126th Legislature
Appropriations and Financial Affairs
Proposal for Inclusion in 2nd Supplemental Budget

State of Maine

Proposal:

- Implementation of a robust surveillance and utilization review of Medicaid payments to providers and consumer uses of Medicaid services to determine the extent of fraud and abuse in the Medicaid System and secure repayment of state and federal funds that have been erroneously expended.

- The Surveillance and Review will be conducted by an independent entity experienced in surveillance and utilization review. The goal is to secure repayment of $7 million in state funds.

Justification

According to the National Council of State Legislatures [NCSL], "fraud and abuse account for between 3% and 10% of Medicaid payments nationwide, yet the average state recovery rate id only 0.09 percent." The range of the states' recoveries of fraudulent Medicaid payments, however, is from less than 0.01 percent to a little more than 1 percent because most states have not invested in fraud recovery and prevention programs. "Most state anti-fraud units have a backlog of cases due mainly to limited staff," according to the NCSL.

Roughly 72 percent of all health care fraud is committed by medical providers, 10% by consumers, and the balance by insurers and their employees.

Healthcare fraud and abuse includes, but is not limited to:

- Billing for services not performed,
- Falsifying diagnoses,
- Billing for more costly services than performed,
- Accepting kickbacks for referrals,
- Ordering excessive or inappropriate tests,
- Overstating the insurer's cost in paying claims
- Billing for covered services when non-covered services are performed,
- Billing for individual therapy sessions for each person attending the group session,
- Insurance company misleading enrollees about health plan benefits.

Total MaineCare [Medicaid] funding in Maine for FY 2013 was $ 2.5 billion in state and federal funds. **Using NCSL data, total Medicaid fraud in Maine could range from 3% or $75,000,000 to 10% or $250,000,000**. Of these amounts,

- **Provider** fraud in Maine [72% of total Medicaid fraud] could range from $54,000,000 or 3% to $180,000,000 for a 10% rate of fraud.

- **Consumer fraud** could range from $7,500,000 for a 3% rate of fraud to as much as $25,000,000 for a 10% rate of fraud in federal and state funds.

A review of State Auditor findings over the past years shows a total of 58 findings of non-compliance and significant deficiencies in DHHS compliance with accepted financial procedures and fraud control. Most findings are recurring deficiencies. Many involve findings of "inadequate controls," "inadequate procedures," inadequate controls over billing," "non-compliance with cash management procedures," "**inadequate surveillance and review of Medicaid services," "Inadequate controls over provider eligibility requirements**," etc.

The most serious investigative finding that is consistently stated throughout the audit is **"corrective action not completed in FY 2010."** As a result, it is necessary that DHHS immediately undertake a vigorous investigation of Medicaid fraud.

The most efficient and effective approach to address provider fraud is to contract the investigation to a professional audit organization. The Department should develop a request for proposal as soon as possible to undertake this activity. The Department of Health and Human Services has too many problems with its data systems to undertake the proposed MaineCare fraud investigation. The contract can be funded from the savings from the investigation.

NCSL points out that "**concerted state anti-fraud and abuse efforts save states millions – and in some cases – billions of dollars each year, and states potentially could double or even triple their collections."** "Officials at the federal Centers for Medicare and Medicaid Services estimate the return on each $1 invested in health care fraud prosecution is between $2 and $7."

States that have undertaken robust Medicaid fraud investigations in recent years have experienced substantial recoveries. Anti Medicaid fraud and abuse enforcement in Texas increased recoveries by $200 million over a two-year period. New York saved $132 million in one year.