guidelines and that Medicaid beneficiaries are significantly more likely to be served through managed care arrangements. In addition, Medicaid is a means-tested program, and provides a different and broader set of benefits than does Medicare.

Increasing program integrity efforts in Medicaid will likely require a careful and balanced approach, and ideally will be undertaken as a broad effort in which the overall effectiveness and efficiency of the program is maximized and progress is charted toward all of the program's many goals. Targeting efforts to focus on high-risk areas and minimizing efforts in low-risk areas could be critical. There are some clear high-risk areas, and efforts to address them could help promote public confidence in the program. These efforts must be balanced with and integrated with program goals of improving coverage, maintaining access to care, paying providers adequately, ensuring quality care, and enrolling eligible people. At the same time, collaboration between states and the federal government will be central to ensuring that it is possible to provide program integrity in 56 state Medicaid programs that vary considerably from each other and to ensuring that state and federal efforts complement, rather than conflict with, each other.

APPENDIX A

Medicaid Program Integrity Provisions in the Deficit Reduction Act

Medicaid Program Integrity Program (\$255 Million 2006-2010 / \$75 Million each subsequent FY)

- Modeled on the *Medicare* Program Integrity Program, the DRA gives CMS new authority to contract with eligible entities to conduct activities to address fraud and abuse including: 1) review actions of individual or entities that furnish item services under Medicaid to determine whether fraud waste or abuse has occurred, is likely to occur, or has the potential to occur; 2) audit claims for services, including cost reports, consulting contracts, and risk contracts; 3) identify overpayments, and 4) educate providers and beneficiaries about program integrity and quality of care
- Requires CMS to hire 100 full time employees “whose duties consist solely of protecting the integrity of the Medicaid program... by providing effective support and assistance to states to combat *provider* fraud and abuse”
- Requires CMS to develop a comprehensive plan in FY 2006 and then every five years to combat fraud, waste and abuse. The plan must be developed by the Secretary of HHS in consultation with other federal and state officials with responsibilities for controlling *provider* fraud and abuse.
- Appropriates an additional \$25million in each year from 2006 through 2010 for the Office of the Inspector General in HHS for fraud and abuse control activities.
- Requires CMS to submit an annual report to Congress identifying the use of the Medicaid Program Integrity Funds.

Medi-Medi Data Matching Project (\$180 Million 2006-2010 / \$60 Million each subsequent FY)

- Call for a national expansion of the *Medicare*-Medicaid (Medi-Medi) data match program that currently operates in CA, FL, IL, OH, NC, WA, NJ, TX, PA and NY
- Coordinates *Medicare* and Medicaid program integrity efforts to protect both programs from fraud, waste and abuse by matching data and comparing billing patterns for providers that participate in both programs
- Funding levels: appropriations of \$12 million in 2006, \$24 million in 2007, \$36 million in 2008, and \$48 million in 2009 and \$60 in 2010 and in each subsequent fiscal year

Other Program Integrity Provisions of the DRA

- Provides states incentives to establish State False Claims Acts (FCA). Reduces amount of federal repayments from amounts recovered by 10 percentage points from the Medicaid match rate for states with false claims acts that meet federal standards. Also

requires entities receiving annual Medicaid payments in excess of \$5 million to provide Federal False Claims Act education for employees

- Prohibits Medicaid payment for the ingredient cost of a drug for which the pharmacy has already received payment under Medicaid (other than a restocking fee)
- Strengthens requirements and procedures for Medicaid programs to seek payment from third parties and use Medicaid as the payer of last resort.

APPENDIX B

Participants in Medicaid Program Integrity Meeting Kaiser Commission on Medicaid and the Uninsured May 5, 2006

Kathy Allen
Government Accountability Office

Leslie Aronovitz
Government Accountability Office

Toby Edleman
Center for Medicare Advocacy

Barbara Edwards
Health Management Associates

Mike Hash
Health Policy Alternatives

Barbara Lyons
Kaiser Commission on Medicaid and the Uninsured

Rob Falk
Powell Goldstein

Kathy Kuhmerker
The Kuhmerker Consulting Group

Mike Mangano
Strategic Management Systems

Andrea Maresca
National Association of State Medicaid Directors

Jennifer Michael
National Governors Association

Jim Moorman
Taxpayers Against Fraud

Patrick O'Connell
Office of Texas Attorney General
Medicaid Civil Fraud Section

Diane Rowland
Kaiser Commission on Medicaid and the Uninsured

Robin Rudowitz
Kaiser Commission on Medicaid and the Uninsured

Matt Salo
National Governors Association

Andy Schneider
Medicaid Policy, LLC

David Schwartz
Senate Committee on Finance

Penny Thompson
Electronic Data Systems

Victoria Wachino
Wachino Health Policy Consulting

Tim Westmoreland
Georgetown University

ENDNOTES

¹ This paper follows on a shorter issue paper that KCMU published in July 2006. See Victoria Wachino and Robin Rudowitz, “Key Issues and Opportunities: Implementing the New Medicaid Integrity Program,” Kaiser Commission on Medicaid and the Uninsured, July 2006.

² See, for example, Penny Thompson, *Medicaid’s State Federal Partnership: Alternatives for Improving Fiscal Integrity*, Kaiser Commission on Medicaid and the Uninsured, 2001, and Shelly Gehshan, et al., *Moving Beyond the Tug of War: Improving Fiscal Integrity in Medicaid*, National Academy of State Health Policy, 2006.

³ Before 2001, the Centers for Medicare and Medicaid Services was called the Health Care Financing Administration. This paper describes the agency as the Centers for Medicare and Medicaid Services when referring to the agency’s actions and reports, whether those actions or reports were undertaken during, after or prior to 2001.

⁴ Areas that GAO identifies as being “high risk” include both areas that are susceptible to fraud, waste and abuse and to areas that require transformation to achieve better efficiency, effectiveness, and accountability. (Government Accountability Office, *High Risk Series: An Update*, January 2003).

⁵ GAO also raised concerns about state/federal financial management issues and the potential for increased federal costs through waivers of federal Medicaid law.

⁶ Government Accountability Office, *Medicaid Fraud and Abuse: CMS’s Commitment to Helping States Safeguard Program Dollars is Limited*, Statement of Leslie G. Aronovitz in testimony before the U.S. Senate Committee on Finance, June 28, 2005.

⁷ CMS issued a comprehensive program integrity plan for Medicare and Medicaid in 1999, but, according to the Government Accountability Office, “Most of the material in this plan focused on Medicare, and the plan has not been updated since 1999.” *Medicaid Integrity: Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud and Abuse*, Statement of Leslie G. Aronovitz, Testimony Before the Subcommittee on Federal Financial Management, Government Information, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate, March 28, 2006.

⁸ The Department of Health and Human Services and The Department of Justice, *Health Care Fraud and Abuse Control Program, Annual Report for FY 2005*, August 2006.

⁹ Medicaid Alliance for Program Safeguards, *Medicare Medicaid Data Match Projects*, May 2005.

¹⁰ Centers for Medicare and Medicaid Services, *Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program, FY 2006-2010*, July 2006, http://www.cms.hhs.gov/DeficitReductionAct/02_CMIP.asp accessed on September 1, 2006.

¹¹ False claims acts also provide for triple damages to the government and provide awards to whistleblowers of between 15 percent and 30 percent, and whistleblower awards average seventeen percent. For more information see *What is the False Claims Act and Why Is it Important?* and *Model State False Claims Act* at www.taf.org.

¹² Jack Meyer, *Fighting Medicare Fraud: More Bang for the Federal Buck*. Taxpayers Against Fraud Education Fund, July 2006, www.taf.org/FCA-2006report.pdf

¹³ To qualify for the fiscal incentive, a state’s false claims act must contain some provisions that are at least as strong as that of the federal false claims act. The Department of Health and Human Services Office of Inspector General, which will review state false claims acts to determine whether a state qualifies for the fiscal incentive, published guidelines for evaluating whether laws qualify. See *Federal Register* Volume 71, No. 161, Monday August 21, 2006, p. 48552. www.hhs.gov/authorities/docs/06/waisgate.pdf, accessed on September 1, 2006.

¹⁴ See July 25, 2006 letter from Center for Medicaid and State Operations Director Dennis Smith to state Medicaid directors (SMDL #06-017), accessed at <http://www.cms.hhs.gov/SMDL/SMD/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1184900> on August 28, 2006.

¹⁵ Government Accountability Office, *Medicaid Integrity: Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud and Abuse*, Statement of Leslie G. Aronovitz, Testimony Before the Subcommittee on Federal Financial Management, Government Information, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate, March 28, 2006.

¹⁶ Within CMS, the new Medicaid Integrity Program will be run by the Center for Medicaid and State Operations (CMSO). This differs from the organizational approach CMS took to implementing the Medicare Integrity Program, which is housed in the CMS Office of Financial Management. Two other primary program integrity efforts that relate to Medicaid, the Medi-Medi project and the Payment Error Rate Measurement (PERM) program, are also housed within the CMS OFM. CMSO is creating a new Medicaid Integrity group with three functions, in addition to the creation of the comprehensive plan. Those functions are: procuring and overseeing the MIP contractors who will be responsible for program integrity reviews, audits and education; conducting field operations to provide assistance to and oversight of state program integrity efforts, and research and detection functions to help analyze and identify fraud and abuse activities. CMSO has hired contractors to develop an audit program and audit protocols and to measure states' program integrity efforts. Centers for Medicare and Medicaid Services, July 2006.

¹⁷ Centers for Medicare and Medicaid Services, "CMS Launches Comprehensive Effort to Combat Medicaid Fraud and Abuse: Unprecedented Effort to Halt Diversion of Critical Funds," press release, July 18, 2006. <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1900>, accessed on September 1, 2006.

¹⁸ Malcolm Sparrow, *License to Steal: Why Fraud Plagues America's Health Care System*, Westview Press, 1996 p. 26.

¹⁹ Sparrow, 1996, p.169-170.

²⁰ Sparrow, 1996, pp. 28-29.

²¹ Government Accountability Office, *Medicaid: State and Federal Leadership Needed to Control Fraud and Abuse*, Statement of Leslie Aronovitz, Associate Director, Health Financing and Public Health Issues, Health Education and Human Services Division, November 9, 1999 before the Subcommittee on Oversight and Investigations, Committee on Commerce, House of Representatives, GAO/T-HEHS-00-30.

²² Testimony of Patrick J. O'Connell, Chief, Civil Medicaid Fraud Section, Office of the Attorney General of Texas, before the U.S. Senate Committee on Finance, June 28, 2005.

²³ Sparrow, 1996, p. 62.

²⁴ Testimony of Penny Thompson, Program Integrity Director, Health Care Financing Administration, on Medicare and Medicaid Program Integrity Before the House Budget Committee Health Care Task Force, July 12, 2000.

²⁵ Sparrow, 1996, pp. 21-22.

²⁶ Department of Health and Human Services and Department of Justice, *Health Care Fraud and Abuse Control Program, Annual Report FY 2005*, September 2006, www.oig.hhs.gov/publications/docs/hcfac/hcfacreport2005.htm.

²⁷ Government Accountability Office, *Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed*, Report to the Subcommittee on Government Efficiency, Financial Management and Intergovernmental Relations, Committee on Government Reform, House of Representatives, February 2002, GAO-02-300.

²⁸ Testimony of Penny Thompson, July 12, 2000.

²⁹ Pub. L. No. 107-300, 116 Stat. 2350.

³⁰ Government Accountability Office, *Improper Payments: Agencies Fiscal Year 2005 Reporting under the Improper Payments Information Act Remains Incomplete*, GAO-07-92, November 2006.

³¹ These concerns are expressed in a series of documents published by the American Public Human Services Association and the National Association of State Medicaid Directors available at http://www.nasmd.org/issues/PERM_resources.asp, including: 1) "Working Document: PERM: State Challenges and Solutions," March 2007 (accessed March 27, 2007); 2) "PERM Survey: Initial Implementation Information Experiences, February 2007);" 3) Letter from Jerry Friedman and Nancy Atkins to Acting CMS Administrator Leslie Norwalk, October 31, 2006.

³² American Public Human Services Association and National Association of State Medicaid Directors, "Working Document: PERM: State Challenges and Solutions," March 2007 (accessed March 27, 2007)

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- ³³ Testimony of Penny Thompson, July 12, 2000.
- ³⁴ Department of Health and Human Services Office of Inspector General, *Semiannual Report to Congress, April 1, 2006 – September 30, 2006*, accessed at <http://www.oig.hhs.gov/publications/semiannual.html> on January 15, 2006.
- ³⁵ “OIG Reports More than \$38 Billion in Savings and Recoveries for FY 2006,” OIG press release, December 5, 2006, <http://www.oig.hhs.gov/publications/pressmaterials.html>.
- ³⁶ Estimates of savings from OIG recommendations that have not yet been fully implemented can be found at <http://www.oig.hhs.gov/publications/redbook.html#1>.
- ³⁷ See Texas Health and Human Services Commission, *Office of Inspector General Semi-Annual Report*, November 2006, available at <http://www.oig.hhs.gov/publications/pressmaterials.html>.
- ³⁸ Centers for Medicare and Medicaid Services, July 2006.
- ³⁹ Government Accountability Office, *Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments*, Report to the Chairman, Committee on Finance, United States Senate, July 2004.
- ⁴⁰ Sparrow, 1996, p. 20-21.
- ⁴¹ KPMG, “Texas Cracks Down on Medicaid Fraud,” KPMG Analysis, July 16, 2006.
- ⁴² Sparrow, 1996, p. 76-80.
- ⁴³ Government Accountability Office, *Medicaid: State and Federal Leadership Needed to Control Fraud and Abuse*, November 1999.
- ⁴⁴ Peter Cunningham and Jessica May, *Medicaid Patients Increasingly Concentrated Among Physicians*, Center for Studying Health System Change Tracking Report: Results from the Community Tracking Study, No. 16, August 2006.
- ⁴⁵ Sparrow, 1996, p. 213.
- ⁴⁶ Andy Schneider, et al., *The Medicaid Resource Book, Kaiser Commission on Medicaid and the Uninsured*, www.kff.org, July 2002, Chapter IV.
- ⁴⁷ The federal matching rate for MFCUs is 90 percent for the first three years of the MFCU’s operations and 75 percent thereafter.
- ⁴⁸ Forty-eight states have MFCUs. See Department of Health and Human Services Office of Inspector General, *State Medicaid Fraud Control Units Annual Report, FY 2003* <http://www.oig.hhs.gov/publications/mfcu.html>, accessed on September 1, 2006.
- ⁴⁹ Malcolm Sparrow, *Controlling Fraud and Abuse in Medicaid: Innovations and Obstacles*, September 24, 1999, http://www.cms.hhs.gov/FraudAbuseforProfs/03_MedicaidReports.asp#TopOfPage.
- ⁵⁰ Government Accountability Office, *Medicaid: State and Federal Leadership Needed to Control Fraud and Abuse*, November 1999.
- ⁵¹ Government Accountability Office, *Medicaid Financial Management: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts*, June 2006 and Government Accountability Office, *Medicaid Fraud and Abuse: CMS’s Commitment to Helping States Safeguard Program Dollars is Limited*, June 28, 2005.
- ⁵² Government Accountability Office, *Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments*, July 2004.
- ⁵³ Shelly Gehshan, et al., 2006.
- ⁵⁴ Government Accountability Office, *Medicaid: State and Federal Leadership Needed to Control Fraud and Abuse*, November 1999.
- ⁵⁵ National Governors Association, Statement of Raymond C. Sheppach on Short-Term Medicaid Reform before the Medicaid Commission, August 17, 2005.
- ⁵⁶ Government Accountability Office, *Medicaid Integrity: Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud and Abuse*, March 28, 2006.
- ⁵⁷ See Penny Thompson, February 2004 and Penny Thompson, *The Deficit Reduction Act Calls for Federal Leadership and Support on Medicaid Integrity; Ideas for Moving Forward*, eds.com.
- ⁵⁸ Government Accountability Office, *Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments*, July 2004.
- ⁵⁹ Centers for Medicare and Medicaid Services, July 2006.
- ⁶⁰ The primary sources for this review have been: reports related to Medicaid program integrity issues by the GAO and the HHS Office of Inspector General, generally those published since 2000; program integrity documents published by CMS over the past ten years; a catalog of false claims act cases for fiscal years

2004-2007 maintained by Taxpayers Against Fraud, as well as a limited number of reports by some outside experts. In the few specific cases or settlements of allegations of fraudulent or abusive practices in health care, information was taken from settlement agreements, corporate integrity agreements, and press accounts. A review of available state-level program integrity reports was not conducted. For the Taxpayers Against Fraud catalog, see *False Claims Act Fraud Settlements and Judgments*, Fiscal Years 2004, 2005, 2006, and 2007 at <http://www.taf.org/statistics.htm>.

⁶¹ Department of Health and Human Services Office of Inspector General, *Semiannual Report to Congress*, April 1, 2006-September 30, 2006, p. 21.

⁶² Government Accountability Office, *Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments*, July 2004, p.8.

⁶³ In addition, there have been a number of cases involving falsification of cost reports, which Medicare uses as a basis of payment to some types of health care providers. This list was compiled using Andy Schneider, *Reducing Medicare and Medicaid Fraud by Drug Manufacturers: The Role of the False Claims Act* for the Taxpayers Against Fraud Education Fund, November 2003, www.taf.org, "Health care (Medicare and Medicaid) fraud," www.phillipsandcohen.com, as well as relevant GAO and OIG reports.

⁶⁴ See, for example, Government Accountability Office, *Health Care Fraud: Schemes to Defraud Medicare, Medicaid and Private Health Insurers*, Statement of Robert H. Hast, Assistant Comptroller General for Special Investigations, Office of Special Investigations, before the Subcommittee on Government Management, Information, and Technology, Committee on Government Reform, House of Representatives, July 25, 2000, GAO/T-OSI-00-15.

⁶⁵ "OIG Executes Tenet Corporate Integrity Agreement, Unprecedented Provisions Include Board of Directors Review," Department of Health and Human Services press release, September 28, 2006, www.oig.hhs.gov, "FY 2006 False Claims Act Settlements" as of September 20, 2006, www.taf.org/total2006.htm, and Tenet Health Care Settlement Agreement between U.S. Department of Justice and U.S. Office of Inspector General and Tenet Health Care Corporation et al., available at <http://www.taf.org/settlements.htm>.

⁶⁶ For a more complete description of how Medicaid pays for prescription drugs, see Andy Schneider, *Reducing Medicare and Medicaid Fraud by Drug Manufacturers: The Role of the False Claims Act*, November 2003.

⁶⁷ Descriptions of the types of Medicaid drug manufacturer fraud cases are largely based on descriptions in Andy Schneider, *Reducing Medicare and Medicaid Fraud by Drug Manufacturers: The Role of the False Claims Act* November 2003, and Andy Schneider, *The Role of the False Claims Act in Reducing Medicare and Medicaid Fraud by Drug Manufacturers: An Update*, for the Taxpayers Against Fraud Education Fund, November 2004, www.taf.org.

⁶⁸ Testimony of Patrick J. O'Connell, Chief, Civil Medicaid Fraud Section, Office of the Attorney General of Texas, before the U.S. Senate Committee on Finance, June 28, 2005; Susan Drury, "Drug Pushing: Why the FBI, the SEC, and other agency you can think of are investigating a Nashville-based Fortune 500 Company" Nashville Scene, June 15, 2006.

⁶⁹ Andy Schneider, 2004.

⁷⁰ Andy Schneider, 2003.

⁷¹ Andy Schneider, *The Role of the False Claims Act in Combatting Medicare and Medicaid Fraud by Drug Manufacturers: An Update*. Taxpayers Against Fraud Education Fund, February 2007, <http://www.taf.org/publications.htm>.

⁷² *Corporate Crime Reporter*, Volume 21, Number 2, Monday, January 8, 2007.

⁷³ Government Accountability Office, *Medicaid: State and Federal Leadership Needed to Control Fraud and Abuse*, November 1999.

⁷⁴ See Sparrow, September 24, 99.

⁷⁵ Health Care Financing Administration, "Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care," National Medicaid Fraud and Abuse Initiative, October 2000. Note that in 2002 CMS also issued guidelines for states to ensure managed care plan compliance. Both of these documents are available at http://www.cms.hhs.gov/FraudAbuseforProfs/02_MedicaidGuidance.asp#TopOfPage.

⁷⁶ In writing this description of the CMS guidelines for Medicaid managed care, the author also relied on the summary of these guidelines that appears in "Reducing Medicaid Fraud: The Potential of the False Claims Act," by Andy Schneider for Taxpayers Against Fraud, June 2003.

⁷⁷ Health Care Financing Administration, “Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care” and , *Medicaid: State and Federal Leadership Needed to Control Fraud and Abuse*, November 1999.

⁷⁸ Rudolph Bush, “Jury Finds HMO Bias in Signing Patients,” Chicago Tribune, October 31, 2006 and Tom Shean, “Amerigroup Seeks Lower Penalties in Illinois Case,” The Virginian-Pilot, November 29, 2006.

⁷⁹ There are also significant quality of care issues that arise from other issues in program integrity, such as cases involving “patient dumping,” or hospitals’ failure to treat patients with emergency conditions, inappropriate use of patient restraints, etc.

⁸⁰ Department of Health and Human Services, Office of Inspector General, *State Medicaid Fraud Control Units: Annual Report, Fiscal Year 2003*.

⁸¹ Andy Schneider et al., July 2002.

⁸² Government Accountability Office, *Nursing Homes: Prevalence of Serious Quality Problems Remains Unacceptably High, Despite Some Decline*, Statement of William J. Scanlon before the U.S. Senate Committee on Finance, July 17, 2003, GAO-03-1016T.

⁸³ Government Accountability Office, *Nursing Homes: More Can Be Done to Protect Residents from Abuse*, March 2002, GAO-02-312.

⁸⁴ See Hillcrest Healthcare, Maxwell Manor Nursing, Life Care Center of Lawrenceville, GA, Illinois Nursing Home Companies, Inc., O’Hara Regional Center for Rehabilitation, General Health System, Baton Rouge, in *False Claims Act Fraud Settlements and Judgments*, Fiscal Years 2004, 2005, 2006, and 2007 at <http://www.taf.org/statistics.htm>.

⁸⁵ Government Accountability Office, *Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety*, January 17, 2006, GAO-06-117.

⁸⁶ Government Accountability Office, *Long Term Care: Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should Be Strengthened*, June 2003, GAO-03-576.

⁸⁷ For a full explanation of the changes made under the DRA to the provision of Medicaid long-term care services, see Jeffrey S. Crowley, *Medicaid Long-Term Services Reforms in the Deficit Reduction Act*, Kaiser Commission on Medicaid and the Uninsured, April 2006.

⁸⁸ The DRA also changes the requirements for who may obtain home and community based services and allows states to place restrictions, such as waiting lists, on their home and community based programs.

⁸⁹ Sparrow, 1996, p. 214.

⁹⁰ OIG reviews and audits have described instances in which one state made payments on behalf of beneficiaries whose eligibility file documentation did not meet requirements or who did not meet eligibility requirements (Department of Health and Human Services Office of Inspector General, *Review of Medicaid Eligibility in New York State*, October 2006, A-02-05-01028); some states have continued to make payments on to providers for services provided to deceased beneficiaries (HHS Office of Inspector General, *Audit of Selected States’ Payments for Services Claimed to Have Been Provided to Deceased Beneficiaries*, September 2006, A-05-05-00030) and some beneficiaries are enrolled in two states’ Medicaid programs (HHS Office of Inspector General, *Medicaid Payments for Beneficiaries with Concurrent Eligibility in Ohio and Michigan*, June 2006, A-05-06-00021).

⁹¹ Danielle Holahan and Elise Hubert, *Lessons from States with Self-Declaration of Income Policies*, United Hospital Fund, 2004. In addition, an OIG review noted that the streamlined design of the SCHIP and Medicaid enrollment process helps ensure that states are accurately determining children’s eligibility for separate SCHIP programs, rather than erroneously enrolling Medicaid-eligible children in SCHIP. (Department of Health and Human Services Office of Inspector General, *State Children’s Health Insurance Program: Ensuring Medicaid Eligibles are not Enrolled in SCHIP*, February 2001, OEI-05-00-00241).

⁹² Brenda C. Spillman, et al., *Beyond Cash and Counseling : The Second Generation of Individual Budget-based Community Long Term Care Programs for the Elderly*, Kaiser Commission on Medicaid and the Uninsured, January 19, 2007.

⁹³ Crowley, April 2006.

⁹⁴ Joan Alker, *What Will Florida’s Medicaid Reform Legislation Mean for Children?* Georgetown University Health Policy Institute Center for Children and Families, November 2005 (updated January 4, 2006), www.ccf.georgetown.edu.

⁹⁵ Celia Hagert, *Updating and Outsourcing Enrollment in Public Benefits: The Texas Experience*, Center for Public Policy Priorities, November 2006, <http://www.cppp.org/research.php?aid=582&cid=3>. See also

presentation by Celia Hagert, Texas Center on Public Policy Priorities, to the Texas Association of Area Agencies on Aging, November 30, 2006, <http://www.cppp.org/research.php?aid=595>.

⁹⁶ Letter from Carole Keehan Strayhorn, Texas Comptroller of Public Accounts, to The Honorable Eliot Shapleigh, Carlos I. Uresti, and Carter Casteel, Austin TX, October 26, 2006. <http://www.window.state.tx.us/comptrol/letters/accnture/index.html>.

⁹⁷ HIPAA also defined which contractors could participate in the Medicare Integrity Program. Title 42 U.S.C., Chapter 7, Subchapter XVIII, Part E, Section 1395ddd.

⁹⁸ HIPAA, together with subsequent legislation, the Balanced Budget Act of 1997, also increased penalties for federal health care offenses, increased exclusion periods, and increased federal fraud detection capabilities.

⁹⁹ U.S. Department of Health and Human Services, *HHS Annual Plan, FY 2007*, www.hhs.gov/budget/07budget/FY2007AnnualPlan.pdf

¹⁰⁰ See Program Assessment Rating Tool, Detailed Information on the Medicare Integrity Program Assessment at ExpectMore.gov; www.whitehouse.gov/omb/expectmore/detail.10000470.2005.html. According to HHS, it works to achieve these goals by educating providers through CMS and its claims processing contractors, clarifying coverage and payment rules with an emphasis on ease and simplification for providers, promoting voluntary compliance while ensuring that the actions of providers who are trying to defraud the program are addressed and strengthening oversight of Medicare contractors. See U.S. Department of Health and Human Services press release, "Reducing Payment Errors and Stopping Fraud in Medicare," May 7, 2002. www.hhs.gov/news/press/2002pres/fraud.html.

¹⁰¹ Centers for Medicare and Medicaid Services *Improper Medicare FFS Payments Report, November 2006, Long Report*, U.S. Department of Health and Human Services, May 18, 2006. The improper Medicare payment reports, a product of CMS' Comprehensive Error Rate Testing (CERT) program, also report error rates by contractor and contractor type, by type of error, and reports the types of services with the highest error rates. Prior to 2003, the HHS Office of Inspector General calculated the improper payment rate.

https://www.cms.hhs.gov/apps/er_report/preview_er_report.asp?from=public&which=long&reportID=5&ab=4

¹⁰² Government Accountability Office, *Improper Payments: Agencies Fiscal Year 2005 Reporting under the Improper Payments Information Act Remains Incomplete*, GAO-07-92, November 2006.

¹⁰³ Government Accountability Office, *Medicare Integrity Program: Agency Approach for Allocating Funds Should Be Revised*, September 2006. GAO reported that CMS' estimate of the return on investment for MIP audit functions was zero due to a change in the method of paying most providers, and that MIP's two other primary activities, benefit integrity and provider education, are measured qualitatively.

¹⁰⁴ In addition, the Government Accountability Office is required to review the amounts appropriated to and from the trust fund that are reported in the annual HCFAC report.

¹⁰⁵ Department of Health and Human Services and Department of Justice, *Health Care Fraud and Abuse Control Program, Annual Report FY 2005*.

¹⁰⁶ According to the report, these amounts include "recoveries from health care investigations -- including criminal fines, forfeitures, civil settlements and judgments, and administrative penalties, but excluding restitution, compensation to the victim agency, and relators' shares."

¹⁰⁷ However, the Government Accountability Office notes, in its 2005 review of the HCFAC reports, that not all of the savings that have been achieved since 1997 are attributable to the HCFAC program; most savings that have been achieved thusfar are from activities that predate the HCFAC program. GAO noted that the first time HCFAC generated savings to the Medicare Trust Fund was in FY 2002. See *Health Care Fraud and Abuse Control Program: Results of Review of Annual Reports for Fiscal Years 2002 and 2003*, Government Accountability Office, April 2005. In addition, the Office of Management and Budget urged OIG to develop additional measures of its performance in addition to recovery measures. See Program Assessment Rating Tool, Detailed Information on the Health Care Fraud and Abuse Control Assessment at ExpectMore.gov; www.whitehouse.gov/omb/expectmore/detail.10000292.2005.html.

¹⁰⁸ Jack Meyer, *Fighting Medicare Fraud: More Bang for the Federal Buck*, Taxpayers Against Fraud Education Fund, July 2006.

¹⁰⁹ Government Accountability Office, *Medicare Management: CMS Faces Challenges in Safeguarding Payments While Addressing Provider Needs*, Statement of Leslie Aronovitz before the Special Committee on Aging, U.S. Senate, July 26, 2001.

¹¹⁰ Testimony of Michael Hash, Deputy Director of the Health Care Financing Administration Before the House Commerce Subcommittee on Health and the Environment, June 27, 2000.

www.cms.hhs.gov/apps/media/press/testimony.asp?Counter-591 accessed on September 5, 2006.

¹¹¹ Government Accountability Office, September 2006.

¹¹² See *Joint Explanation Statement of the Committee of Conference*, Conference Report to Accompany H.R. 1, Medicare Prescription Drug, Improvement, and Modernization Act of 2003, November 21, 2003.

¹¹³ Government Accountability Office, *Medicare: Opportunities and Challenges in Contracting for Program Safeguards*, Report to Ranking Member, Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Committee on Appropriations, U.S. Senate, May 2001.

¹¹⁴ Department of Health and Human Services Office of Inspector General, *Medicare's Program Safeguard Contractors: Performance Evaluation Reports*, OEI-03-04-00050, March 2006.

¹¹⁵ Cunningham and May, August 2006.

¹¹⁶ Department of Health and Human Services Office of Inspector General, *Improper Fiscal Year 2002 Medicare Fee-for-Service Payments*, January 2003

¹¹⁷ Centers for Medicare and Medicaid Services, *2004 Medicaid Managed Care Enrollment Report*. www.cms.hhs.gov/MedicaidDataSourcesGenInfo.

¹¹⁸ Andy Schneider, et al., July 2002.

¹¹⁹ Stephanie Peterson and Marsha Gold, *Tracking Medicare Health and Prescription Drug Plans*, Monthly Report for April 2007 for the Kaiser Family Foundation, accessed at www.kff.org on May 2, 2007.

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1330 G STREET NW, WASHINGTON, DC 20005
PHONE: (202) 347-5270, FAX: (202) 347-5274
WEBSITE: WWW.KFF.ORG/KCMU

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