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Savings in Medicaid Series

Increase Prevention and Detection of Fraud, Waste and Abuse

Issue Defined

Fraud, waste and abuse plague the health care industry and account for hundreds of billions of dollars lost annually, affecting taxpayers, the Medicare and Medicaid programs and all of their stakeholders. Although there is increased awareness, as well as action being taken, more can be done to prevent and detect fraud, waste and abuse.

Fraud is the intentional deception or misrepresentation that an individual or entity makes knowing this could result in unauthorized benefits to that individual, entity or some other party. Fraud is not committed by accident or mistake. Examples include billing for services not rendered, altering or falsifying documentation, paying or receiving a kickback for services, and purposefully charging a fee for items that carried no cost.

Waste results in the expenditure of resources in excess of need. Waste can simply be the result of sloppy, careless or inefficient billing or treatment. This carelessness results in unnecessary costs being incurred by the Medicaid program. Unlike fraud, waste does not involve the intent to deceive or misrepresent. Examples include unintentional duplicate claim submissions for the same service and improper coding resulting in unnecessary payments.

Abuse is an activity inconsistent with generally accepted business, medical or fiscal standard practices. These practices would be unintentional and include such examples as billing for services not medically necessary; inappropriate or insufficient documentation to support services billed; quality of care issues that fail to meet professionally recognized standards; and services mistakenly billed that should not be paid for by Medicaid

Background

According to the Joint Commission, the United States spends more than $2 trillion on health care annually. Industry experts estimate that between 3 and 10 percent – or approximately $60 billion to $200 billion – is lost to fraud each year. This loss directly impacts health care insurers, Medicare, Medicaid and consumers through higher costs of care, insurance premiums and taxes. Financial losses caused by health care fraud are only part of the story, as health care fraud may result in unnecessary or unsafe procedures. Individual victims of health care fraud are exploited and subjected to unnecessary or unsafe medical procedures, or whose medical records are compromised or whose legitimate insurance information is used to submit falsified claims.

It is estimated that between 30 to 40 cents of each health care dollar is wasted, that is, spent on no-value-added activities. The proportion of the national gross domestic product devoted to health care spending is 50 percent greater than in any other country and growing, without any evidence that the quality of health care in the United States is comparatively better or improving.

Recommendations

State governments play an integral role in the prevention and detection of fraud, waste and abuse. In advancing these efforts, state Medicaid programs may want to consider implementing the following strategies:

- *Partner with managed care organizations (MCOs) that take fraud, waste and abuse seriously.* Since they are closer to the perpetrators – providers, members or even their own employees – MCOs are naturally effective partners in detection and prevention. MCOs that are experienced in combating fraud, waste and abuse typically share the following characteristics:
  - They have a robust fraud, waste and abuse plan or policy in place that includes an education initiative targeting employees, contracted providers, and the program beneficiaries they serve
  - They have successful track records in detecting and preventing fraud, working with external resources such as state regulatory agencies and law enforcement and prosecutorial entities
  - They use technology, including data mining and anti-fraud tools, to enhance their efforts.
- *Set more demanding contract requirements that result in less fraud, waste and abuse.* If the regulations within a state's contract with an MCO are unclear, vague or lenient, this may open the door for fraud, waste and abuse. States should consider including stringent requirements regarding:
  - *Provider network.* If managed care organizations' recruiting and credentialing processes are contractually held to a higher standard, it may eliminate the number of unscrupulous providers entering the Medicaid system.
  - *Performance penalties related to fraud, waste and abuse.* Financial liability for performance will likely increase an MCO's commitment to – as well as its time and monetary investment in – fraud, waste and abuse efforts.

Savings Outlook

Although states can not realistically eliminate the total amount of health care spending lost to fraud, waste and abuse, there remains a significant amount of savings that can be realized if additional detection and prevention measures are taken nationwide. Conservatively, if increasing anti-fraud measures result in a 3 percent savings in health care spending as estimated by the National Health Care Anti-Fraud Association, a savings of $60 billion can be achieved. If additional waste prevention and detection efforts demonstrate a decrease to 25 cents of each health care dollar wasted (versus the 30 to 40 cents of each health care dollar wasted according to the Joint Commission), a national savings of between $1 billion and $3 billion can be realized.

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