State and Local Government
Health Care Expenditures as a Share of Revenue

Health care spending grew more than twice as fast as revenue between 1987 and 2011, intensifying the pressure on state and local budgets.
1987-2021
State and Local Government
Health Care Spending by Category
(Actual and Projected)

$800
2011 dollars in billions

Medicare contributions for public employees
$11.3b

$148.4b Health insurance for public employees

$145.7b Other programs

$164.8b Medicaid

Spending growth has consistently outpaced inflation, rising at an annual average rate of 7.7 percent between 1987 and 2011.
Wrong recipient.

Right recipient receives incorrect amount of funds.

$11 Billion State Medicaid Improper Payments
Source: CMS

Insufficient documentation.

Recipient uses funds improperly.
ALABAMA: 2009

Provider Regulation: Excluding Problem Providers

Deactivation of the Medicaid provider number when the address is unknown

The Alabama Medicaid Agency deactivates a provider's Medicaid provider number when mail is returned due to a problem with the provider's address and an attempt to find the correct information has failed. The provider number stays deactivated until the address issue is resolved.

Routine checking for excluded providers

The Alabama Medicaid Agency (AMA) runs its Medicaid provider list, through its fiscal agent, against the List of Excluded Individuals/Entities each month. Soon after the CMS Medicaid Integrity Group review, AMA began checking its state list of excluded providers with the Department of Industrial Relations to see if any excluded persons are working elsewhere, for example, as managing employees. The state exclusion list includes both the Medicare Exclusion Database and Alabama-initiated exclusions.
Health Care Challenges in the States
This issue brief is part of a series that explores promising state efforts to manage health care costs across a range of spending areas.

ISSUE BRIEF
Combating Medicaid Fraud and Abuse

Fraud and abuse in Medicaid threaten Americans’ health and well-being by draining funds needed for legitimate care and potentially subjecting patients to unnecessary or ineffective tests and treatments. The toll on state and federal budgets is substantial. In 2012, an estimated $19 billion—or 7 percent—of federal Medicaid funds was absorbed by improper payments, which include fraud and abuse as well as unintentional mistakes such as paperwork errors. Improper payments totaled an estimated $1.1 billion—or 9 percent—tremendous Medicaid budgets in 2010, the most recent year for which data are available.

Addressing these problems has become more urgent as the program expands to serve more people. In part because of unemployment and other financial hardships caused by the Great Recession, states’ Medicaid enrollments grew to 53 million in June 2011, up from 34 million a decade earlier. And many states are preparing to extend coverage with the implementation of the Affordable Care Act in 2014.

Use our database to learn about hundreds of state strategies to reduce fraud and abuse. www.pewstates.org/Medicaid-fraud
Provider Accountability
- Excluding Problem Providers

Provider Regulation

Prepayment Review
- Service Verification
- Prior Authorization and Claims Review
- Recipient Lock-In

Post Payment Recovery
- Data Mining
- Detection and Investigation
- Penalties and Recovery
- Medicaid Fraud Control Unit Coordination

Cross-Cutting
- Stakeholder Coordination
- Provider Outreach and Education
- Managed Care Oversight
- Targeting High-Risk Providers
• Provider Accountability
• Excluding Problem Providers

Provider Regulation

Kentucky
Innovative provider enrollment and exclusion checking techniques.
• Service Verification
• Prior Authorization and Claims Review
• Recipient Lock-In

Prepayment Review

New York
Patients swipe benefit cards. Select providers must post orders before another provider can bill the transaction. Combined cost savings of $683 million from 2008 to 2011.
Georgia

Three-day readmit project.

Post Payment Recovery

- Data Mining
- Detection and Investigation
- Penalties and Recovery
- Medicaid Fraud Control Unit Coordination
California

Uses a Medicaid Payment Error Study to identify provider types at greatest risk for payment errors.

• Stakeholder Coordination
• Provider Outreach and Education
• Managed Care Oversight
• Targeting High-Risk Providers

Cross-Cutting

State Health Care Spending Project | www.pewstates.org/healthcarespending
Majority of states’ actions are focused on providers.

Important to strike balance between combating fraud and abuse without overburdening honest providers and harming access.
Affordable Care Act
Medicaid Program Integrity Provisions
(Among Others)

- Targeted screening.
- Temporary enrollment freeze.
- Payment suspensions.
- Recovery Audit Contractor (RAC).
- Coordinated provider termination.
Total FFY 2009 PI Expenditures: $394 million
Total FFY 2009 Recoveries: $2.3 billion

Source: CMS State Program Integrity Assessment FY 2009 Executive Summary
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Mission

The Georgia Department of Community Health

We will provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight.

We are dedicated to A Healthy Georgia.
Georgia Department of Community Health

Office of Inspector General

Honor. Performance. Integrity.
DCH OIG Medicaid PI Objectives

- Safety and Security of our Member
- Fiduciary Responsibility to the Tax Payer
Layers of Protection for High Priority Target
Enrollment

- Site Visits for Moderate and High Risk area providers
- Random Site Visits
- Revalidation
- Constant Provider enrollment criteria review
  - SSA Death Master File
  - LEIE (List of Excluded Individuals and Entities)
  - EPLS (Excluded Parties List System)
  - Licensure
Pre-Payment Safeguards

- Beneficiary Eligibility
- Provider/Beneficiary Education
- Prior Authorization
- Provider Contracts
Prevention

- Presence
- Education – information
- Communication
- Self-disclosure
• Medi-Medi State Collaborative
• Collaborate with MCO’s
• Diversion in ALF/NH (remaining meds being taken)
• Take Back Day (Realty Scam)
• States can make CDS more restrictive than Federal

• Restricted recipients/lock-in
• Quantity limits reasonable time/location
• Data analytics – effective search, review, look for
  1) Commonly diverted drugs
  2) High or low reversal volume
  3) Pharmacy & pain medication naive patient suddenly on high dose
• Use of Pain Management contracts
• ACA rule regarding referring/ordering prescribers
System Testing

The OIG must be able to review not only providers and payments, but also the actual MMIS vendor. Complete access to everything in, and pertaining to, that system is absolutely necessary for the OIG.
Post-Payment Safeguards

- Explanation of Benefits
- Remittance Notices to Providers
- Audits/Investigations/Reviews
- Fraud Investigations & Referrals
- Self Disclosure