Deficit Reduction Act Important Facts for State Policymakers

April 1, 2007

Fighting Medicaid Fraud and Abuse

Fraud and abuse in the Medicaid program diverts dollars that could otherwise be spent to safeguard the health and welfare of beneficiaries.

Background

Although States are primarily responsible for policing fraud in Medicaid, the Centers for Medicare & Medicaid Services (CMS) provides technical assistance, guidance and oversight for these efforts. The Deficit Reduction Act (DRA) included three provisions that address Medicaid program integrity and target fraud and abuse.

The CMS Medicaid Integrity Program

The CMS Medicaid Integrity Program (MIP) was established by Section 6034 of the DRA and provides more resources to fight Medicaid fraud, waste, and abuse. CMS has developed, and will regularly update, a five-year Comprehensive Medicaid Integrity Plan to guide MIP development and operations. The MIP's major operational roles will be to review provider activities, audit claims, identify overpayments, conduct provider education, and to provide effective support and assistance to States in their efforts to combat provider fraud and abuse. The CMS Medicaid and Medicare Integrity Programs will collaborate on fraud prevention and detection, including the national expansion of the Medicare-Medicaid Data Match pilot project, better known as "Medi-Medi." The DRA also provides the Department of Health & Human Services Office of Inspector General (OIG) with additional funding to expand its Medicaid fraud activities. Other partners include State Medicaid agency officials and Federal and State law enforcement agencies.

False Claims Acts

The DRA also has two False Claims Act related provisions to promote fraud "whistleblower" activities in Medicaid. The federal False Claims Act permits a person with knowledge of fraud against the United States Government to file a lawsuit on behalf of the Government against the entity that committed the fraud. If the action is successful, the plaintiff is rewarded with a percentage of the recovery.

Section 6031 of the DRA creates financial incentives for State fraud and abuse laws. If a State enacts a False Claims Act that is closely modeled on the federal version of the law, CMS will increase the State's share of any amounts recovered under such a law by 10 percent. The OIG has released guidelines for State legislatures to enact State False Claims Acts.

Section 6032 of the DRA requires any entity that receives or makes payments under the State Medicaid program of at least $5,000,000 annually, to provide False Claims Act education to their employees. CMS issued a State Medicaid Director letter with guidance on what constitutes an "entity" covered under this provision.