STRATEGIC MANAGEMENT SERVICES

Results of 2022 Medicaid Enforcement Efforts

Richard P. Kusserow | March 2023

Key Points:

- **MFCUs reported 1,327 convictions and $1.1 billion in recoveries in 2022**
- **Medicaid Enforcement return to Pre-Pandemic levels**
- **Common types of Medicaid fraud cases**

The 2023 Compliance Benchmark Survey by SAI360 and Strategic Management found about one in five responding organizations had encounters with a state Medicaid Fraud Control Unit (MFCU) within the last three years. However, for those providers in the long-term sector, the rate was likely much higher. This evidences significant Medicaid enforcement activity, which was underscored by the OIG in their 2023 "Medicaid Fraud Control Units Fiscal Year 2022 Annual Report" on results in all 50 States, the District of Columbia, Puerto Rico, and U.S. Virgin Islands. The report cited 1,327 convictions (946 for fraud and 381 for patient abuse or neglect) and 553 civil settlements. In addition, there were reported criminal and civil recoveries of $1.1 billion ($416 million criminal, $641 million civil). This further evidences the return to the pre-COVID levels of enforcement. During the Pandemic there was relaxation on enforcement that focused on delivering care to beneficiaries. Enforcement is now being stepped up to address a backlog of potential fraud cases by providers who improperly took advantage of the massive increase in funding and reduced controls during the crisis. This renewed effort will include ensuring compliance with the Affordable Care Act provisions requiring skilled nursing homes to implement effective compliance programs to guard against fraud and abuse. Among the most common types of Medicaid fraud cases being encountered are:

- Paying kickbacks for referrals for medical services or items
- Collaborating with beneficiaries to file claims for tests and services not performed
- Providing incorrect information to gain ineligible Medicaid benefits
- Billing for services at a higher level of complexity than provided
- Claiming reimbursement for someone other than an eligible beneficiary

- Drug diversion through fraudulent billing or other illegal activities
- Billing for medically unnecessary treatments and products
- Performing unnecessary tests or giving unnecessary referrals, known as “ping-ponging”
- Billing for services that weren’t provided in the form of “phantom billing” and upcoding
- Charging separately for services usually charged at a package rate, known as “unbundling”
- Falsifying medical credentials to treat patients and prescribe drugs
- Billing for the cost of a brand-name prescription when a generic drug was supplied
- Falsifying diagnosis and symptoms for unnecessary laboratory tests or equipment
- Billing for a comprehensive procedure when only a limited one was administered
- Billing for expensive equipment and providing cheap substitutes
- Nursing homes submitting falsified cost reports

For answers to compliance FAQs, see https://www.compliance.com/faqs/.

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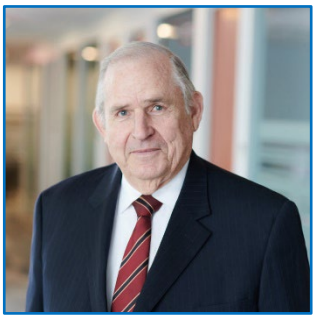

About the Author

Richard P. Kusserow established Strategic Management Services, LLC, after retiring from being the DHHS Inspector General, and has assisted over 2,000 health care organizations and entities in developing, implementing and assessing compliance programs.