Medicaid Fraud: Who You Gonna Call?

By Bill Benson and Nancy Aldrich

Health Benefits ABCs

Almost every state has a Medicaid Fraud Control Unit (MFCU) that investigates and prosecutes Medicaid fraud. Federal law requires each state to have a MFCU to investigate and prosecute Medicaid provider fraud, as well as patient abuse and neglect, in health care programs and home health services that participate in Medicaid. Medicaid is a state-federal health insurance program for qualifying low-income and needy people, including certain older adults.

Most MFCUs are located in state offices of the attorney general, but seven are housed in other state agencies such as law enforcement units, according to the National Association of Medicaid Fraud Control Units (NAMFCU). MFCUs receive most of their referrals for suspected Medicaid fraud from their state Medicaid agency's program integrity or surveillance units. "That is the main source of our referrals," NAMFCU Executive Director Barbara Zelner said. MFCUs also have ongoing relationships with AARP, state ombudsman programs and adult protective services agencies, Zelner added. Some state MFCUs have hotlines for reporting Medicaid fraud, do public outreach and produce brochures.

Unlike the federally operated Medicare program, states hold the primary responsibility to detect and control Medicaid fraud and abuse, according to the U.S. Government Accountability Office (GAO). Only one state, North Dakota, has a waiver from having a MFCU because it demonstrated that there is a minimal amount of Medicaid fraud and that Medicaid beneficiaries are protected from abuse and neglect, according to NAMFCU.

How much Medicaid fraud is there?

According to GAO, there are no estimates of Medicaid fraud. Zelner said she was unaware of anyone who collected data on Medicaid fraud against older adults. GAO estimated in 2003 that a nationwide improper Medicaid payment rate as low as 3 percent would have meant a loss of almost $4.6 billion in federal funds. In that year, Medicaid covered nearly 54 million people, and the program's benefit payments totaled $261 billion, of which the federal share was about $153 billion.

Anti-fraud activities by MFCUs in the last fiscal year amounted to more than $1.3 billion in recoveries, Assistant Attorney General Tony West said at the NAMFCU 2009 Annual Training Program in Louisville, KY.

What is Medicaid fraud?

According to NAMFCU, Medicaid fraud can be perpetrated by individual practitioners, such as submitting claims for services they did not provide, or by large institutions that claim to have provided higher levels of care or more care than was actually provided. Medicaid fraud can also be committed by beneficiaries, although this type of fraud is not within the jurisdiction of the MFCU. It would be a state welfare fraud bureau that would investigate Medicaid fraud by individuals, Zelner explained.

"Fraud in nursing homes can range from cost report fraud (billing for unnecessary medical services or services never provided), to theft of patient trust funds, to theft of patients' private funds whether a credit card, piece of jewelry, cash that is in their room," Zelner said. "Also in the nursing homes, MFCUs can investigate complaints of resident abuse and neglect," she noted. One of the difficulties for detecting Medicaid fraud is that patients do not receive an Explanation of Benefits like they do under the Medicare program, Zelner added.

GAO reported in 2009 that Medicaid paid for controlled substance prescriptions filled for deceased beneficiaries or "written" by dead doctors. "The extent to which these claims were paid because of fraud is not known," GAO said. That is because, for example, certain nursing homes use long-term care pharmacies to fill prescriptions for drugs and these nursing homes may not notify pharmacies of a resident's death.

A new survey by the National Governors Association and National Association of State Budget Officers indicates that 28 states plan to reduce Medicaid payments in fiscal year 2011 to health care providers. Another 20 states have proposed freezing provider payments, 25 states plan to eliminate or limit benefits, nine states plan to delay expansions and eight states plan to institute new or higher copayments. (The survey is online at http://www.nga.org/Files/pdf/FSS1006.PDF).

To report Medicaid fraud, contact your state MFCU. You can identify a state MFCU by going to http://www.namfcu.net/states.

Medicaid Fraud Schemes

The following are typical schemes that providers use to defraud the Medicaid program, according to NAMFCU:

• Billing for services not provided - A provider bills for blood tests, x-rays or other services that were not given, or a nursing home continues to bill for services rendered to a patient who is no longer at the facility either because of a death or transfer.

• Double billing - A provider bills both Medicaid and a private insurance company (or recipient) for treatment, or two providers request payment on the same recipient for the same procedure on the same date.

• Billing for phantom visits - A provider falsely bills the Medicaid program for patient visits that never take place.

• Billing for more hours than there are in a day - A provider inflates the amount of time spent with patients; for example a psychiatrist bills for more than 24 hours of psychotherapy treatment on a day.

• Falsifying credentials - Misrepresenting the qualifications of a licensed provider in order to defraud Medicaid. For example, a physician allows a non-physician to impersonate a licensed doctor who medically treats patients and prescribes drugs and then bills the Medicaid program.

• Substitution of generic drugs - A pharmacy bills Medicaid for the cost of a brand-name prescription but actually supplies a generic substitute.

• Billing for unnecessary services or tests - A provider falsifies the diagnosis and symptoms on recipient records and billings to obtain payments for unnecessary laboratory tests or equipment.

• Billing for more expensive procedures than were performed - A provider bills for a comprehensive procedure when only a limited one was administered or bills for expensive equipment but supplies lower-cost substitutes.

• Kickbacks - A nursing home owner or operator requires another provider, such as a laboratory, ambulance company or pharmacy, to pay owner/operator a certain portion of the money received for rendering services to patients in the nursing home. Examples of this type of payment include vacation trips, personal services and merchandise, leased vehicles and cost payments.