



Medicaid Improper Payments

Background

In late April 2012, the program review committee authorized a study to describe and evaluate the processes the state uses to prevent, detect and recover any improper payments in the Medicaid program due to fraud, abuse, and errors.

Medicaid, a means-tested medical assistance program for the poor, elderly, and disabled, is authorized under Title XIX of the Social Security Act of 1965. It is jointly funded by federal and state governments.

In Connecticut, the Department of Social Services (DSS) is responsible for administering the Medicaid program. Connecticut's Medicaid program is one of the state's largest expenditures, representing over one-fifth of the state budget. It receives 50 percent reimbursement from the federal government for most services provided.

The federal government requires the state, through DSS, to develop procedures that protect the integrity of Connecticut's Medicaid program by reducing the amount of improper payments that result from fraud, abuse, and errors. These program integrity measures are implemented by the department's Office of Quality Assurance (OQA).

OQA is required to refer cases of suspected fraud to the state's Medicaid Fraud Control Unit (MFCU), located in the Office of the Chief State's Attorney for possible criminal prosecution.

Referrals are also made to the Office of the Attorney General for civil litigation. Furthermore, other sanctions against a provider's license and ability to write prescriptions may be taken by the Departments of Public Health and/or Consumer Protection.

Main Points

Improper payments are defined in the Improper Payments Information Act of 2002 (as amended). An improper payment: 1) means any payment that should not have been made or that was made in an incorrect amount; and 2) includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received, and any payment that does not account for credit for applicable discounts.

Improper payment can result from:

- *Error*: inadvertent actions resulting from mistakes, misinterpretation of rules, or poor recordkeeping;
- *Fraud*: intentional deception or misrepresentation made to obtain unauthorized benefits; and
- *Abuse*: actions inconsistent with sound, fiscal, business, or medical practices that result in unnecessary costs.

Examples of improper Medicaid payments:

- Missing or insufficient documentation;
- Upcoding – billing for more expensive procedure than performed;
- Unbundling – separate billing for services that should be billed together;
- Billing recipient for difference between provider charge and Medicaid rate; and
- Failing to properly bill a third party since Medicaid is the payor of last resort.

Multiple federal and state agencies are involved in preventing, detecting, and possibly sanctioning clients and providers who receive improper payments. Figure 1 shows the major players at the federal and state level who have a role in preventing, detecting, and recovering payment for claims that were improperly paid, as well as those agencies that impose sanctions where fraud is found.

Medicaid program integrity activities. Figure 2 shows that program integrity activities can focus on two areas: 1) preventing improper Medicaid payments from being made for ineligible clients or to providers; or 2) identifying and recovering payments that have already been made, and possibly imposing sanctions that may result.

Next Steps

PRI staff will be evaluating how well state agencies perform their Medicaid program integrity responsibilities by assessing standards and measures used by DSS to discover and monitor improper payments. As part of that, staff will examine the extent of coordination among the entities that exists to combat fraud and abuse.

Figure 1. Major Agencies Relevant to Medicaid Improper Payments

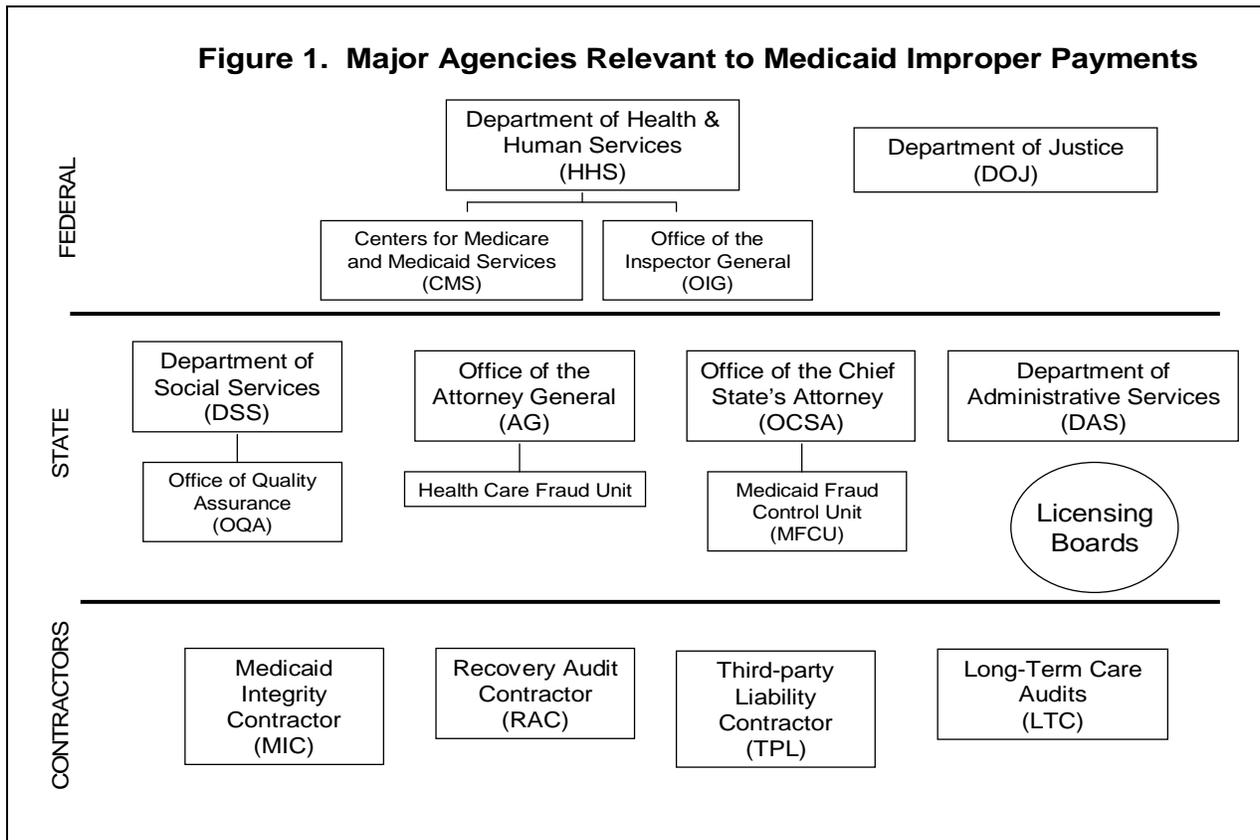


Figure 2. Medicaid Program Integrity Activities

