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MEDICAID PROGRAM INTEGRITY

State and Federal Efforts to Prevent and Detect Improper Payments

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Highlights

Highlights of GAO-04-707, a report to the Chairman, Committee on Finance, U.S. Senate

Why GAO Did This Study

During fiscal year 2002, Medicaid—a program jointly funded by the federal government and the states—provided health care coverage for about 51 million low-income Americans. That year, Medicaid benefit payments reached approximately $244 billion, of which the federal share was about $139 billion. The program is administered by state Medicaid agencies with oversight provided by the Centers for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services. Medicaid's size and diversity make it vulnerable to improper payments that can result from fraud, abuse, or clerical errors. States conduct program integrity activities to prevent, or detect and recover, improper payments. This report provides information on (1) the types of provider fraud and abuse problems that state Medicaid programs have identified, (2) approaches states take to ensure that Medicaid funds are paid appropriately, and (3) CMS's efforts to support and oversee state program integrity activities. To address these issues, we compiled an inventory of states' Medicaid program integrity activities, conducted site visits in eight states, and interviewed CMS's Medicaid program integrity staff.

www.gao.gov/cgi-bin/getrpt?GAO-04-707.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Leslie G. Aronovitz at (312) 220-7600.

What GAO Found

Various forms of fraud and abuse have resulted in substantial financial losses to states and the federal government. Fraudulent and abusive billing practices committed by providers include billing for services, drugs, equipment, or supplies not provided or not needed. Providers have also been found to bill for more expensive procedures than actually provided. In recent cases, 15 clinical laboratories in one state billed Medicaid $20 million for services that had not been ordered, an optical store falsely claimed $3 million for eyeglass replacements, and a medical supply company agreed to repay states nearly $50 million because of fraudulent marketing practices.

States report that their Medicaid program integrity activities generated cost savings by applying certain measures to providers considered to be at high risk for inappropriate billing and by generally strengthening their program controls for all providers. Thirty-four of the 47 states that completed our inventory reported using one or more enrollment controls with their high-risk providers, such as on-site inspections of the applicant's facility, criminal background checks, or probationary or time-limited enrollment. States also reported using information technology to integrate databases containing provider, beneficiary, and claims information and conduct more efficient utilization reviews. For example, 34 states reported conducting targeted claims reviews to identify unusual patterns that might indicate provider abuse. In addition, states cited legislation that directed the use of certain preventive or detection controls or authorized enhanced enforcement powers as lending support to their Medicaid program integrity efforts.

At the federal level, CMS is engaged in several initiatives designed to support states' program integrity efforts; however, its oversight of these state efforts is limited. CMS initiatives include two pilots, one to measure the accuracy of each state's Medicaid claims payments and another to identify aberrant provider billing by linking Medicaid and Medicare claims information. CMS also provides technical assistance to states by sponsoring monthly teleconferences where states can discuss emerging issues and propose policy changes. To monitor Medicaid program integrity activities, CMS teams conduct on-site reviews of states' compliance with federal requirements, such as referring certain cases to the state agency responsible for investigating Medicaid fraud. In fiscal year 2004, CMS allocated $26,000 and eight staff positions nationally for overseeing the states' Medicaid program integrity activities, including the cost of compliance reviews. With this level of resources, CMS aims to review 8 states each year until all 50 states and the District of Columbia have been covered. From January 2000 through December 2003, CMS has conducted reviews of 29 states and, at its current pace, would not begin a second round of reviews before fiscal year 2007. This level of effort suggests that CMS's oversight of the states' Medicaid program integrity efforts may be disproportionately small relative to the risk of serious financial loss.